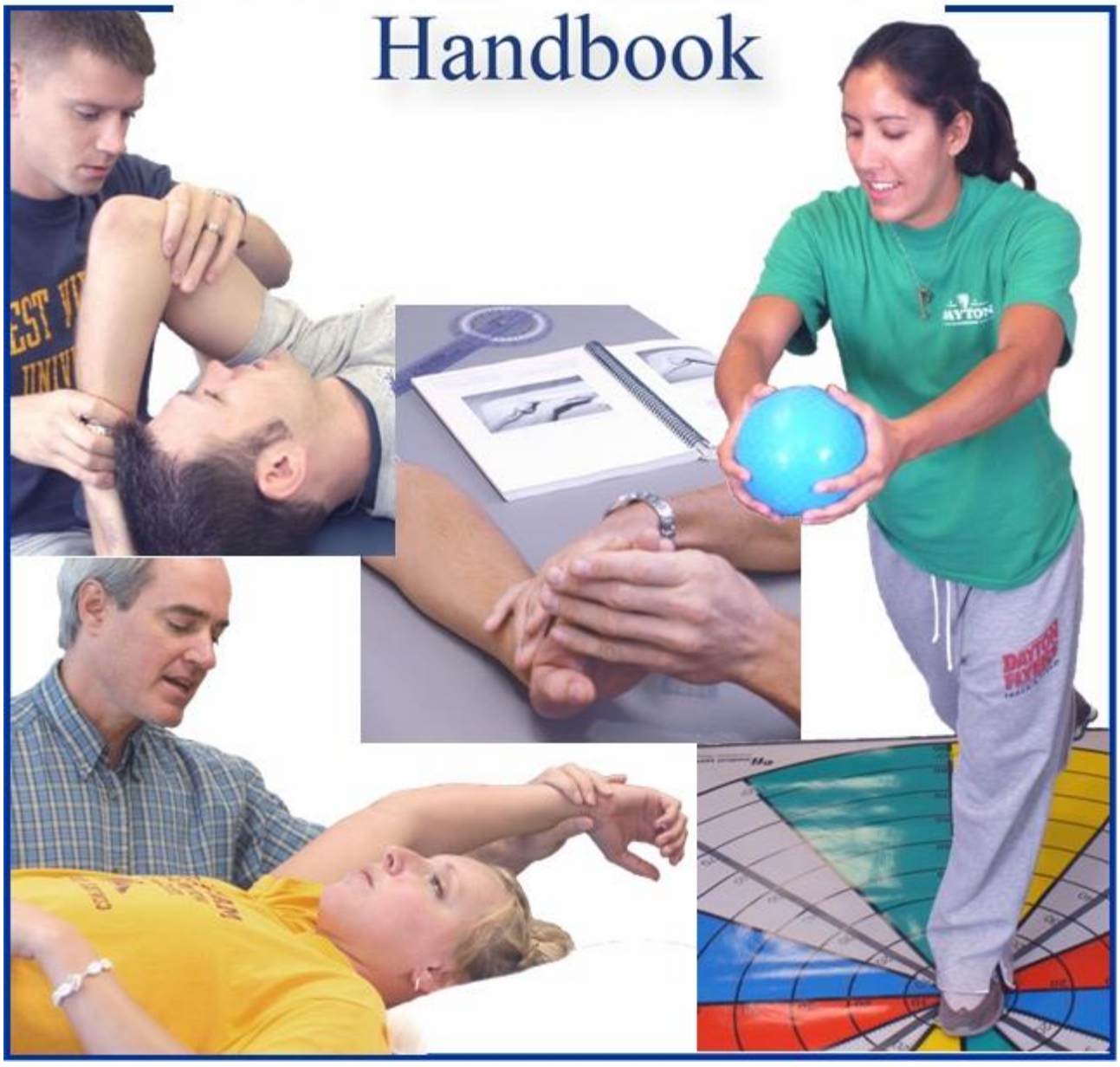
UNIVERSITY of DAYTON

Doctor of Physical Therapy

Clinical Educator's Handbook



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Mission, Goals, & Objectives

Mission

In accordance with the mission of the University of Dayton and the School of Education and Allied Professions, the fundamental purpose of the Program in Physical Therapy is to provide high quality physical therapist education in the context of the Catholic faith. The physical therapist professional education program at the University of Dayton aims to graduate knowledgeable, service-oriented, self-assured, adaptable, reflective practitioners who, by virtue of critical and integrative thinking, lifelong learning, and ethical values, render independent judgments concerning patient/client needs that are supported by evidence; promote the health of the client; and enhance the professional, contextual, and collaborative foundations for practice. The program faculty and graduates will contribute to society and the profession through practice, teaching, administration, and the discovery and application of new knowledge about physical therapy. The program will offer an education with structured and varied experiences of sufficient excellence and breadth that allows for the acquisition and application of essential knowledge, skills, and behaviors that can be applied to the practice of physical therapy. *(Adapted "A Normative Model of Physical Therapist Professional Education, 2004")*

Goals:

I. The UD DPT program goals related to **Teaching and Learning** are:

a. The program will provide an education that promotes for effective, evidence-based, ethical physical therapy service to all clients, communities, and areas of need.
b. The program will provide an education and opportunities that fosters the development of essential professional and ethical behaviors.
c. The program faculty will maintain current clinical/content expertise through active clinical involvement and/or professional development activities.

These goals are measured by the following outcomes:

1. The graduation rate will be equal to or higher than the national average.
2. The pass rate on the NPTE will be equal to or higher than the national average.
3. The employment rate will be equal to or higher than the national average.
4. Fifty percent or greater of graduates (with greater than one year post-graduation) will become clinical instructors.
5. Seventy five percent or greater of the core faculty will hold a terminal degree (PhD or equivalent).
6. Sixty percent or greater of the eligible core faculty will be board-certified specialists.
7. Greater than 10% of graduates will be involved in teaching within the physical therapy profession as identified in the 3 Year Graduate Survey.
8. Eighty percent or greater of responses to teaching and learning related questions on the UD DPT Graduate Surveys will be scored 4 or 5 (on a 1-5 scale).

II. The UD DPT program goals related to professional **Leadership and Advocacy** are:

a. The program will encourage faculty and students to assume leadership roles within the profession and
the community.
b. The program will encourage and provide opportunities for faculty and students to advocate for positive
change for the profession of physical therapy.

These goals are measured by the following outcomes:

1. One hundred percent of eligible faculty and students will be members of the APTA.
2. Eighty percent or greater of faculty will be members of other professional organizations as documented on their CV.
3. Thirty five percent or greater of program graduates will be members of the APTA as indicated in the UD DPT 3 year graduate survey.
4. Ten percent or greater of program graduates or faculty will hold leadership positions in the Physical Therapy profession as indicated in the UD DPT graduate surveys.
5. Ten percent or greater of program graduates will hold employment positions that involve supervisory duties as indicated in the 3-year UD DPT graduate surveys.
6. Eighty percent or greater of responses to leadership and advocacy related questions on the UD DPT Graduate Survey will be scored 4 or 5 (on a 1-5 scale).

III. The UD DPT Program Goals related to **Scholarship** are:

a. The program faculty and students will be committed to lifelong learning.
b. The program faculty and students will demonstrate critical analysis and reflective thinking.
c. The program will contribute to the advancement of knowledge through scholarship.

These goals are measured by the following outcomes:

1. Program faculty will average one peer reviewed publication annually.
2. Program faculty will average one peer reviewed presentation annually.
3. The collective core faculty will disseminate at least 9 scholarly products as described in the Characteristics of Scholarship document outlined by CAPTE.
4. One hundred percent of student will complete a graduate research project under the mentorship of program faculty.
5. One hundred percent of students will present research at a professional meeting.
6. Eighty percent or greater of responses to scholarship related questions on the UD DPT Graduate Survey will be scored 4 or 5 (on a 1-5 scale).

IV. The UD DPT Program Goals related to **Service** are:

a. The program faculty and students will demonstrate a commitment to the community through service.
b. The program faculty and students will demonstrate integration of the Marianist Charisms in the practice of physical therapy.

These goals are measured by the following outcomes:

1. One hundred percent of students will demonstrate evidence of participation in at least eight hours of community service each year as documented by the UD DPT office.
2. The program faculty will demonstrate evidence of at least 25% of their faculty workload in university and community service during their annual review.
3. The program will offer at least one Chapel service per month as documented by the UD DPT office.
4. Eighty percent or greater of responses to service related questions on the UD DPT Graduate Survey will be scored 4 or 5 (on a 1-5 scale).

Objectives for Clinical Rotations

1. Establish patient and peer rapport through effective communication skills.
2. Determine an evaluation strategy and perform examinations for the appropriate patient population. Evaluation includes a comprehensive patient chart review, patient history, and physical examination.
3. Establish treatment strategies and patient-centered outcomes and goals.
4. Research diagnoses and conditions using appropriate resources.
5. Perform evaluations and provide treatment under the supervision of a licensed Physical Therapist.
6. Explore and critique treatment effectiveness and adjust plans accordingly.
7. Interact successfully with payers, ancillary services, and health care services and make recommendations or referrals as appropriate.
8. Plan and prepare for appropriate patient discharge and demonstrate effective documentation.
9. Present an in-service or case report to the affiliation site's staff.

Contracting

A student will only be given a clinical assignment in those facilities which have a signed written agreement between that facility and University of Dayton. Most clinical sites have signed the standard University of Dayton Agreement. If a "non-standard" agreement has been signed, the green file folder in the clinical education department will be tagged. Students are encouraged to review the clinical education agreement prior to beginning their clinical assignment. Contract folders are available for review in the clinical Education Department during regular business hours.

Philosophy of Clinical Education

University of Dayton is dedicated to providing quality clinical education in a variety of clinical settings both locally and throughout the United States. Approximately one-third of the entire three year doctoral level program is performed in the clinical setting. An objective of the Physical Therapy program is to prepare students for their clinical rotations above and beyond the "norm" for student performance. The problem-based format of education has greatly enhanced the students' ability to problem solve, apply critical information to each unique patient situation, and to "think on their feet" as they move from case to case. Another important feature of the curriculum has been to prepare the students didactically for a specific type of rotation and then follow up by having their clinical placement "match" that patient population. Although it is not always possible to make a "match" with 100% accuracy, every attempt is made. An overview of clinical rotations is as follows:

- General Medicine (6 weeks): Ideally, this rotation takes place in a setting where patients are more medically complex. Examples of settings that work well for this rotation are inpatient acute care, skilled nursing, long term care, home health, and inpatient rehabilitation. Outpatient settings can work well when the clinical instructor plans the student's caseload to include patients who require medical monitoring or those with comorbidities.

- Neuro/Rehab (8 weeks): Can be performed in an inpatient or outpatient setting with an emphasis in a neurologic patient population. Pediatric settings are also appropriate at this level of the curriculum.

- Orthopedic (12 weeks): Performed in an outpatient orthopedic or sports medicine environment.

- Elective (12 weeks): Unless a student has a specific need (i.e., they require more exposure to a certain population), this rotation allows a student to further develop in an area of their choosing. Decisions are made in cooperation with the ACCE.

Because University of Dayton has a very strong commitment from its professional community, most students are provided the option of remaining in the local vicinity while performing their clinical responsibilities. **(Note: "Local" is defined as being within a 90 mile radius from the School)** Provisions are also available for students who wish to travel outside the 90 mile radius. (See section #8 under the heading "Student Guidelines for Clinical Education" for further details).

Students are expected to participate in clinical activity on a full-time basis during clinical rotations. Regular classes are not scheduled. While on rotation, students are given the opportunity to practice their newly acquired skills, as well as learn how to function as a professional in a variety of settings. Students are assigned to a clinical instructor at each facility. The ACCE at the University of Dayton is available to both the Clinical Instructor and the student to provide guidance, counsel, and assistance as needed. The ACCE also performs regular random on-site visits to follow up with students and their instructors during the clinical rotations. Students will be assessed according to the national APTA performance criteria and are graded on a pass/fail basis.

Clinical Education Faculty Rights and Privileges

(Revised February 8, 2010)

Clinical Education Faculty members (Center Coordinators of Clinical Education and Clinical Instructors) of the University of Dayton's Doctor of physical therapy program have the following rights and privileges associated with their participation in the DPT clinical education program:

1. To be treated fair, with dignity and without discrimination by all students and UD Faculty.
2. Invitation to an annual clinical education continuing education seminar provided by the Ohio Consortium of Physical Therapy Programs (UD DPT Program is a member). This program is offered in the spring each year at rotating locations around the state; at very low cost to Clinical Education Faculty of participating programs ($25) and for which Ohio approved CEUs are provided. Each clinical education site affiliating with an Ohio Consortium educational program is sent an invitation inviting the entire staff to these programs.
3. All CIs who have supervised UD DPT students during a given calendar year are invited as complimentary guests to the Annual Graduate Research Presentation Night and Keynote Stuart Lecture address each May.
4. The right to request individual in-services by the clinical site regarding effective teaching strategies, as well as presentations on requested topics in their areas of specialization.
5. The right to request assistance from the academic program in dealing with clinical education issues or problems that arise in clinic.
6. The right to attend periodic continuing education sponsored by the UD DPT Program.
7. The right to library privileges. A request to the ACCE is required and then a library card is issued by the DPT program.
8. The right to receive information regarding affiliating students, changes in clinical education, and the physical therapy program in a timely fashion.
9. The right to terminate a student's participation in the clinical education experience if it is felt that the continued participation of a student is unsafe, disruptive, or detrimental to the clinical site or patient care, or otherwise not in conformity with the clinic's standards, policies, procedures, or health requirements.

Competencies and Objectives by Rotation

Clinical Rotation I: General Medicine

For successful completion of this course, the student must meet each of the following objectives:

1. Establish patient and peer report through effective communication skills.
2. Determine an evaluation strategy and perform examinations for a "general or acute" patient population. Evaluation would include a comprehensive patient chart review, patient history, and physical examination.
3. Establish treatment strategies and patient centered outcomes and goals.
4. Research diagnoses and conditions using appropriate resources.
5. Perform evaluations and provide treatment under the supervision of a licensed Physical Therapist.
6. Explore and critique treatment effectiveness and adjust plans accordingly.
7. Interact successfully with payers, ancillary services, and health care services and make recommendations or referrals as appropriate.
8. Plan and prepare for appropriate patient discharge and demonstrate effective documentation.
9. Providing an in-service or case report is recommended as part of the requirements.

At this level of their education, students are expected to be able to demonstrate competency in the following tests and measures:

- Vital signs (BP, HR, Respiratory rate, and pulses)
- Assess breathing patterns and auscultation of heart and lungs
- Anthropomorphic measures for height, weight, length, and girth
- Basic assessment of patient orientation
- Analysis of basic assistive and adaptive devices
- Analysis of kinematics including gait and balance scales and Wheelchair mobility
- Evaluation of skin and wounds including skin integrity, wound location, shape, size, depth, color, drainage, odor, and infection
- Basic analysis of posture (static and dynamic) including observation and palpation.
- Basic Musculoskeletal Exam including Joint Play Tests, MMT , DTRs, palpation, and functional and goniometric ROM (active and passive), including end-range feel.
- Basic myotome and dermatome screens
- Assessment of autonomic responses to position changes
- Analysis of thoracoabdominal movement, breathing patterns, capillary refill
- Analysis of heart and lung auscultation, pulse oximetry, vital signs and pulmonary function

Students are also expected to demonstrate competency in performing the following interventions:

- Breathing strategies (pursed lip, paced, stair case breathing)
- Wound care for dressing changes, oxygen therapy, hydrotherapy, and topical agents
- TENS
- Basic ADL training, transfers, and gait techniques
- Assistive equipment (walkers, canes, crutches)
- Modalities (cryotherapy, superficial and deep thermal, CPM, tilt table, and compression.
- Therapeutic exercise: aerobic endurance, conditioning, strengthening, stretching, and flexibility

Clinical Rotation II: Neurology

For successful completion of this course, the student must successfully meet each of the following objectives:

1. Establish patient and peer report through effective communication skills
2. Determine an evaluation strategy and perform examinations for a "neurologic" patient population. Evaluation would include a comprehensive patient history and chart review, and physical examination.
3. Establish treatment strategies and patient centered outcomes and goals.
4. Research diagnoses and conditions using appropriate resources.
5. Perform evaluations and provide treatment under the supervision of a licensed Physical Therapist.
6. Explore and critique treatment effectiveness and adjust plans accordingly.
7. Interact successfully with payers, ancillary services, health care services and make recommendations or referrals as appropriate
8. Plan and prepare for appropriate patient discharge or discontinuation of Physical Therapy and demonstrate effective documentation.
9. Providing an in-service or case report is recommended as part of the requirements.

At this level of their education, students are expected to be able to build on the objectives from Clinical Rotation I as well as demonstrate competency in taking the following tests and measures:

- Assessment of arousal attention and cognition using standardized measures
- Assessment of level of consciousness and memory
- Assessment of orientation to person, place, time and events
- Analysis of assistive and adaptive devices and components
- Assessment of alignment and fit of assistive device as well as patient's ability to use it
- Utilization of ADL scales or indexes
- Assessment of cranial nerve integrity including dermatomes, gag reflex, swallowing, and muscles innervated by cranial nerves
- Assessment of response to auditory, gustatory, olfactory, visual and vestibular stimuli.
- Analysis of kinematics including gait on various terrains and surfaces and safety assessment
- Analysis of stereotypic movements, postural equilibrium, and righting reactions
- Assessment of sensorimotor integration and Motor Assessment scales
- Assessment of muscle tone and functional strength, power and endurance
- Neuromotor development and sensory integration including age and sex appropriate development, involuntary movement, reflex movement patterns, gross and fine motor skills, and motor control and motor learning
- Assessment of pain perception (e.g. phantom pain)
- Analysis of self-care and home management activities including safety and adaptive skills
- Sensory integrity including combined cortical sensations, deep sensations, gross receptive, and superficial sensations

Students are also expected to build on the skills developed during Clinical Rotation I as well as demonstrate competency in performing the following interventions:

- Assistive cough techniques and suctioning
- Electrotherapeutic modalities including functional and neuromuscular electric stim
- ADL training and assistive and self-care or home management task adaptation
- Assistive and adaptive devices (beds, raised toilet seats, seating systems, etc.)
- Balance & coordination training, developmental activities, motor learning, and therapeutic exercise

Clinical Rotation III: Orthopedics

For successful completion of this course, the student must successfully meet each of the following objectives:

1. Establish patient and peer report through effective communication skills
2. Determine an evaluation strategy and perform examinations for an "Orthopedic" patient population. Evaluation would include a comprehensive patient history, chart review, and physical examination.
3. Establish treatment strategies and patient centered outcomes and goals.
4. Research diagnoses and conditions using appropriate resources.
5. Perform evaluations and provide treatment under the supervision of a licensed Physical Therapist.
6. Explore and critique treatment effectiveness and adjust plans accordingly.
7. Interact successfully with payers, ancillary services, and health care services and make commendations or referrals as appropriate
8. Plan and prepare for appropriate patient discharge or discontinuation of Physical Therapy and demonstrate effective documentation
9. Providing an in service or case report is recommended as part of the requirements.

At this level of their education, students are expected to be able to build on the objectives from Clinical Rotations I and II, as well as demonstrate competency in taking the following tests and measures:

- Environmental and ergonomic analysis of community, work and leisure activities
- Assessment of functional capacity
- Analysis of physical space including identification of current and potential barriers, measurement of space, and inspection of the environment
- Body mechanic analysis of selected task and activities
- Analysis of biomechanical, kinematic, and kinetic aspects of gait, locomotion and balance
- Assessment of skin integrity including color, warmth, sensation, mobility, turgor, texture and positions and postures that may jeopardize skin integrity
- Assessment of scar tissue
- Joint integrity and mobility including assessment of hyper and hypomobility and joint play
- Assessment of dexterity, coordination, agility, and physical performance scales
- Assessment of oromotor, phonation and speech production
- Analysis of pain behavior and reaction during movement including use of questionnaires, graphs, and scales
- Analysis of resting, static and dynamic postures using plumb lines, posture grids, videos, etc.
- Analysis of functional range of motion, environment, and tasks

Students are also expected to build on the skills developed during Clinical Rotations I and II,, as well as demonstrate competency in performing the following interventions:

- Wound care management including adaptive and protective devices, debridement and physical and mechanical agents
- Electrotherapeutic modalities including, muscle stim, and iontophoresis
- Functional training including adaptive and protective equipment, ergonomic training, injury prevention, leisure, and play activity training
- Manual therapy techniques (i.e. connective tissue massage, joint mobilization, manual traction, soft tissue mobilization, and massage)
- Mechanical traction
- Therapeutic exercise including body mechanics and ergonomics, gait, locomotion, and

neuromuscular education/reeducation, relaxation and inhibition

Clinical Rotation IV: Contract Clinical

For successful completion of this course, the student must successfully meet each of the following objectives:

1. Establish patient and peer report through effective communication skills
2. Determine an evaluation strategy and perform examinations for a non-specified patient population. Evaluation would include a comprehensive patient history, chart review, and physical examination.
3. Establish treatment strategies and patient centered outcomes and goals.
4. Research diagnoses and conditions using appropriate resources.
5. Perform evaluations and provide treatment under the supervision of a licensed Physical Therapist.
6. Explore and critique treatment effectiveness and adjust plans accordingly.
7. Interact successfully with payers, ancillary services, health care services and make recommendations or referrals as appropriate
8. Plan and prepare for appropriate patient discharge or discontinuation of Physical Therapy and demonstrate effective documentation
9. Providing an in-service or case report is recommended as part of the requirements.

At this level of their education, students are expected to be able to build on the objectives from Clinical Rotations I, II and III as well as demonstrate competency in taking the following tests and measures:

- Interpretation of oxygen consumption and analysis of electrocardiogram
- Measurement of body fat composition
- Assessment of edema (palpation, girth, volumetrics)
- Assessment of functional capacity
- Assessment of response to manual provocation tests
- Analysis of myoelectric activity using EMG, nerve conduction, etc.
- Electrotherapeutic modalities including biofeedback
- Dynamometry
- Orthotic devices including analysis of need, effects and benefits, alignment and fit, safety and proper care and use
- Prosthetic devices including analysis of need, effects and benefits, alignment and fit, safety, proper care and use and assessment of residual limb
- Muscle length testing
- Reflex integrity including normal and pathological reflexes
- Ventilation assessment including cough and sputum and ability to clear airway

Students are also expected to build on the skills developed during Clinical Rotations I, II and III, as well as demonstrate competency in performing the following interventions:

- Airway clearance techniques including assistive devices (e.g. flutter valve), Autogenic drainage, chest percussion, vibration, shaking and pulmonary postural drainage and positioning
- Functional training for environmental adaptation (job, school, play), job coaching, and functional training programs
- Orthotic and protective devices including taping, splints, braces, shoes, casts, and helmets
- Prosthetic device or equipment training

Guidelines for Clinical Sites

DISCLAIMER: We are not attorneys, nor do we consider ourselves experts in interpreting Medicare policy. We encourage you to visit this topic with your facility's risk management officer.

Q: What are the program's guidelines regarding clinical affiliations?

A: The University of Dayton Doctor of Physical Therapy Program has adopted the APTA's guidelines for clinical sites as outlined by the House of Delegates and the Board of Directors as our policy and our guidance as well. As the guidelines may be updated from time to time, we are providing a link to the APTA's guideline pages.

Q: What is required for the student to pass the affiliation?

A: The requirements that students must meet in order to pass clinical affiliations are contained in the syllabus specific to each affiliation. All affiliations are graded on a pass/fail basis. The success of each clinical affiliation depends on a partnership among the ACCE, CCCE, CI, and student.

All partners contribute to evaluating the student's performance. The UD DPT program uses the APTA PT CPI Web (Version 2.0) evaluation instrument for student self-evaluation and for CI evaluation. While there are not specific requirements for where the student should be marked on any rotation, the course syllabus does give a range that makes sense for the level of rotation. The program does require that the student make entry-level on each criterion at least once in the four clinical rotations.

Students are also graded on other items during the rotations such as written assignments, completion of an in-service, and completion of forms and surveys that must be turned in after the rotation. These are spelled out in the syllabi in the section called "Examination and Grading Policy."

It is the ACCE's responsibility to assign the grade for the rotation (Credit = CR; No Credit = NC; or Incomplete = I). The ACCE will use the scores on the CPI and the various assignments as the primary indicators. However, there are considerations that may influence the final grade. These would usually only come into play when assigning the grade is a "close call." They are:

- Complexity of the clinical environment
- Congruence between clinical instructor and student assessments on the CPI
- Clinical instructor skill using the CPI

- Clinical instructor experience as a clinician and as a clinical instructor
- ACCE individual communications with students, clinical instructors, or CCCEs
- Student adherence to University of Dayton policies regarding professional behavior, attire, and attendance. Student expectations regarding these areas are found in the *Student Clinical Education Handbook*.

Some of these factors represent development opportunities for student and for clinical instructors. It is the role of the ACCE to provide Clinical Education Faculty development and to evaluate the performance of clinical instructors as well as students. These opportunities may involve one-on-one discussion or the provision of in-services so that all CIs at a site may benefit.

Q: So where can I find the syllabi for the rotations?

A: The syllabi for the rotations are contained in the *Student Clinical Education Handbook.*

Q: How does complexity of the clinical environment make a difference in the ACCE's grading?

A: When a student is working in a facility where the patients are very complex, such as an LTAC or acute rehab, they may progress to the point that they are capable of having a 100% caseload my the midterm, but move to a unit of even higher acuity and need increased supervision and may not be entry-level in that setting by the final. This is not necessarily an ominous sign as it is not unusual for a student to need more supervision and reduced caseload when faced with very challenging patients.

Q: How does the University of Dayton define entry level?

A: The CPI provides most of the answer to this question. It says that entry-level performance is:

- A student who is **capable of** functioning without guidance or clinical supervision managing patients with simple or complex conditions.
- At this level, the student is consistently proficient and skilled in simple and complex tasks for skilled examinations, interventions, and clinical reasoning.
- Consults with others and resolves unfamiliar or ambiguous situations.
- The student is **capable of** maintaining 100% of a full-time physical therapist's caseload in a cost effective manner.

In addition to this definition, we ask sites to reflect on what entry-level performance means in their setting, with their patients, and their policies. Then they should ask themselves what they would expect from a new graduate physical therapist in each area of their facility. This often helps clarify entry-level performance as it relates specifically to the clinical site.

Q: What happens when the student and the CI are far apart on marking the CPI?

A: The online CPI provides a valid mechanism for measuring disparity between CI and student ratings. Students and CIs are often far apart at the midterm and closer together on the final evaluation. Differences become apparent in the comments. If the student and CI are more than 4 marks apart on any red flag criterion at the midterm, or on more than 4 other criteria, the ACCE will discuss the situation with both the student and the CI. The purpose of the conversation is to determine the root cause of the incongruence and to establish: 1) a common understanding on what the actual situation is; and 2) develop a plan as needed to resolve the appearance of wide disparities. It is understood that the disparities may present an opportunity for Clinical Education Faculty development when they have unrealistic expectations (high or low), or as is often the case, it may be that the student is being unrealistic in their self-evaluations.

For the final, when the student and CI are more than 2 marks apart on any red flag criterion, or on more than 2 other criteria, the ACCE will initiate the discussion as indicated above.

Q: Are there restrictions on students doing clinical rotations where they have been or may be employed?

A: Under most circumstances, we don't assign students to facilities where they have been employed. Exceptions may be approved in situations where the student may be with a CI with whom they haven't worked and in an area of the facility where they haven't worked.

Students are not permitted to do a clinical rotation in a facility where they have signed an employment agreement or where they have been offered a position before or after graduation.

Q: Do I have any rights or privileges as a CCCE or a clinical instructor?

A: Yes, you do. You are considered clinical education faculty and as such, you have rights and privileges. We updated our rights and privileges on February 8, 2010. Click here to see your Clinical Education Faculty Rights and Privileges.

Q: Why did the ACCE stop making routine midterm site visits?

A: It is the ACCE's responsibility to monitor clinical rotations. Historically, ACCE's accomplished this by making midterm site visits. With the advent of the online CPI, the ACCE has much greater availability to ongoing evaluative materials. This makes visiting most students unnecessary. However, many situations may arise where the ACCE needs to make a site visit. The ACCE will make a site visit under the following circumstances:

1. It is apparent to the ACCE through monitoring the CPI or by talking with the student, CI, or CCCE that a site visit is necessary.
2. A site visit is requested by the CCCE, CI, or the student.
3. The ACCE has not visited the site before and needs to be familiarized with the facility and staff. This may or may not be during a clinical rotation.
4. The site requests a site visit for the purpose of consultation or for the ACCE to provide an in-service.

Q: How should the student sign his/her name on notes?

A: This answer applies only to Ohio facilities. In Ohio, the student may sign their name on notes and behind their name place any of the following descriptors:

1. Student Physical Therapist
2. Student PT
3. SPT

Q: What is the University of Dayton's guidance on supervising student?

A: Our guidance is that it is necessary to follow federal, state, and local laws and regulations at all times. The Ohio practice act says this about supervision:

> **4755-27-04, Supervision**
>
> (D) Supervising of the student physical therapist.
>
> > (1) A student physical therapist may only be supervised by a physical therapist licensed pursuant to Chapter 4755. of the Revised Code.
> > (2) The supervising physical therapist is required to be on-site and available to immediately respond to the needs of the patient whenever the student physical therapist is performing patient examinations, evaluations, and interventions.

Medicare: There has been considerable confusion over the years regarding supervision of students while treating Medicare patients. The following is an excerpt from Medicare Manual 100-2, Chapter 15, Subsection 230 (Effective 1/1/2007):

> **B. Therapy Students**
> **1. General**
> Only the services of the therapist can be billed and paid under Medicare Part B. The services performed by a student are not reimbursed even if provided under "line of sight" supervision of the therapist; however, the presence of the student "in the room" does not make the service unbillable. Pay for the direct (one-to-one) patient contact services of the physician or therapist provided to Medicare Part B patients. Group therapy services performed by a therapist or physician may be billed when a student is also present "in the room".

EXAMPLES:
Therapists may bill and be paid for the provision of services in the following scenarios:

- The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.
- The qualified practitioner is responsible for the services and as such, signs all documentation. (A student may, of course, also sign but it is not necessary since the Part B payment is for the clinician's service, not for the student's services).

The take home message here is that students may provide interventions with Medicare Part B patients, but you, the CI must be there with the student, directing their actions and making the decisions. You may not be on the phone, writing notes, or treating another patient. When you are supervising in this manner, you are providing the service in Medicare's eyes and, therefore, may bill for the service.

Q: What about Medicare Part A?

A: Under the same section of Manual 100-2, Chapter 15, regarding the differences of Part A and Part B billing, Medicare says:

> The payment methodologies for Part A and B therapy services rendered by a student are different. Under the MPFS (Medicare Part B), Medicare pays for services provided by physicians and practitioners that are specifically authorized by statute. Students do not meet the definition of practitioners under Medicare Part B. Under SNF PPS, payments are based upon the case mix or Resource Utilization Group (RUG) category that describes the patient. In the rehabilitation groups, the number of therapy minutes delivered to the patient determines the RUG category. Payment levels for each category are based upon the costs of caring for patients in each group rather than providing specific payment for each therapy service as is done in Medicare Part B.

The take home message in this excerpt is in the last sentence. Essentially, what it seems to be saying to us is, "follow your state's supervision guidelines for Part A Medicare patients."

DISCLAIMER: We are not attorneys, nor do we consider ourselves experts in interpreting Medicare policy. We encourage you to visit this topic with your facility's risk management officer.

APTA ACCREDITATION GUIDELINES: CLINICAL EDUCATION

We are including selected accreditation criteria from the Commission on Accreditation in Physical Therapy Education (CAPTE) that are particularly applicable to clinical education. The entire accreditation criteria document (2006 revision) can be found on the CD that accompanies this handbook.

F-1. Each individual core faculty member, including the program administrator and ACCE/DCE, has contemporary expertise in assigned teaching areas.

F-11. The ACCE/DCE is a physical therapist and core faculty member with an understanding of contemporary physical therapist practice, quality clinical education, the clinical community, and the health care delivery system.

F-12. The ACCE/DCE is effective in developing, conducting, coordinating, and evaluating the clinical education program.

F-13. The ACCE/DCE communicates necessary information about the clinical education program to core faculty, clinical education sites, clinical education faculty, and students and facilitates communication about clinical education between these groups, as needed.

F-14. The ACCE/DCE has the responsibility to ensure that there are effective written agreements between the institution and the clinical education sites that describe the rights and responsibilities of both, including those of their respective agents. Agreements address at a minimum: the purpose of the agreement; the objectives of the institution and the clinical education site in establishing the agreement; the rights and responsibilities of the institution and the clinical education site; and the procedures to be followed in reviewing, revising, and terminating the agreement.

F-15. The ACCE/DCE uses a process to determine if the academic regulations, policies, and procedures related to clinical education are upheld by core faculty, students, and clinical education faculty (CCCEs and CIs) and takes appropriate corrective actions, when necessary.

F-16. The ACCE/DCE, using information provided by the clinical education faculty and other information as needed, is ultimately responsible for assessment of student learning in the clinical education experiences.

F-17. The ACCE/DCE determines if the clinical education faculty are meeting the needs of the program. This determination is based at a minimum on the assessment, in collaboration with the CCCE, of the clinical education provided by CIs who supervise the same student for at least 160 hours in a given academic year.

F-23. The clinical education faculty (CCCEs and CIs) have a minimum of 1 year of clinical experience and demonstrate clinical competence in the area of practice in which they are providing clinical instruction.

F-24. The clinical education faculty (CCCEs and CIs) demonstrate the ability to be effective clinical teachers, including the ability to assess and document student performance, including deficits and unsafe practices.

F-25. The responsibilities of the clinical education faculty (CCCEs and CIs) are delineated and communicated to them and to other program faculty, as needed. The participation of clinical education faculty in program activities and curriculum review is consistent with institutional policy and with their level of participation in the program.

F-26. The clinical education faculty (CCCEs and CIs) are afforded rights and privileges that are appropriate for their level of participation in the program and similar to the rights and privileges afforded to the clinical education faculty in other programs throughout the institution. The rights and privileges of the clinical education faculty are delineated and communicated to core and clinical education faculty.

CP-2.10. [The curriculum plan includes] a description of the methods used by the program to assign students to clinical education experiences. These methods are designed to ensure that the type and amount of clinical supervision and feedback provided are appropriate for the students' experience, ability, and point of progression in the program.

CP-3. There is on-going and formal evaluation of the professional curriculum. The curriculum evaluation plan is written and addresses individual courses within the curriculum, as well as the curriculum plan as a whole. The plan incorporates consideration of the changing roles and responsibilities of the physical therapist practitioner and the dynamic nature of the profession and the health care delivery system. Data are collected from appropriate stakeholders, including, at a minimum, program faculty, current students, graduates of the program, and at least one other stakeholder group such as employers of graduates, consumers of physical therapy services, peers, or other health care professionals. The evaluation plan is used to determine strengths and weaknesses of the curriculum and to determine if the practice expectations and specific mission, goals, and expected student outcomes of the curriculum are met.

CP-4. There is ongoing and formal evaluation of the clinical education program.

CC-4. The physical therapist professional curriculum includes clinical education experiences for each student that encompasses:

a) Management of patients/clients representative of those commonly seen in practice across the lifespan and the continuum of care;
b) Practice in settings representative of those in which physical therapy is commonly practiced;
c) Interaction with physical therapist role models whose practice is consistent with the program's philosophy of practice;
d) Opportunities for involvement in interdisciplinary care; and
e) Other experiences that lead to the achievement of expected student outcomes.

The "Five-Minute Clinical Manager

Dr. Debra F. Stern, PT, Dr. Rebecca Rosenthal, PT, and Dr. Leah Nof, PT

A Method for Efficient Evaluation and Feedback

The "Five-Minute Clinical Manager" is a strategy for efficiently structuring and interaction with a learner. It consists of the following steps:

1. **Get Learner Commitment**
    - So, what do you this is going on with this patient?
    - How would you like to treat this patient?
    - Why do you think the patient needs treatment?
    - What would you like to accomplish in this session?

2. **Probe for supportive findings/evaluate the thinking leading to that commitment**
    - How did you reach your conclusion?
    - What findings support your diagnosis?
    - What else did you consider?

3. **Reinforce what was correct/give positive feedback**
    - I agree with your decision(s)/conclusion(s).
    - I am pleased that you included…in that aspect of the examination/intervention.
    - I appreciate your consideration of reimbursement issues…

4. **Constructive guidance about errors or omissions/give negative feedback**
    - I disagree with…your differential diagnosis/conclusions/decisions.
    - What else do you think you might have included?
    - A more effective way to…

5. **Teach a general principle/clarify the "take home" lesson**
    - So, in general, it's important to remember…
    - It is always important to think about…
    - In general, taking a little extra time…
    - Why don't you read up on this tonight and report back tomorrow…

Adapted from:

Nova Southeastern University Physician Assistant Program Preceptor Handbook. (2005-2006).
Blanchard, K., & Johnson, S. (2003). *The One-Minute Manager.* New York: HarperCollins.
Nether, J. O., Gordon, K. C., Meyer, B., & Stevens, N. (1992). A Five-Step "Microskills" Model of Clinical Teaching. *Journal of American Board of Family Practice*, 419-424.

Resources

A. UD DPT Curriculum Summary
B. UD DPT Course Descriptions
C. UD DPT Faculty & Staff Roster
D. Clinical Performance Instrument (CPI)
E. CPI Web
F. APTA CPI training course
G. UD DPT tutorial for APTA CPI training course
H. APTA Student Evaluation of Clinical
I. UD DPT Weekly Feedback Form
J. Student and Curricular Information/CE Resource From for Clinical Sites
K. Sample Clinical Education Affiliation Agreement

Glossary of Terms

Academic Coordinator of Clinical Education (ACCE): The core faculty member responsible for the planning, coordination, facilitation, administration, monitoring, and assessment of the clinical education component of the curriculum. The ACCE is the faculty member of record for the clinical education courses.

Clinical Education Faculty: Those individuals engaged in providing the clinical education components of the curriculum, generally referred to as either Center Coordinators of Clinical Education (CCCEs) or Clinical Instructors (CIs). While the educational institution/program does not usually employ these individuals, they do agree to certain standards of behavior through contractual arrangements for their services.

Center Coordinator of Clinical Education (CCCE): The individual at each clinical education center who coordinates and arranges the clinical education of the physical therapy student and who communicates with the ACCE and faculty at the educational institution. This person may or may not have other responsibilities at the clinical education center.

Clinical Instructor (CI): A person who is responsible for the direct instruction, supervision, and provision of clinical education experiences for the physical therapy student in the clinical education setting.

Clinical Education: The portion of the student's professional education which involves practice and application of classroom knowledge and skills to on-the-job responsibilities. This occurs at a variety of clinical sites and includes experience in evaluation and patient care, administration, research, teaching, and supervision. It is a participatory experience with limited time spent in observation. In general, the clinical education courses account for at least one third of the curriculum (whether measured by credits, contact hours, or length in weeks). These courses are critical to the development of competent, professional (entry-level) practitioners. It is, therefore, important that the clinical education experiences be designed to maximize student learning. And, because the institution/program maintains responsibility for the clinical education courses while relying heavily on practitioners to design, implement, and assess student learning experiences and student performances, mechanisms used to coordinate assignment of students to experiences, to communicate with clinical education faculty, to monitor the quality of the students' experiences, and to assess student performance are all vital to the quality of the students' education.

Clinical Education Site/Facility: A health care agency or other setting in which learning opportunities and guidance in clinical education for physical therapy students are provided. The clinical education center may be

a hospital, agency, clinic, office, school, or home and is affiliated with one or more educational programs through a contractual agreement.