Clinical Teaching While Sustaining or Improving Productivity:
How to Manage or Maximize Productivity with Students

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Objectives

• Explore Relevant Literature
  • Exploring Different Clinical Education Models
  • Productivity when taking PT Students
• Brief Review of Student Supervision Regulations
• Common or Possible Efficiencies and Inefficiencies
• Recommendations & Where Do We Go
Do We Need to Change Clinical Education??

  - Effective Clinical Educators require specific training/preparation
  - Presented 10 different models of Clinical Education
  - Concluded that None of the presented models will address all the needs of PT clinical education
  - “Without a clear understanding of the current status of clinical education, the needs of the profession remain uncertain”
ATPA Annual Conference 2010: Economic Models and Clinical Education Principles
http://www.apta.org/Educators/Clinical/EducationResources/ModelsPrinciples/

• Gandy et al.
  • 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.

  • 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.
University of Pittsburg Department of Physical Therapy

- Established a partnership in clinical education, clinical practice, management, research, education, and professional development

**Vision:** To develop a clinical education model within UPMC-affiliated physical therapy entities in which entry-level physical therapy graduates will be able to function in an optimal, cost-effective manner in today’s health care environment --from Day 1.
ATPA Annual Conference 2010: Economic Models and Clinical Education Principles

http://www.apta.org/Educators/Clinical/EducationResources/ModelsPrinciples/

- University of Pittsburg Department of PT
- Clinical Education Partnership

An Integrated HC System

UPMC

- Centers for Rehab Services
  - 50 outpatient clinics
  - 6 hospital contracts
  - 4 specialty programs
  - 3 APTA credentialed residency programs
- Senior Living Communities
  - SNFs
  - Continuum of care retirement communities
- UPMC Rehab Network and Institute for Rehabilitation & Research
- Home Health Agency
- UPMC Health Plan

Non-UPMC Affiliates

Non-UPMC Affiliates

- Pediatric facilities
- VAMC Regional Centers
- Select local community hospitals & SNFs

- Inpatient Rehab and Day Schools
- Hospitals
- Community based centers
- SNF
- Outpatient Services

- University of Pittsburg
- Department of Physical Therapy
ATPA Annual Conference 2010: Economic Models and Clinical Education Principles
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• Tomlinson, DCE @ Arcadia DPT Program
  • Collaborative Clin Ed Model: 3 students:1 clinical instructor
  • Arcadia Clinical Education Network (ACE), 25 Systems serve as Clinical Sites (down from 170 previously)
    • Education for CCCEs/CIs:
    • APTA CI Credentialing
    • APTA Advanced CI Credentialing
    • Collaborative Model (3:1)
Do We Need to Change PT Clinical Education??

- ACAPT Clinical Education Summit, Kansas City, 2014

    - Concerns regarding lack of Standardization
    - Final clinical experiences range from 8-68 wks
    - Private Practice especially susceptible to challenges in taking students due to time to educate and reimbursement regulations
    - Expectations of student to perform “Beyond Entry Level” per the CPI during the final phases of Internship,
      - thus increased productivity will be expected for students
Evidence in Motion
Clinical Excellence Network: EIM CEN

- Predicated on current system with Decreased Efficiency
- Promotes Peer Learning among students
- Standardizes the Clinical Education Process

<table>
<thead>
<tr>
<th>CURRENT PT INTERNSHIPS</th>
<th>MEDICAL INTERNSHIPS</th>
<th>CEN PROGRAM</th>
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<tbody>
<tr>
<td>Difficulty placing students in quality clinical education experiences</td>
<td>Standardized Internship Matching Program with huge hospital network</td>
<td>Vast ‘footprint’ of Network Partners makes it easy to ‘match’ interns</td>
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<tr>
<td>Inefficient, individual method of teaching &amp; learning — 1:1 student to instructor ratio</td>
<td>Collaborative, 1:2-4 clinical faculty to intern ratio facilitates increased retention rates and enhanced learning experience</td>
<td>Enhanced clinical productivity with 1:2-4 faculty to intern ratio</td>
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<td>Short duration experiences mitigates potential for students to become productive/revenue generating</td>
<td>Length of internship allows residents to earn a modest salary and receive high-quality standardized training</td>
<td>9-12 month program in EIM Network Partner practice allows students to become productive staff members/increase productivity</td>
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<td>Inconsistent or nonexistent curriculum</td>
<td>Standardized curriculum for each intern</td>
<td>Consistent standards: placement system, faculty training, curriculum, accreditation</td>
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<td>Few incentives for instructors to provide high quality clinical training</td>
<td>Clinical faculty adhere to rigorous quality and accreditation standards</td>
<td>Experienced, world-class, “CEN” trained Faculty</td>
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Productivity Findings in the Literature


- Clinical Instructor productivity in acute and inpt. rehab settings
  - Examined productivity 4 weeks with and without students
    - (2/3 of students were first year)
  - With students:
    - More CPT codes generated
    - More patients seen
    - Similar # of Evals/day

![Graph showing productivity measures with and without SPT](image-url)
Productivity Findings in the Literature


- Studied productivity in 1:1 vs. 2:1 Model in Australian PT Program
- CI direct patient care time decreased by 19% with 1:1 model and 47% in 2:1 model
- Facility Productivity of CI & Student/s
  - Increased from CI baseline of 78% to 120% with 1:1 model
  - Increased from CI baseline of 73% to 94% with 2:1 model


- Productivity of 2:1 model in an Canadian acute care setting
  - Perspective that hospital offerings were difficult and in decline
  - 2:1 model may be more cost effective and produce higher quality learning
  - CI’s instructed to supervise and educate students, student’s to provide more of treatment
  - Students expected to manage 2/3 case load
- Increases in Productivity by 2:1 students/CI compared to control of CI alone:
  - 34% more pts were treated and pts received 60% more treatment time
Productivity Findings in the Literature

• Older Studies (1980’s) found increases in Productivity when PT students were involved:
  • Lopopolo (1984). Financial benefit of seeing more patients per day with students
  • Leiken (1983). Found PT students had an insignificant increase in number of treatments provided by staff, however productivity was based on treatments and not evaluations completed
  • Graham et al. (1991). Longer placements (greater than 5 weeks) produced greater productivity than shorter placements

• What Happens to CI/Student Productivity in Today’s Environment??
Medicare Student Supervision Regulations

- Medicare A (Y1): Students are NOT required to be in line-of-sight of the supervising PT
  - MDS Time Coding rules apply
  - The supervising therapist cannot be treating or supervising other individuals
- Medicare A (Y3 & Y4): This is NOT specifically addressed in the Regulations, defer to state law and standards of practice
- Medicare B (X1): Direct Supervision
  - Only services of the PT can be billed

http://www.apta.org/Payment/Medicare/Supervision/
Student Supervision Requirements

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.
Student Supervision Requirements

Medicare Part B: Direct Supervision

• Only the services of the PT can be billed and paid under Medicare B. However, a student may participate in the delivery of the services if the PT is directing the service, making the judgement, responsible for the treatment and present in the room guiding the student...

• As CMS states, only services provided by the licensed physical therapist can be billed to Medicare for payment. Physical therapists should consider whether the service is being essentially provided directly by the physical therapist, even though the student has some involvement in providing the care. In making this determination, the therapist should consider how closely involved he or she is involved in providing the patient's care when a student is participating. The therapist should be completely and actively engaged in providing the care of the patient. As CMS states in their letter,

• "the qualified practitioner is present in the room guiding the student in service delivery when the student is participating the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time."
Efficiency / Inefficiency: Acute Care examples

**Efficiency**

- Late/Longer Rotations: Up to 25-50% increase in Productivity
- Students can serve in “tech-like” capacity, providing extra set of hands, but students MUST be willing to provide/understand this
  - (Students need to understand Productivity standards)

**Inefficiency**

- Early Rotations: Reported ~50% Decline in Productivity, especially in first 2-4 weeks
  - Orientation to Facility, EMR, Chart Reviews, etc.
  - Treatments are done under license of CI, thus may provide extra supervision
Efficiency / Inefficiency: Rehab-LTC Examples

Productivity Expectations:
• 30% reduced expectation first week
• Weeks 2-4, 75% of “Normal” staff
• Midterm Week 6, 100% of “Normal” staff
• Final Weeks of Terminal Rotation, between CI & student, up to 150% of Normal

**Efficiency**
• Terminal Rotations: May be able to schedule CI & student to see individual patients simultaneously, or at least staggered.

**Inefficiency**
• Orientation: facility, EMR, Equip, etc
• Time to prepare for every patient interaction
• Time for CPI completion
Efficiency / Inefficiency: Outpatient Examples

**Efficiency**

- Early Rotations: Limited examples of increased Productivity
- Longer Final Rotations, students can produce units in efficient manner, adding to those produced by the CI

**Inefficiency**

- Early Rotations: Reported 30-50% Decline in Productivity
- Primarily to Educating/Guiding Student, not so much Orientation Issues
  - Orientation does exist but not to extent of large facilities
- Concerns with Medicare B patients
Recommendations for DPT Programs

• Students have better understanding of Productivity standards and Expectation (Global Recommendation)
  • Students realize they need to move at similar pace as CI’s
  • Productivity will decline with Orientation and Learning, but must make attempts to minimize the decline throughout time in clinic
  • Students must Own the knowledge and skills they have been taught, Rotations are not the time to have this re-taught

• Programs need to understand CI’s are clinicians for a reason, and not educators. Do NOT expect them to think/function as faculty
Recommendations for Clinics

• CI’s (with DPT Program support) emphasize to students the necessity to prepare/spend time outside of clinic hours

• Scheduling Strategies between Medicare and Private Insurance
To identify and develop resources that will help PTs and PTAs negotiate successfully around productivity and performance in ways that ensure the provision of quality physical therapy care.

“the need for more analysis and tools has arisen in the face of a changing health care climate that has created "uncertainties" that have caused some employers to turn to "productivity" measures as the primary measure of PT and PTA performance. These productivity measures may not be realistic and generally do not reflect the value of PT care and the patient related outcomes of PT practice.”

The motion adopted by the House could result in the development of resources for PTs and PTAs who, according to the support statement, "seek to balance their clinical, ethical, and professional responsibilities against the demands inherent in the employment relationship."