APTA Combined Sections Meeting

CPR or DNR: Revive or Abandon Current Acute Care Curricular Approaches?

Part 1

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Presenters

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Disclosures

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Learning Objectives

At the conclusion of this presentation, participants will be able to:
1. Analyze the impact current healthcare trends have upon the delivery of physical therapy services.
2. Understand the critical thinking and decision making skills required for competent physical therapist practice in the acute care setting.
3. Identify areas of uniformity and domains of gap between didactic instruction and 21st century physical therapy practice in the acute care setting.
4. Hypothesize potential strategies to address the educational gap between didactic instruction and clinical practice demands.

NOTE: Information posted here is intended to provide an outline of the presentation. Enhanced slides will be used on-site, and posted in advance of the conference (replacing these).

Content Outline

I. What is acute care?
   a. “Acute care” is everywhere…..patient acuity transcends distinct practice setting; “acute-on chronic” management is the new normal
      i. Assisted living communities, ambulatory care clinics, private homes, hospitals, community care centers, “subacute” rehab facilities, long-term care facilities
      ii. It is our premise that physical therapists in training don’t get the key knowledge and experience for adequate management of patients with acute medical conditions when encountered only outside a hospital setting.
b. Path to establishing our identity
   i. Early training of physical therapists occurred in facility-based environments
      1. Prior to the evolution of the profession from “technical” to professional, these settings provided the most stability for students in training.
      2. It was once an implicit expectation that all PT students would have clinical education experiences in hospitals as part of entry-level education.
      3. We now find ourselves facing a clinical education landscape where getting any experience in a hospital setting is a real challenge.
   ii. In addition to the historical changes in academic preparation, the level of practice required of a skilled acute care clinician has dramatically evolved, along with the complexity of the environment(s) in which patients with acute health needs are managed.
      1. The rapid transformation of healthcare delivery in the United States has altered this environment significantly.
      2. Healthcare has embraced the Triple Aim of improving the patient experience, improving health outcomes, and reducing costs. All while:
         a. Shorter LOS
         b. Directives to reduce readmissions
         c. Longer life expectancies
         d. Increased comorbid conditions and complex populations
         e. Focus on wellness
      3. Current transformation emphasizing value, not volume
   iii. While entry-level education has attempted to keep pace, the movement of academic preparation to educational institutions and away from clinical settings produced a dissonance between classroom simulation and real-world expectations.

c. Birth of the Acute Care Section
   i. Need
      1. To address tensions experienced amongst physical therapy managers struggling with changes in healthcare delivery
      2. To provide a platform for modeling optimal clinical care for individuals with acute health care needs
   ii. Numerous presentations over the last 20+ years to raise awareness on continuing challenges
      1. Elevate clinical practice
      2. Address gaps between entry-level preparation and expectations of current clinical practice (moving target)
      3. Develop the evidence base for clinical excellence
      4. Outline opportunities for advancement
   iii. Key documents/achievements
      1. Completion of first analysis of practice
      2. Minimum skills task force.....entry-level competencies document
      3. Residency/fellowship task force….first accredited post-professional residencies in acute care

II. Gaps in entry-level education
a. Entry-level curricula may not teach to the complexity of the environment and current expectations for clinical decision-making

b. Acute care clinical decision-making has not been reflected in CAPTE documents that guide entry-level physical therapist education

c. Key documents that guide entry-level education
   i. Minimal Skills Document (neglects acute care)
   ii. Normative Model (neglects acute care)
   iii. NPTE exam blueprint (minimal focus on acute care)

d. Clinical education landscape is such that getting any experience in a hospital setting is a real challenge
   i. Acute care or hospital facility-based clinical education is not a nationwide requirement in entry-level physical therapist education
      1. May reflect an unintended consequence of efforts to raise awareness that acuity transcends location
      2. Raises question of whether “hospital” experience is necessary in the entry-level preparation of physical therapists
   ii. Insufficient academic prep + inability to obtain relevant clinical experience = unprepared workforce to meet 10-15% vacancy rate in acute care hospital positions

e. Even if this were changed tomorrow, the purpose of this discussion is to identify current educational gaps leading to students / future clinicians largely unprepared to practice at the necessary level in acute care settings.

f. Lessons learned from medicine
   i. Medicine was in a similar predicament at the turn of the last century
      1. When traditional training moved from the almshouses and medical wards to academic institutions, elements of clinical reasoning were lost
      2. “Internship” was required in early American medical schools, but there was no opportunity for the academic institutions to regulate or influence the type of clinical study students received; medical students arranged their own “apprenticeships”
   ii. In a landmark study entitled “Medical Education in America,” Abraham Flexner questioned the variability existent in clinical education and the devastating outcomes in medical practice that resulted (danger to society of ill-prepared physicians who lacked sufficient clinical training)
      1. Changed the trajectory of medical education in America forever
      2. Gave rise to the residency program, matching system, and structure of clinical education in American medical schools that still exists today

III. CAPTE influences
   a. 2016 Standards (effective 1/16)
      i. Provides the summary of current perspectives on significant factors underlying quality PT academic programs
ii. Do these standards force academic programs to address the educational and clinical gaps specific to acute care? If so, where and how?

iii. Has the significance of acute care education become a more explicit objective/priority or does it persist as an implicit educational goal?
   1. Is CAPTE overt in requiring clinical training in authentic acute care facilities or is it silent?
   2. If training is required, is it to the level of competency?

b. Standard 4: The program faculty are qualified in their roles and effective in carrying out their responsibilities
   i. Do we have a cohort of qualified faculty with contemporary expertise in the acute care setting and with medically complex populations?

c. Standard 5: The program recruits, admits and graduates students consistent with….societal needs for physical therapy services for a diverse population.
   i. Are programs producing graduates capable of serving the need of medically fragile patients?
   ii. Are we looking at population diversity only by diagnostic category or by practice setting as well?

d. Standard 6E: The curriculum includes organized sequences of learning experiences that prepare students to provide physical therapy care to individuals with diseases/disorders involving the major systems, individuals with multiple system disorders, and individuals across the lifespan and continuum of care, including individuals with chronic illness. The clinical education component provides organized and sequential experiences coordinated with the didactic component of the curriculum.
   i. While exposure to the acute care clinical setting may be required in this setting, ensuring a sufficient level of competency in that setting is not mandated.

e. Standard 6L: The curriculum plan includes clinical education experiences for each student that encompass, but are not limited to:
   i. 6L1: management of patients/clients with diseases and conditions representative of those commonly seen in practice across the lifespan and the continuum of care;
   ii. 6L2: practice in settings representative of those in which physical therapy is commonly practiced;
   iii. 6L3: involvement in interprofessional practice
      1. Wording provides leniency for academic programs to bypass the acute care setting and substitute in other practice settings
      2. Would students have sufficient transferrable skills to be competent in the hospital setting if only exposed to patients with acute medical needs outside of the hospital?

f. Standard 7C: The physical therapist professional curriculum includes content and learning experiences about the cardiovascular, endocrine and metabolic, gastrointestinal, genital and reproductive, hematologic, hepatic and biliary, immune, integumentary, lymphatic, musculoskeletal, nervous, respiratory, and renal and urologic systems; system interactions; differential diagnosis; and the medical and surgical conditions across the lifespan commonly seen in physical therapy practice.
   i. What are those learning experiences that are provided?
   ii. Wording provides quite a bit of leniency here.
g. Standard 7D39: Participate in the provision of patient-centered interprofessional collaborative care.
   i. No setting-specific requirement
   ii. Are the challenges of implementing patient-centered interprofessional collaborative care in an inpatient rehab center similar to those experienced in a hospital facility? If students can only practice such collaboration in one practice setting, which would be most advantageous for future transfer of skill?

h. Standard 8F: The clinical sites available to the program are sufficient to provide the quality, quantity and variety of expected experiences to prepare students for their roles and responsibilities as physical therapists.
   i. Are academic programs not requiring full time clinical experiences in hospitals because of setting-specific placement difficulties or because the value of this experience is not viewed as critical as obtaining full-time exposures to other settings?
   ii. Currently there is difficulty in solidifying clinical education internships in acute care
      1. Expanded student cohorts
      2. Increased number of PT programs
      3. Fewer clinical sites

IV. NPTE
   a. Often viewed as the “gold standard outcome”
   
   b. Areas
      i. Examination
      ii. Interventions
      iii. Foundations for Evaluation, Differential Diagnosis, Prognosis
      iv. Non-system Domains (equipment, modalities, safety, professional responsibility, research)

   c. Content areas
      i. Cardiopulmonary and Lymphatic (16.5%)
      ii. Musculoskeletal (30.5%)
      iii. Neuromuscular (25.0%)
      iv. Other: GI, metabolic, endocrine, GU, integumentary (15.5%)

   d. Is acute care adequately represented?
      i. If not tested, should it be taught?
      ii. If it is a less significant part of exam, is it appropriate to allow this content to be a less significant part of the curriculum?

V. Acute care didactic curriculum
   a. What is taught
      i. Skills
         1. Bed mobility
         2. Transfers
3. Gait
4. Assistive devices
5. Lab value ranges
6. Disease process
7. Intervention techniques
8. General pharmacology and imaging principles

b. What is often neglected
   i. Integration of knowledge
   ii. Dynamic evaluation and time-sensitive nature of complex decisions impacted by:
      1. Interplay of disease state with physical functioning
      2. How/when to progress and when to stop therapy
      3. Application of abnormal medical findings on physical therapy plan of care
      4. Pace of decision making/ability to prognosticate
      5. Ability to synthesize data from multiple sources
      6. Anticipate secondary complications
      7. Prioritization of multiple comorbidities
      8. Financial aspects of hospital based care
      9. Management of the authentic environment

c. Are we preparing our students to meet the Triple Aim?

VI. What do we do? Call it? One more round of epinephrine? Consult palliative medicine to examine goals of care?
   a. Strategies to overcome deficits
      i. Increase curricular strength
         1. Match instruction and testing with realities of practice
         2. High fidelity simulation on “people” and “mannequins”
      ii. Faculty
         1. Hire expert faculty
         2. Cultivate a pool of qualified faculty
      iii. Integrate authentic learning experiences / introduce realities of practice
      iv. Academic-clinical partnerships with sites demonstrating quality practice
         1. ICE (early-exposure to reinforce didactic teaching on real patients, possibly under the direction of “faculty”)
         2. Full-time experiences (quality)
            a. Alternate models of clinical education (2:1)
         3. Identify / groom qualified lab assistants

VII. Question/Answer
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References:


