Making the Collaborative Model Work in a Busy Outpatient Practice

Darren Calley, PT, OCS

Objectives

- Learn the benefits & challenges of collaborative model in an outpatient setting
- Understand the student & CI role in the collaborative model
- Describe how the collaborative model works in our busy outpatient practice
- Be aware of some ideas for group learning activities in an outpatient practice

Disclosures: I have no conflicts of interest, nothing to disclose.

Collaborative Model

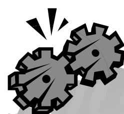
- How many students can a CI handle?
- What is the right number of students in a collaborative model? 1? 3? 6?
- Collaborative model has been in use at Mayo for many years – came about out of necessity

3:1 Model – Does it work in an outpatient setting?

- Yes! If done well, it works for CI's, students, academic programs, and patients.
- Win, win, win, win situation
- I've been the outpatient CEC at Mayo for almost 3 years, used the 1:1, 2:1, and 3:1 models – I generally prefer the 3:1 model because of the many collaborative advantages.

Requirements for the 3:1 Model to Work

- Need to have a supportive staff
- Support from academic programs is vital
- Students need to get used to a paradigm shift – depend and use each other collaboratively, not competitively



Requirements for the 3:1 Model to Work

- As schedule gets busier, students are required to be more independent.
- Students must be adult learners.
- CI needs to be able to multitask, problem solve, walk fast, handle difficult patient and student situations.

Before the Rotation Begins…

- Amazed at how much planning, calendaring, scheduling needs to take place.
- Introductory email to students sent out 1 month ahead of time
  - What to expect, what to bring
  - What to do to prepare
  - Give each student an assignment
  - Remind the student to send an email reply

Preparatory Assignment

- Current assignment is for students to:
  - Review evaluations, special tests, differential diagnosis, treatment planning, evidence based practice info from school, info from other clinicals, references, etc.
  - Read "Mindful Practice" article and come prepared to discuss this the 1st day.

First Day

- Orientation – entire first week and beyond
- Professionalism in Physical Therapy Core Values document & "Mindful Practice" article
- Review expectations of group collaboration, interaction, and expectations
- Evidence based practice
- Interpreting diagnostic tests – Spins, Snouts, +/- LRs, Nomogram
- Action learning & reflection

First Day

- CI goals for the rotation
- Common things CI's look for to grade a student at entry level (Jette 2007)
- Ask students to complete:
  - Learning style worksheet
  - Their goals for the rotation
  - Give input into learning activities
- Safety, dress standards, how department runs, inservice requirements, tour
- 3 Strategies of clinical diagnosis (Sackett & Rennie: pattern recognition, exhaustive testing, hypothetical-deductive)

Applying Core Values

- Accountability
- Altruism
- Compassion/Caring
- Excellence
- Integrity
- Professional Development
- Social Responsibility

AACEIPS – Write acronym on the board, ask students to list as many core values as they can. Ask students to share examples.

Action Learning/Reflective Practice

- Review definition of action learning
- Review how to reflect (Schon)
  - On Action….
  - In Action….
  - For Action….
- Discuss how we use this in the collaborative model

“Big Three” in Outpatient

1. Differential Diagnosis
2. Treatment Planning
3. Clinical Decision Making

Review the Guide
(1. Examination (history, systems review, tests and measures), 2. Evaluation, 3. Diagnosis, 4. Prognosis/Plan of Care, 5. Intervention)

Stress the importance of letting your history guide exam.
Review Red and Yellow Flags, answering question #1 – Is patient appropriate for therapy?
Discuss strategies for what to do when you don’t know what to do.

Typical Day

- Students expected to be ready to discuss patients at 8:00 am
- Morning and afternoon group meetings for 30 minutes
  - Review patient cases
  - CI directed inservices
  - Integrate learning activities
  - Collaborative discussions
- Patient care – goal is for students to be able to bill for 18-20 units/day (staff goal is 24 units/day)

Daily Group Meetings

- 1st part of every morning and afternoon meet together as a collaborative group for 30 min (8-8:30 discuss patients and 1-1:30 learning activity)
- Responsibility for learning on each student and on the group
- Ask for other student input into problem solving
- Later in the rotation, discuss only patients that are more challenging, ask for group suggestions, use CI as more of a mentor

Student/PT Eval Team

- All students are assigned to be teamed up with an experienced PT to work together 6-7 times during the rotation
- Student works with assigned PT completing 2 or 3 new evaluations per morning
- Each student is also assigned to be teamed up with our most seasoned therapist doing 2-3 evals before midterm and 2-3 evals after midterm
- These two therapists each give input on items 10-13 on the student’s midterm & final CPI
- Student feedback on this is very positive – get to work with at least 3 different physical therapists on new patient evaluations during the rotation (see different interaction styles, artful questioning, physical exam organization, palpation skills, etc.)

Scheduled Learning Activities

- Students are scheduled for several learning activities during the rotation
  - Vestibular Lab ½ day
  - Two to three mornings following Amputee Clinic
  - Two hours following Occupational Therapy
  - 2 days of Cardiovascular Rotation with selected students
  - Women’s Health with female students who express an interest
  - Special topic 1 hour inservices with other staff or primary CI on Manual Therapies, Real Time US, Cervical and Lumbar Stabilization, Sacroiliac disorders, Orthotics, Functional movement/strengthening, etc.

Weekly Student and CI Meetings

- Schedule 30 min weekly meetings
  - Student come prepared to discuss their completed weekly status sheet (strengths, areas to improve, what they can do independently, what they need help with, student weekly goals and a place for CI to add goals/comments)
- Midterm and Final meetings scheduled for 1 hour (review goals for the rotation, weekly goals, application of learned concepts between clinicals, student/CI concerns, feedback, both student and CI complete midterm and final CPI)

Advantages of Collaborative Model to Students in Outpatient Setting

- Group Collaboration/Peer learning (DeClute & Ladyshewsky, 1993, Ladyshewsky et al, 1998, 2000)
- Group Interaction – vent, share successes, challenges
- Development of teamwork, collaboration & clinical competence (DeClute & Ladyshewsky, 1993)
- Enhanced learning and communication (Triggs et al, 1996, Ladyshewsky et al, 1998)

Advantages of Collaborative Model to Students in Outpatient Setting

- Improved cognitive skills (Hillerbrand, 1989)
- Increased opportunity for discussion & reflection (Bruce et al, 2001, Ladyshewsky et al, 1998)
- Improved opportunity to practice manual therapies, other treatments
- Sharing caseload/sharing patients

Advantages of Collaborative Model to Students in Outpatient Setting

- Appreciate different learning styles, other students from different therapy schools, varied clinical rotations
- High ratings on site evaluation forms
- More resources available – if stuck, student has 2 peers to help with problem solving, assist with difficult patients.

Advantages of Collaborative Model for Facility in Outpatient Setting

- Financial Viability/Productivity (Ladyshewsky et al, 1998)
  - Goal for our outpatient setting is to bill 24 units/day
  - Recent financial data supports that outpatient CI is above 24 units/day on average during the rotation with 3 therapy students
  - Early in rotation less productive but made up for during mid and late rotation
- Education of staff on best practices
- Model fits well with evidence based practice (Rose & Best, 2005)

Advantages of Collaborative Model for Academic Program

- More available clinical slots
- Model fits well with evidence based practice (Rose & Best, 2005)
- Can make for improved student clinical experiences (increased student exposure to students of other programs to enhance learning)
- Excellence in practice
- Students gain appreciation of what their program taught in school (and can give feedback on what other programs are teaching that would've been beneficial if taught in their program)

Advantages of Collaborative Model for Clinical Instructors in Outpatient Setting

- Improved clinical knowledge and management skills for CI (Triggs et al, 1996)
- Evidence based practice (Rose & Best, 2005)
- Don't need to carry your own caseload with a 3:1 model
- Available to be the "expert" to assist with mentoring when needed – (my pager is always on)
- Use of other therapists to be on Evaluation Team allows for multiple CI's to have student interactions, foster team approach.
- Improved handling of exceptional students (CI gets to work with a lot more students!)

Differences Between Traditional and Collaborative Learning

Traditional	Collaborative
Educator is expert	Educator is co-learner in group
Educator is in control of time and response	Group membership shares timing and response
Educator in control of content, transfers knowledge to student	Group decides content and sequence, knowledge is jointly constructed and modified by group process
Predictable learning objectives	Objectives formed by group
Competitive	Cooperative

(Cohn, E.S, Dooley, N. R., Simmons, L. A. 2001)

Differences Between Traditional and Collaborative Learning

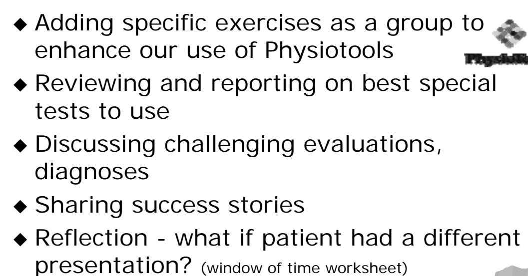
Traditional	Collaborative
Educator establishes learning structure	Group shares responsibility for structure
Educator is autonomous	Group is interdependent/share individual roles
Students are more passive learners	Students are more active learners
Students work independently, little interaction, impersonal transaction among students	Prolonged interaction, oral rehearsal of material being studied, peer tutoring/learning and general support

(Cohn, E.S, Dooley, N. R., Simmons, L. A. 2001)

Group Learning Activities

- Grand rounds style – everyone asks a question
- Most challenging patient diagnosis worksheet (collect these in a binder for other students to use)
- Manual therapy practice
- Differential diagnosis scenarios
- PTA or no PTA
- Identify and review ethical dilemmas – may use RIPS model (realm, individual process, & situation dimensions)

Group Learning Activities



- Adding specific exercises as a group to enhance our use of Physiotools
- Reviewing and reporting on best special tests to use
- Discussing challenging evaluations, diagnoses
- Sharing success stories
- Reflection - what if patient had a different presentation? (window of time worksheet)

Group Learning Activities

- Radiography review – discuss role of imaging with differential diagnosis
- Searching literature for a relevant research article on a student generated clinical question (Use APTA Connect, Hooked on Evidence, Pubmed, Google Scholar, etc)
- Jeopardy – cognitive domain
- Student completes a short power point presentation on a unique diagnosis, treatment strategy

Group Learning Activities

- Planning – what are the "top 5" things they would include in their physical exam on a last minute add on patient here for a 1 time visit.
- Student directed inservices – share treatment ideas, manual techniques, clinical reasoning that they've learned from other inservices
  - Swiss ball, vestibular, manual therapies
- Student mentoring of new students (teach new student how to enter a note, have student observe, palpate significant finding, etc.)

Group Learning Activities

- Practicing treatments with each other
  - Lumbar stabilization
  - Manipulation
  - Muscle energy techniques
  - Spine and Extremity Mobilizations
  - Mobilization with movement
  - Etc.

Integrating Manipulation

- Now a component of CAPTE requirements for all physical therapy programs.
- Some students come without learning basic lumbar, SI, thoracic techniques recommended in the APTA Manipulation Education Manual.
- Very intimidating for some students
- Group practice allows for students to increase number of manipulations they've performed from very few or none by factor of 3 (good for them to perform on CI and other students to get feedback)

Challenges

- CI not always instantly available
  - At times, CI is busy assisting another student with collaboration, manual therapy, decision making, etc.
  - CI is accessible, but not at student's beckoned call.
  - Scheduling issues with Medicare B and Medicaid patients
- Some students feel like they are compared to another student, which adds to their stress level.
  - One student felt another student from a different program was more advanced, and felt inferior to the other student - was always comparing herself.
- Students with poor confidence (those that like to defer decision making to the CI and want the CI always present) are more challenged early in rotation.

Challenges

- Challenging for the CI to adapt to each different learning style
- Remembering everything with each student
- Keeping up with everything
  - Signing up to 25 notes/day
  - Everything is multiplied by 3
    - Weekly meetings, calendaring, setting up evaluations, collaborative learning experiences, physician contacts, dismissal summaries, inservices, student requests, number of questions, and 3 times the midterm and final CPI's!

Challenges

- Limited availability for individual students
- Negative group dynamics
- Differing skill and knowledge levels
- Physical barriers
- Differences in learning styles
- Logistical demands for CI

(Rose & Best, 2005, Shepard & Jensen, 2002, Bruce et al, 2001, Dunfee et al, 2001, Triggs et al, 1996)

Supervision Guidelines

- Rules vary state to state
- In Minnesota…

As dictated by the MN state practice act, <u>physical therapist students</u> should have <u>"on site"</u> supervision by the supervising therapist, and the supervising physical therapist needs to have <u>direct contact with the patient at least every second treatment session</u>.

Levels of Supervision

(MN state practice act)

- In **Minnesota**, the state practice act dictates the supervising therapist needs be on site. In this act, " **'on-site supervision'** means the physical therapist is easily available to the student physical therapist….. telecommunications, except within the facility, does not meet the requirement of on-site supervision."
- **Direct supervision**, as defined in the MN state practice act, "means the physical therapist is physically present and immediately available to provide instruction to the student physical therapist assistant".

Levels of Supervision

(APTA definition)

- **Direct supervision**, as defined by APTA and applied to either a SPT or SPTA: "the physical therapist is physically present and immediately available for direction and supervision. The physical therapist will have direct contact with the patient/client during each visit that is defined in the *Guide to Physical Therapist Practice* as all encounters with a patient/client in a 24-hour period. Telecommunication does not meet the requiremants for direct supervision."

Medicare B - Supervision

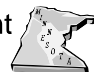
- Services primarily or independently provided by the student are not reimbursable. Student services are not reimbursable under Medicare B since a student physical therapist or student physical therapist assistant do not meet the definitions of a qualified practitioner.
- However, "students may participate in the delivery of services when the qualified practitioner is **present and in the room** for the entire session….The qualified practitioner is **directing** the service, making the **skilled judgment** and is **responsible** for the assessment and treatment…and is **not engaged in treating another patient or doing other tasks** at the same time".

Medicaid - Supervision

(Revised June 2007)

- Medicaid will cover physical therapy services when provided by a SPT or SPTA as long as Medicare B student supervision guidelines are followed (see above). Students may perform documentation but the PT must co-sign and write that she/he was directly involved in providing the intervention. Until the state writes/publishes new rules, the MCHP Provider manual will not reflect this change, even though the change **is currently** in effect.

Supervision in Our Outpatient Collaborative Model



- In our outpatient setting at Mayo, using the 3:1 model allows the level of supervision according to recommended guidelines
  - All patients on one floor
  - Morning and afternoon conferences
  - CI is easily accessible by pager
  - Put the responsibility back on the student to make sure I have seen their patient at least every other treatment, or government payer patient.

Worksheets Used

- Collaborative Education Differential diagnosis and Treatment Planning Worksheet
- Learning Styles
- Goals for the rotation
- Window of time
- What makes up a complex patient
- Experience using the collaborative model at the end of the rotation

Summary

- A Collaborative model has been in use in Mayo's outpatient department for many years
- A 3:1 student to CI model works well
- Many advantages of this model for students, facility, and CI have been discussed
- Supervision requirements for MN are met

Summary

- Collaborative model is financially viable
- Challenges include student and CI adaptations
- Collaborative model makes for an excellent clinical learning environment if the student is committed to adult learning.
- More research is needed to describe and validate use of the collaborative model in an outpatient population.

References

- Cohn ES, Dooley NR, Simmons LA. Collaborative Learning Applied to Fieldwork Education. Occupational Therapy in Health Care, 2001; Hawthorne Press Inc.
- DeClute J, Ladyshewsky RK. Enhancing clinical competence using a collaborative clinical education model. ***Phys Ther.*** 1993;73:683-689.
- Epstien R.M. Mindful Practice. ***JAMA***. 1999; 282:833-839.
- Hillerbrand, E. Cognitive differences between experts and novices: implications for group supervision. ***Cognitive Psychology***. 1989;67(5):293-296.
- Jette D.W., Bertoni A., Coots R., Johnson H., McLaughlin C., Weisbach C. Clinical Instructors' Perceptions of Behaviors That Comprise Entry-Level Clinical Performance in Physical Therapist Students: A Qualitative Study. ***Phys Ther.*** 2007;87(7):833-843.
- Ladyshewsky RW. Clinical teaching and the 2:l student-to-clinical instructor ratio. ***Journal of Physical Therapy Education.*** 1993;7(1):31-35.

References

- Manipulation Education Manual. APTA. 2004.
- Minnesota Department of Human Services, MHCP Provider Manual, Chapter 17. Located at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&Redirected=true&dDocName=id_008951. Accessed October 9, 2006.
- Minnesota Physical Therapy Practice Act, Chapter 148.65, Subdivisions 5-6. Located at http://www.physicaltherapy.state.mn.us/docs/Minnesota_PT_Practice_Act_and_Rules2005.pdf. Accessed October 9, 2006.
- Sackett DL, Rennie D. The science of the art of the clinical examination. JAMA. 1992;267:2650-2652.
- Shepard KS, Jensen GM. Handbook of Teaching for Physical Therapists. 2002, Butterworth-Heinemann.
- Student Supervision During Clinical Education. Minnesota Clinical Education Consortium (MCEC) Revised June 2007; Created October 28, 2006
- Triggs Nemshick M, Shepard KF. Physical therapy clinical education in a 2:l student-instructor education model. ***Phys Ther.*** 1996;76:968-981.