CLINICAL EDUCATION: Economic Models and Clinical Education Principles
Session Overview

- A word about the presenters
- Learning objectives
- *Clinical Education Principles*
- Economic models in clinical education
- Panel presentations on five different models of clinical education (including available data)
- Participant question and answers
- Session wrap up
Presenters

- Jody Gandy, PT, DPT, PhD
- Ken Harwood, PT, PhD, CIE
  - American Physical Therapy Association
- LTC Stephen Goffar, PT, PhD, OCS
  - US Army Baylor University
- M Kathleen Kelly, PT, PhD
  - University of Pittsburgh
  - Director, EIM Orthopaedic Residency
  - VP of Clinical Excellence, Texas Physical Therapy Specialists
  - Associate Professor, Texas State University
- Dee Schilling, PT, PhD
  - Western University of Health Sciences
- Susan Tomlinson, PT, DPT
  - Arcadia University
- LTC Robert Wainner, PT, PhD, OCS, ECS, AAOMPT
Learning Objectives

- Describe the current status related to Clinical Education Principles for physical therapist education.
- Describe ways in which academic programs and clinical sites could use this voluntary document as a resource.
- Describe literature review on economic models used in physical therapist clinical education.
- Describe academic and clinical education programs that are using unique clinical education models and how they are integrating economic models and clinical education principles, and collecting data related to learner, clinical instructor, program, and patient outcomes.
- Discuss the implications and evidence associated with the five clinical education models and how this could apply to academic and clinical education programs.
CLINICAL EDUCATION PRINCIPLES: Where are we now?

- **December 2007**
  - Developed clinical education standards and preferred model of clinical education through a consensus-based conference.

- **September 2008 - October 2009**
  - Conducted 15 regional forums throughout the US to obtain specific comments from all stakeholders involved in clinical education on the performance outcomes standards for new graduates and CIs and obtained feedback about the strengths and limitations of the preferred model of clinical education.
CLINICAL EDUCATION
PRINCIPLES: Where are we now?

- **February 2010**
  - Final report compiled that integrated comments and feedback from 1000 persons for review at the March Board of Directors meeting.

- **March 2010**
  - APTA Board of Directors approval: “That the [Clinical Education Principles](#) for new graduate and clinical instructor performance be made available to physical therapist academic and clinical educators as a resource for their use in curriculum planning.”
CLINICAL EDUCATION PRINCIPLES: How can this resource be used?

- Discuss the new graduate performance outcome principles with academic and clinical faculty and examine how these relate to current program outcomes.
- Discuss the clinical instructor performance outcomes with academic and clinical faculty to assess the level of investment and willingness to partner to address these principles.
CLINICAL EDUCATION PRINCIPLES:
How can this resource be used?

- Determine the resources required to achieve the clinical instructor performance outcomes and how these could be shared or used to incentivize clinical educators.
- Discuss with stakeholders the preferred model of clinical education and identified strengths and challenges to assess if any components should be further explored or tested.
**CLINICAL EDUCATION PRINCIPLES:**
How can this resource be used?

- Explore the strengths and challenges of current program models to identify where models could be enhanced and studied to provide evidence for best practice in clinical education.
- Discuss how models of clinical education maybe affected by healthcare reform for future planning.
APTA will be developing and funding a grant process to investigate innovative models of clinical education in 2010.

- Proposals should include measures of cost-effectiveness, student performance outcomes, patient outcomes, economic models used, and defined expectations for quality clinical sites and clinical instructors.
CLINICAL EDUCATION PRINCIPLES: Next Steps?

- APTA will develop a compilation of resources (innovative clinical education models, research, reports, etc) accessible to all stakeholders that further define quality and evidence in clinical education.
ECONOMIC MODELS IN CLINICAL EDUCATION
Increasing demands and expectations on students and clinical instructors.
Increasing federal regulations and payment policies that were unfavorable for clinical education.
Anecdotal evidence from the education community on decreasing placements.
Anecdotal evidence from the practitioners on the growing business case against having clinical education programs.
Medicare Part A: Concurrent Therapy

- The treatment of 2 residents, who are not performing the same or similar activities, at the same time, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant.
- When a therapy student is involved with the treatment, and one of the following occurs, the minutes may be coded as concurrent therapy:
  - The therapy student is treating one resident and the supervising therapist/assistant is treating another resident and the therapy student is in line-of-sight; or
  - The therapy student is treating 2 residents, both of whom are in line-of-sight of the therapy student and the supervising therapist/assistant; or
  - The therapy student is not treating any residents and the supervising therapist/assistant is treating 2 residents at the same time, regardless of payer source, both of whom are in line-of-sight.

May 2010 CMS’s RAI Version 3.0 Manual CH 3: MDS Items (pg 19)
Increase the array of economic and organizational models for academic and clinical education and physical therapist residencies and fellowships to optimize resource utilization.
Literature Review

- Worked with APTA Information Resources to search on multiple terms for clinical education, health care, and economic models.
- Included both quantitative ad qualitative studies
- Majority reviewed clinical education model structure and format with focus on student outcomes (although few had objective measures).
- No studies included patient level measures (satisfaction, outcomes)
Two studies described financial models that addressed “business case for clinical education”.

- Unable to apply results to present system due to changes in regulatory and payment policy changes.

Two studies of note:

Perspectives article.
Described needs for Clinical Education, models and tools utilized, how models and tools met the identified needs.
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Adapted from Strohschein, et al
“Limitations in the number of sites for clinical education, reductions in staffing, administrative policies, staff attitudes, and reimbursement practices...necessitate creative and innovative approaches to accommodate clinical education while maintaining acceptable levels of productivity and quality of care.”

- Strohschein, Hagler, May
Lekkas et al. No model of clinical education for physiotherapy students is superior to another: A systematic review

- Systematic Review: quantitative and qualitative studies
- Questions:
  - Which models of clinical education for PT students is superior (looked at multiple disciplines)?
  - What are the advantages, disadvantages and recommendations for implementation of different models of clinical education?
- Models: (1:1, 1:2, 2:1, 2:2, non discipline specific educator, & student as educator)
- Outcomes: productivity, student assessment; and advantages and disadvantages and recommendations
Results:

- 3662 articles reviewed, 3372 excluded and 61 underwent formal review.
- 44 quantitative studies, 17 qualitative
- No systematic reviews, all others level 4 (Case series or poor quality cohort/case–control) or level 5 (expert opinion)
- 53% literature in PT from 4 countries (UK, US, Australia, Canada)
Conclusions:

- No model was superior or a gold standard.
- Model quality was based on opinion and anecdotal and historical evidence.
- Higher level studies demonstrated equivocal results while lower level studies unanimously supported the models they explained.
- Although the purpose of many studies was to build placement capacity, the majority of the studies failed to identify the impact of the model on placement capacity.
From an Australian perspective, there is a growing sense of unease regarding the sustainability of historical models of clinical education due to funding restrictions in the education and healthcare sectors, an exponential growth of universities providing physiotherapy programs and a decreasing source of patients in clinical placements.

- Lekkas, et al.
International Perspective

- Review of other countries clinical education models:
  - Economic system
  - Health Care system
  - Education system
    - e.g. Canada

- International Summit on Education
Conclusions

- No current literature on economic impact of clinical education.
- No current information on patient outcomes in practices that have clinical education programs.
- Need to identify multiple aspects of CE when determining best models. (e.g. student learning, economics, regulatory and legislative policy)

Future Directions/Opportunities
- Medpac report
- Patient Protection and Affordable Care Act (PPACA)
Without change there is no innovation, creativity, or incentive for improvement. Those who initiate change will have a better opportunity to manage the change that is inevitable.

William Pollard
Models of Clinical Education