**ACUTE CARE CORE COMPETENCY: COMMUNICATION**

Comptency Definition: *Communicates with all members of the interprofessional medical team – including the patient and family – to ensure the patient receives optimal care.*

Specific Expectations:

1. Selects the most appropriate communication method/style, with consideration of the patient’s age, learning style, cognition, culture and communication needs, communicating for understanding by both the patient and the patient’s family.

2. Clearly communicates the PT’s clinical decisions, with supporting data as available, in regard to: the patient’s safe mobility status; the need for ongoing therapy services in the acute environment; referral for additional services (OT, speech, social work, ortho, neuro, chaplain, psych, patient liaison, etc.); needed assistance from the interprofessional team; and future physical therapy needs.

3. Implements an evidence-based care plan and communicate it in a manner that advocates and represents the PT’s independent clinical judgment in order to determine initiating, continuing, withholding or discontinuing the PT’s services.

4. Collaborates with the interprofessional team to create an environment that eliminates barriers to the patient accessing physical therapy services and promotes safe and effective care. This includes using communication strategies such as: SBAR; briefs/debriefs; curbside consults, rounds, as indicated.

5. Educates members of the interprofessional team of the patient’s circumstances that impact the therapy plan of care, including safe mobility status, tolerance of activity and coordination of therapy services with medical interventions and medications.

6. Provides clear instruction to support personnel and other members of the interprofessional team in order to supplement the patient’s physical therapy care plan.

7. Communicates aspects of the patient’s care through formal and informal conferencing in a manner that respects regulations, team members, the patient’s needs/wants and the PT’s best clinical judgment.

8. Initiates and maintains professional communication with every team member at all times, including adverse, challenging and crucial conversations.
Want to be successful?

SPT confidence in their ability to communicate their clinical decision making was the best predictor of success on their acute care clinical internships.

- Making decisions about proper frequency/duration of therapy
- Educating a patient on optimal mobility strategies for their specific situation
- Judging the level of assistance needed for patient mobility/safety
- Educating physicians/others about the role of physical therapy

“Items that were not correlated with predicting performance were those regarding mobility skills or ambulation and task-specific questions such as measuring range of motion or taking blood pressure.”

Greenwood, KC; Nicoloro, D; & Iverson, MD. Reliability and Validity of the Acute Care Confidence Survey: An Objective Measure to Assess Students’ Self-Confidence and Predict Student Performance for Inpatient Clinical Experiences. JACPT. 2014.
PATIENT/FAMILY COMMUNICATION

Five Fundamentals of Patient Centered Care at Mayo Clinic (AIDET)

1. Acknowledgment
   - Acknowledge patients & family members by name, with eye contact, a friendly smile, and physical closeness/touch (a pat on the shoulder/handshake). Create rapport quickly with a welcoming atmosphere.

2. Introduction
   - Have a friendly, unhurried and courteous tone. Introduce yourself by name, department, and your role. “Good morning Mr. Jones, My name is Mary and I am a Physical Therapy Intern from the Department of Physical Medicine and Rehabilitation. Dr. Berry consulted me to see if I can help with XXXX. As a PT Intern, my expertise is XXX” (I’ll help with making an activity plan with you and we can talk about what your needs are when you leave the hospital.)
   - Let the patient know what you know and who you have spoken to. Speak positively about other team members. “I’ve reviewed your medical chart and have spoken with your nurse, Betty. She’s an excellent nurse.” “I’m aware that you…”

3. Duration/Time Frame
   - Give an estimate of the time you will be with the patient. "I’ll be with you for about 30-45 minutes this morning."
   - Also let the patient know when you will be back. “I’ll be back again this afternoon to continue to work with you.” If you give a timeframe for your return, then be on time.

4. Explanation
   - Give an explanation of what you are going to do. “First, I would like to discuss how you were doing before you came to the hospital, then I’ll do a quick examination to see how you are doing now, and finally I’ll help you get moving. Before we get started, do you have any questions or is there anything you think that I should know?” (Attend to any immediate comfort needs.)
   - During the history: Elicit patient concerns and repeat them back. “Share with me what you understand about the situation?” “What are the main concerns you have right now?” “What concerns you most about leaving the hospital?” “To take care of yourself at home, what do you need to learn?” “What is the most important thing you want or need to accomplish?”
   - After the exam, summarize your findings, areas of concern, and how you will help. Collaboratively determine a prioritized plan. Write goals/plan/homework on whiteboard. “Let me re-cap what you have said, what the issues are…” “This is what I saw with the exam, this is what I am concerned about…” “Here’s how I can help…Here’s what we can do…” (Informed consent)

5. Thank You
   - “Thank you, I look forward to working with you while you are here. Is there anything else I can do for you?” or, "Do you have any questions I can answer for you?" followed by, “I have the time.”

Strong patient-centered care/satisfaction = staff courtesy, employees working together as a team, and skillful communications that keep patients/families informed and collaboratively involve them in decisions about care.


Patients consider switching hospitals for 2 main reasons:
1) Not feeling well informed before/during/after the visit
2) Scheduled appointments were not on time.

When asked to prioritize these 2 items, 3 times as many patients valued “feeling informed” over “timeliness”.

(2007 McKinsey survey)
**Productive Therapist Communication Quiz**  Modified from Kovacek Management Services, Inc. (www.PTManager.com)

Score yourself on each of the following characteristics.

<table>
<thead>
<tr>
<th>Handling Interruptions Throughout My Day</th>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have systems to limit interruptions throughout my day.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I schedule specific times to address email messages/calls.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I am able to focus on my clinical care. I am not easily distracted.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scheduling and Organizing My Day</th>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am aware of my schedule for the day.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I anticipate discharge and plan accordingly.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I have a system in place to prioritize my tasks.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I prepare at the end of the day for the next day’s activities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I prepare at the end of each morning for my afternoon activities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My Treatment Philosophy</th>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>I emphasize what works rather than a specific clinical technique.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I emphasize the patient’s role in their recovery.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I define quality from the patient’s perspective, not mine.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I define good therapy as what produces the best and quickest results.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I use a tiered approach to patient care, beginning with the least costly/risky treatments if I am unsure of the best course of action.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Structuring My Initial Patient Interactions</th>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>I explain the importance of participation at the time of the initial evaluation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I do not give permission to cancel/decline/&quot;no-show&quot; for therapy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I help patients develop a mental image of what success in PT will be for them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I develop, negotiate, and ensure commitment to mutual goals with patients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I emphasize patient responsibility and team effort for optimal recovery.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Structuring My Ongoing Patient Interactions</th>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am committed to patient education.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I use simple language and avoid jargon and multi-syllable words.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I back up verbal instructions with written materials.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I use demonstration and teach-back to make my teaching more effective.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I personalize handouts by highlighting what’s most important for that patient.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I remind myself to listen more and talk less with my patients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I work to improve my listening skills and eye contact with my patients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I determine my patient’s commitment to exercise/mobility and to following recommendations &amp; ask about their actual success in doing so.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My Documentation</th>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>I complete notes immediately after treating the patient.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I keep up with my notes and rarely fall significantly behind.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
## PATIENT-INTERVIEW ASSESSMENT TOOL

**SPT:** ___________________________________________  **Date:** ___________________________

<table>
<thead>
<tr>
<th>Warm Welcome</th>
<th>Score</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduces self: name/profession</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welcomes patient/family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confirms patient's name (2 identifiers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains flow of visit: history/exam</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Interview</th>
<th>Score</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirms reason for hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systems review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening for falls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional concerns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determines learning style</td>
<td></td>
<td></td>
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<tr>
<td>Logical sequencing of questions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-verbal skills</th>
<th>Score</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calm, poised, relaxed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attempts to be at eye level with patient</td>
<td></td>
<td></td>
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<tr>
<td>Head nodding, facial expression, gestures encourage communication</td>
<td></td>
<td></td>
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<tr>
<td>Demonstrates empathy</td>
<td></td>
<td></td>
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<tr>
<td>Attends to patient privacy/comfort</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognizes and responds to patient non-verbals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Verbal skills</th>
<th>Score</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explains rationale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks relevant questions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoids jargon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoids tentative language/repetitive habits (maybe, umm, ok)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks for patient understanding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re-phrases/summarizes to ensure mutual understanding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses transition statements to change topics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tone of voice demonstrates respect and interest in the patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allows patient to express full set of concerns/questions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deals sensitively with embarrassing or challenging topics</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL SCORE**

**Comments**

**Scoring**

0 = needs improvement (elaborate in Comments section)  
1 = satisfactory, meets expectation, is competent  
2 = superior, performs beyond expectations (elaborate in Comments section)

# The Four Habits Model

<table>
<thead>
<tr>
<th>Habit</th>
<th>Skills</th>
<th>Techniques and Examples</th>
<th>Payoff</th>
</tr>
</thead>
</table>
| **Invest in the beginning** | Create rapport quickly | - Introduce self to everyone in the room  
- Refer to the patient by last name and Mr. or Ms. until a relationship has been established  
- Acknowledge wait  
- Make a social comment or ask a non-medical question to put patient at ease  
- Convey knowledge of patient’s history by commenting on prior visit or problem  
- Consider patient’s cultural background and use appropriate gestures, eye contact, and body language | - Establishes a welcoming atmosphere  
- Allows faster access to real reason for visit  
- Increases diagnostic accuracy  
- Requires less work  
- Minimizes “Oh by the way…” at the end of visit  
- Facilitates negotiating an agenda  
- Decreases potential for conflict |
| Ellicit the patient’s concerns | Start with open-ended questions:  
- “What would you like help with today?”  
- Or, “I understand that you’re here for… Could you tell me more about that?”  
- Speak directly with patient when using an interpreter  
- Make eye contact and smile at patient so you are perceived as attentive | | |
| Plan the visit with the patient | Repeat concerns back to check understanding  
- Let patient know what to expect: “How about if we start with talking more about …, then I’ll do an exam, and then we’ll go over possible tests/ways to treat this? Sound OK?”  
- Prioritize when necessary: “Let’s make sure we talk about X and Y. It sounds like you also want to make sure we cover Z. If we can’t get to the other concerns, let’s…” | | |
| **Ellicit the patient’s perspective** | Ask for the patient’s ideas | - Assess patient’s point of view:  
- “What do you think might be causing your problem?”  
- “What worries or concerns you most about this problem?”  
- “What have you done to treat your illness so far?”  
- “Have you sought help in your community?”  
- Ask about ideas from loved one | - Respects diversity  
- Allows patient to provide important diagnostic clues  
- Unveils hidden concerns  
- Reveals use of alternative treatments or requests for tests  
- Improves diagnosis of depression and anxiety |
| Ellicit specific request | Determine patient’s goal in seeking care: “How were you hoping I could help?” | | |
| Explore the impact on the patient’s life | Check context: “How has the illness affected your daily activities/work/family?”  
- “What are the main problems your illness has caused for you?” | | |
| **Demonstrate empathy** | Be open to the patient’s emotions | - Respond in a culturally appropriate manner to changes in body language and voice tone | - Adds depth and meaning to the visit  
- Builds trust, leading to better diagnostic information, adherence, and outcomes  
- Makes limit-setting or saying “no” easier |
| Make an empathic statement | Look for opportunities to use brief empathic comments  
- Name a likely emotion: “You seem really worried”  
- Complain patient on efforts to address problem | | |
| Convey empathy nonverbally | Use a pause, touch, or facial expression | | |
| Be aware of your own reactions | Use your emotional response as a clue to what patient might be feeling | | |
| **Deliver diagnostic information** | Frame diagnosis in terms of patient’s original concerns | | |
| Provide education | Explain rationale for tests and treatments  
- Review possible side effects and expected course of recovery  
- Discuss lifestyle changes that are consistent with patient’s lifestyle, cultural values and beliefs  
- Provide resources, for example, written materials, in patient’s preferred language when possible | | |
| Involve the patient in making decisions | Discuss treatment goals: express respect towards alternative healing practices  
- Assess patient’s ability and motivation to carry out plan  
- Explore barriers: “What do you think we could do to help overcome any problems you might have with the treatment plan?”  
- Test patient’s comprehension by asking patient to repeat instructions. “Just so I am sure that I have explained things well, would you tell me your understanding of the next steps?”  
- Set limits respectfully: “I can understand how getting that test makes sense to you. From my point of view, since the results won’t help us diagnose or treat your symptoms, I suggest we consider this instead.” | | |
| **Invest in the end** | Complete the visit | - Summarize visit and review next steps  
- Ask for additional questions: “What questions do you have?”  
- Ask family members if they have other questions  
- Assess satisfaction: “Did you get what you needed?”  
- Close visit in a positive way:  
- “It’s been nice meeting you.”  
- “See you in ______ months.”  
- “Thanks for coming in.” | | |

©1996, Physician Education & Development, TPAC, Inc. Revised April, 2003 in partnership with the Institute for Culturally Competent Care.
<table>
<thead>
<tr>
<th>Functions of the Medical Interview</th>
<th>Roles and Responsibilities of the Physician</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fostering the relationship</td>
<td>• Build rapport and connection</td>
<td>• Greet patient appropriately</td>
</tr>
<tr>
<td></td>
<td>• Appear open and honest</td>
<td>• Maintain eye contact</td>
</tr>
<tr>
<td></td>
<td>• Discuss mutual roles and responsibilities</td>
<td>• Listen actively</td>
</tr>
<tr>
<td></td>
<td>• Respect patient statements, privacy, autonomy</td>
<td>• Use appropriate language</td>
</tr>
<tr>
<td></td>
<td>• Engage in partnership building</td>
<td>• Encourage patient participation</td>
</tr>
<tr>
<td></td>
<td>• Express caring and commitment</td>
<td>• Show interest in the patient as a person</td>
</tr>
<tr>
<td></td>
<td>• Acknowledge and express sorrow for mistakes</td>
<td></td>
</tr>
<tr>
<td>Gathering information</td>
<td>• Attempt to understand the patient's needs for the encounter</td>
<td>• Ask open-ended questions</td>
</tr>
<tr>
<td></td>
<td>• Elicit full description of major reason for visit from biologic and psychosocial perspectives</td>
<td>• Allow patient to complete responses</td>
</tr>
<tr>
<td>Providing information</td>
<td>• Seek to understand patient's informational needs</td>
<td>• Listen actively</td>
</tr>
<tr>
<td></td>
<td>• Share information</td>
<td>• Elicit patient's full set of concerns</td>
</tr>
<tr>
<td></td>
<td>• Overcome barriers to patient understanding (language, health literacy, hearing, numeracy)</td>
<td>• Elicit patient's perspective on the problem/illness</td>
</tr>
<tr>
<td></td>
<td>• Facilitate understanding</td>
<td>• Explore full effect of the illness</td>
</tr>
<tr>
<td></td>
<td>• Provide information resources and help patient evaluate and use them</td>
<td>• Clarify and summarize information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inquire about additional concerns</td>
</tr>
<tr>
<td>Decision making</td>
<td>• Prepare patient for deliberation and enable decision making</td>
<td>• Explain nature of problem and approach to diagnosis, treatment</td>
</tr>
<tr>
<td></td>
<td>• Outline collaborative action plan</td>
<td>• Give uncomplicated explanations and instructions</td>
</tr>
<tr>
<td>Enabling disease- and treatment-related behavior</td>
<td>• Assess patient's interest in and capacity for self-management</td>
<td>• Avoid jargon and complexity</td>
</tr>
<tr>
<td></td>
<td>• Provide advice (information needs, coping skills, strategies for success)</td>
<td>• Encourage questions and check understanding</td>
</tr>
<tr>
<td></td>
<td>• Agree on next steps</td>
<td>• Emphasize key messages</td>
</tr>
<tr>
<td></td>
<td>• Assist patient to optimize autonomy and self-management of his or her problem</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Arrange for needed support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Advocate for, and assist patient with, health system</td>
<td></td>
</tr>
<tr>
<td>Responding to emotions</td>
<td>• Facilitate patient expression of emotional consequences of illness</td>
<td>• Assess patient's readiness to change health behaviors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Elicit patient's goals, ideas, and decisions</td>
</tr>
</tbody>
</table>

*Modified using Makoul, Levinson et al., Epstein and Street, McCormack et al., and Smith et al.*
Specific Clinical Actions that Bring Healing
F. Benedetti, M. Amanzio / Patient Education and Counseling 84; 2011

1) Speak positively about treatments and their expected benefits. Use language that minimizes negative connotations and instead offer positive hints (“this exercise will loosen up your knee and help you get better” vs. “this exercise might cause pain”)
2) Provide encouragement.
3) Develop trust by confidence, competence, transparency, timely follow-through, and respectfulness.
4) Listen and provide reassurance when patients are disappointed, anxious, discouraged.
5) Support relationships with patients, families, and team-members.
6) Respect the uniqueness and individuality of the patient.

Motivational Interviewing for Behavior Change

Helps those who seem passive, ambivalent, or unable to make a decision

FOUNDATIONS

- Collaboration
  - Listen.
  - Work together to reach common goal.
  - View patients as the experts of their own lives.

- Autonomy
  - Respect the patient’s ability to make own decisions.
  - Acknowledge their freedom to adopt a behavior.
  - Resist the urge to “change their mind.”

- Evocation
  - Elicit information about internal motivations.
  - Help patient to reflect on advantages and barriers.
  - Understand what motivates them. Empower them.

FACILITATORS OF BEHAVIOR CHANGE

- Personal
  - Write collaborative determined goal(s) on whiteboard.
  - Use of diaries/logs with MI = statistically significant improvement in outcomes.
  - “I’m excited about how I can help you and what we can accomplish together. Are you willing?”
  - What will they do right now? By end of week?

- Social
  - Tell everyone about the goal(s) in front of the patient. (nurse, MDs, etc.)
  - Build in peer support. Ask them to encourage patient.

- Structural
  - Strategically choose equipment, furniture, and arrange room set-up for success.
  - Build goal into daily routine (i.e. walk to bathroom, chair for meals).
1. Using simple language without medical jargon, explain the concept or demonstrate the process to the patient/caregiver. Limit to 3-4 items to recall, if possible. If the patient/caregiver has limited English proficiency, a professional translator should be utilized to reduce miscommunication.

2. Ask the patient/caregiver to repeat in his or her own words how he or she understands the concept explained. If a process was demonstrated to the patient, ask the patient/caregiver to demonstrate it, without your assistance.

3. Identify and correct any misunderstandings of or incorrect procedures by the patient/caregiver.

4. Again, ask the patient/caregiver to demonstrate his or her understanding or procedural ability to ensure the above-noted misunderstandings are now corrected.

5. Repeat Steps 3 and 4 until the clinician is convinced the comprehension of the patient/caregiver about the concept or ability to perform the procedure accurately and safely is ensured.
Utilizing a Medical Interpreter

• Prior to the Interview
  o Allow extra time.
  o Explain the situation and your education/intervention plan briefly to the interpreter.
  o Find out the proper form of address and the correct pronunciation of the patient's name.
  o Encourage the interpreter to let you know if communication problems arise.

• During the Interview
  o Introduce yourself.
  o Look and speak directly at the patient, not the interpreter because it is the patient you are talking to, not the interpreter.
  o Address the patient rather than the interpreter as “you.” ("When did you start feeling the pain?")
  o Ask one question at a time. Speak slowly and clearly with frequent pauses.
  o Avoid slang, jargon, technical terms, metaphors or proverbs.
  o Don’t say anything that you don’t want interpreted.
  o Make sure the patient understands what you are saying; observe body language.
  o Expect the interpreter to interrupt when necessary for clarification.
  o Summarize the conversation and ask the patient if clarification is needed.

• After the Interview
  o Give the interpreter the opportunity to discuss any cultural or linguistic issues that may have arisen.
Compensation Techniques for Impairments

**Visual Impairments**
- Ensure adequate light. Reduce glare.
- Use large print and strongly contrasting colors.
- Use touch/tactile cues to aid communication.
- Describe environment/situation.
- Ensure all items are in reach and patient is oriented to their location.

**Hearing Impairments**
- Face the person at eye level.
- Before speaking, be certain you have eye contact and the attention of the person.
- Check to see if the patient uses a hearing aid, and has it adjusted properly.
- Stay within 2 feet of the person, if possible.
- Speak slowly and clearly, but do not shout.
- Repeat information exactly the same way initially before using different words.
- Talk naturally with a few more pauses than usual.
- Lower the pitch of your voice.
- Minimize background noise (turn off TV, close curtain/door).
- Use nonverbal communication, such as facial expressions, demonstration, & tactile cues.
- Write any messages that need clarification.

**Cognitive Impairments**
- KISS principle.
- Try a warm, calm, gentle, matter-of-fact approach.
- Begin the conversation socially to establish trust and a relaxed atmosphere. Include orienting information.
- Look directly at the person and ensure you have their attention before you speak.
- Gently touch an arm or hand to gain attention. Say the person’s name multiple times, if needed.
- Speak slowly and clearly, but not in a demeaning fashion. (Talk less, do more, be specific.)
- Minimize distractions.
- Use tactile guidance to help convey your message throughout the session.
- Choose meaningful, familiar functional tasks.
- Initially give global commands “sit up” rather than “bend your knees, reach over here” etc. Patient can get lost in multi-step commands that don’t seem to make sense.
- Respond to emotions being conveyed, not necessarily the words being used.
- Ask simple questions that require a choice, rather than an open-ended question.
- Allow plenty of time for information to be processed.
- If frustration occurs, temporarily drop the subject and respond to emotions.
- Be patient.
- Use positive phrases rather than negative. “Let’s sit here.” Instead of “you can’t sit there.”
- Use distraction.
- Don’t argue, scold, be condescending, ask a lot of questions, or talk about the patient in front of them.
- Remember, confabulation is not purposeful lying. The patient believes the information is true.
NON-EMERGENT TEAM COMMUNICATIONS

Verbal Hand Offs & Discussion of Concerns (SBAR, I-PASS, CUS)

Communication breakdowns cause > 50% of sentinel events reported in our country. Most of these are associated with transition of care and can result in patient death. The Joint Commission National Patient Safety Goals require health care organizations to implement standardized handoff communications, including an opportunity to ask and respond to questions.

SBAR is an easy-to-use, evidence-based verbal framework for sharing pertinent information. It facilitates focused delivery and receipt of patient information. SBAR is not a documentation process or a replacement for a clinical note.

- **“S”** = situation (what is going on with the patient).
- **“B”** = background (background or context of the patient/situation).
- **“A”** = assessment (your assessment of the patient/situation).
- **“R”** = recommendation (what you think needs to be done).

Always use SBAR format when speaking over the phone:

**S: Situation:**
Identify yourself and the patient you are calling about.

**Example:** “Hello, I am Annie from Physical Therapy.” “I am calling you to clarify activity orders for Mr. Johnson.” OR “I am concerned that Mr. Johnson is having: a change in oxygen needs, significant back pain, new complaints of XX.”, or “I have concerns about Mr. Johnson’s dismissal plan.”

**B: Background:**
Explain clinical background or context leading to situation
- Use physical findings, vitals, pertinent medical history, response to interventions, etc.
- Give objective information that will help the doctor understand your concerns.

**A: Assessment:**
What do you think is happening with the patient?
- I am concerned that this patient is....

**R: Recommendation:**
What do you think needs to be done?
- I think you should come see the patient.
- I think the patient may need imaging.
I-PASS is a newer mnemonic also being used to reduce medical errors. It is similar to SBAR, but adds components of: illness severity, contingency plans, and receiver understanding (synthesis).

"I" = illness severity
"P" = patient summary (similar to the SBA in SBAR)
"A" = action items (similar to the R in SBAR)
"S" = situation awareness and contingency plans
"S" = synthesis by receiver

Team members must initiate communication and ask questions when a concern develops. The rest of the team must be open to and respectful of those asking, make time, and be responsive to concerns raised.

CUS is a tool used to signal to others a concern that needs discussion and/or resolution before proceeding.

"C" = concerned (I’m concerned about doing X.)
"U" = uncomfortable (I’m uncomfortable doing X.)
"S" = stop (I think we need to stop X and re-assess this situation.)

PATIENT CARE CONFERENCES

Patient care conferences provide an opportunity to improve patient care in situations where there is a need to assure appropriate communication or a need for in-depth planning. It may be a complex situation with multiple disciplines involved, a prolonged hospitalization, family issues, or maybe a need to plan for discharge.

Prior to Care Conference:
- Collaborate with the multidisciplinary team and patient to determine the purpose of the conference and what needs to be accomplished at the care conference.
- Review the patient’s chart and make notes on objective data. Be prepared to give a short summary of the patient’s therapy plan of care, issues, and current/future needs – particularly in regard to safety, equipment, function, assistance required.

During the Care Conference:
- Introduce yourself. State how long you have been working with the patient.
- Provide pertinent therapy input.
- Encourage confirmation of patient status from the nurse, patient, & family.
- Encourage the patient and family to participate in the discussion.
- Summarize therapy’s role, focus, and recommendations.

After the Care Conference:
- Note participation in the care conference in your documentation and the input your provided. Specify any particular actions that will be implemented or follow-up issues to be addressed.
CONFLICT MANAGEMENT

When conflicts arise, please speak to the CI about what happened and what you can do next to manage the situation.

Have a BLAST with Upset Patients/Families
Adapted from Dr. Howard Steinman, 3/1/10, Medscape

Believe. Believing is the “cornerstone” of the process. Express belief that their expectations have not been met, even if the patient is exaggerating, lying, emotional or irrational, or incorrect. Belittle or trivialize their belief at your own peril.

Listen. Stop the mind and mouth. Listen to what the patient is saying – let them vent. Give them a “magic minute” to get out all their grievances. Do not mentally react and start preparing your rebuttal. Pause, relax, clear your head, and stay calm. That means not getting upset with patients who are rude or angry, or who swear, threaten, or repeat their complaints more than once.

After the patient has finished talking, restate the patient’s concerns in a relaxed tone: “What I hear you saying is that you expected …..” The statement may need to be rephrased or repeated or until the patient is satisfied. Phrasing the statement in terms of an expectation is helpful, especially if the patient’s expectation is not appropriate or accurate. Do not try to defend or justify. The patient doesn’t care. They want solutions, not excuses.

Apologize. Making an apology does not mean acceptance of legal responsibility. Instead, apologize for what the patient’s unmet expectations. Apologize even if you did nothing wrong. The patient feels they have a legitimate complaint and expects an apology. A sincere apology will diffuse much of the patient’s fear, frustration, and anger.

Satisfy. Re-assure the patient that you will make every effort to make it right going forward. Explain the options, the time frame, and whether the problem can be completely solved. If the patient is complaining about another provider, never add your own commentary, but encourage the patient to speak to that provider or the supervisor of that provider.

Thank. Thank the patient for sharing their feelings and concerns with you.
2 Things You Should Do If Faced with a Conflict

Adapted from “Can We Talk” presentation given by Mary Ann Djonne, Human Resources, Mayo Clinic, 2009

1. SELF-CHECK
   a. Be aware of your usual response: avoidance, complaining, aggressive confrontation.
   b. Pause, take a deep breath/create some space if needed.
   c. Reflect: Why would a decent person do this? How have I contributed to the problem? What are the facts and what assumptions am I making?
   d. Consider if it is a minor issue that can be ignored or not. If the problem might continue, affect your relationship with that person, or affect patient care, then you need to ACT.

2. SPEAK TO THE PERSON
   a. Take the conversation away from patient care areas.
   b. Be non-defensive: respectful, objective, empathetic, listen to understand, depersonalize.
   c. State your good intent to preserve your relationship with that person and to ensure optimal patient care.
   d. Ask permission, “Can we talk about XXX?” Describe facts. Describe the impact on you.
   e. Ask for their perspective. Re-phrase/repeat to them.
   f. Try to collaborate on a solution.

If you don’t “talk it out,” you will be likely to “act it out.”

- Avoiding the person or work area.
- Gossiping or complaining to someone else.
- Taking your frustration out on someone else.
- Ruminating with negative self-talk.
- Reinforcing defensive non-verbals and poor communication skills.
- Attacking like a bull in a china shop when the next little issue tips you over the edge.
INTROVERTS & EXTROVERTS

TIPS FOR EXTROVERTS

• Welcome introverts to state their opinions, but avoid putting them on the spot.
• Give prior notice of discussion topics to give them time to compose their thoughts.
• Limit chitchat to the beginning of a conversation, and get to the more substantive parts more quickly.
• Just as you may have a breadth of knowledge on many topics, appreciate introverts for their deep understanding of fewer topics.
• Respect introverts' need for private space.
• Remember that what you find stimulating may be overwhelming for introverts; many need to quietly focus on one thing at a time.
• Give introverts some time alone to do their best thinking and problem-solving.
• Recognize that introverts tend to undersell their accomplishments and potential contributions.
• Let introverts finish speaking, count to three (to yourself!), and then speak; do not fill in the pauses.

TIPS FOR INTROVERTS

• Be prepared to discuss a few light conversation topics to help the extroverted person feel connected.
• Arrive at meetings well rested and refreshed to help prevent sensory overload.
• Just as you prefer to think through your ideas before you talk about them, extroverts often like to work through their ideas out loud and bounce them off others.
• Expect to do brainstorming out loud with extroverts.
• While you may normally prefer to wait your turn to speak, be prepared to jump in when speaking with a group of extroverts.
• If you're stumped by a question, respond that you need a moment to think about it or that you'll follow up with an answer later.
• Recognize extroverts' needs to have plenty of varied activities and people to talk to.
• An extrovert may be bored by an in-depth discussion behind closed doors with one person on a single topic.
• Keep in mind that extroverts tend to be action oriented and to rely on the outside world for input and stimulation; balance that with your more inward focus.
• Just as you may have deep knowledge about a few topics, appreciate extroverts' breadth of knowledge on many topics.
## TABLE 1: EVIDENCE SUPPORTING USE OF COMMUNICATION SKILLS IN MEDICAL ENCOUNTERS

<table>
<thead>
<tr>
<th>Communication Outcome</th>
<th>Source, y</th>
<th>Study Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient satisfaction</td>
<td>Korsch et al,&quot; 1968</td>
<td>• Studies as a group show strong, consistent association of physician behaviors with patient satisfaction</td>
</tr>
<tr>
<td></td>
<td>Bertakis,&quot; 1977</td>
<td>• Both “task behaviors” (facilitating patient talk, giving detailed instructions) and “affective behaviors” (socioemotional exchanges,</td>
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<tr>
<td></td>
<td>Stiles et al,&quot; 1979</td>
<td>being empathic, showing caring) shown to be positively associated, with varying primacy of each</td>
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<tr>
<td></td>
<td>Buller and Buller,&quot; 1987</td>
<td>• Nonverbal behaviors also positively associated (e.g., eye contact)</td>
</tr>
<tr>
<td></td>
<td>Roter et al,&quot; 1987</td>
<td>• Negative behaviors (being overly directive, not addressing patients’ main concern) can attenuate effect</td>
</tr>
<tr>
<td></td>
<td>Stewart and Roter,&quot; 1989</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rowland-Morris,&quot; 1990</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wanzer et al,&quot; 2004</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bredart et al,&quot; 2005</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Roter et al,&quot; 2006</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tallman et al,&quot; 2007</td>
<td></td>
</tr>
<tr>
<td>Recall, understanding,</td>
<td>Francik et al,&quot; 1969</td>
<td>• Studies show weaker, but positive, association of physician behaviors with recall of encounter events, giving of medical advice, and</td>
</tr>
<tr>
<td>adherence</td>
<td>Ley et al,&quot; 1976</td>
<td>adherence</td>
</tr>
<tr>
<td></td>
<td>Garrity,&quot; 1989</td>
<td>• Information given needs to be clear, simple, jargon-free</td>
</tr>
<tr>
<td></td>
<td>Bartlett et al,&quot; 1984</td>
<td>• Checking patients’ understanding of physician explanations and instructions is fundamental but less frequently performed by physicians</td>
</tr>
<tr>
<td></td>
<td>Tuckett et al,&quot; 1985</td>
<td>• Attending to patient satisfaction is a necessary accompaniment</td>
</tr>
<tr>
<td></td>
<td>Roter et al,&quot; 1987</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stewart and Roter,&quot; 1989</td>
<td></td>
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<tr>
<td></td>
<td>Kjellgren et al,&quot; 1995</td>
<td></td>
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<td></td>
<td>Stewart,&quot; 1995</td>
<td></td>
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<td></td>
<td>Silk et al,&quot; 2008</td>
<td></td>
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<tr>
<td></td>
<td>Zolnierek and DiMatteo,&quot; 2009</td>
<td></td>
</tr>
<tr>
<td>Health outcomes</td>
<td>Orth et al,&quot; 1987</td>
<td>• Some studies show positive association with physiologic measures (blood pressure, blood glucose), health status (headache frequency,</td>
</tr>
<tr>
<td></td>
<td>Kaplan et al,&quot; 1989</td>
<td>depression), functional status (levels of distress with illness); others unable to find such effects</td>
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<tr>
<td></td>
<td>Fallowfield et al,&quot; 1990</td>
<td>• Data set is suggestive but incomplete—effect sizes are small, studies are inconsistent</td>
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<tr>
<td></td>
<td>Stewart,&quot; 1995</td>
<td></td>
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<tr>
<td></td>
<td>Kimmons et al,&quot; 1998</td>
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<td></td>
<td>Stewart et al,&quot; 2000</td>
<td></td>
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<tr>
<td></td>
<td>Epstein and Street,&quot; 2007</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Levinson et al,&quot; 2010</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weiner et al,&quot; 2013</td>
<td></td>
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<tr>
<td>Negative outcomes</td>
<td>Beckman et al,&quot; 1994</td>
<td>• Physicians with higher malpractice complaints have twice as many complaints about communication</td>
</tr>
<tr>
<td></td>
<td>Hickson et al,&quot; 1994</td>
<td>• Physicians with poor communications scores on Canadian licensing examination have higher subsequent malpractice claims</td>
</tr>
<tr>
<td></td>
<td>Levinson et al,&quot; 1997</td>
<td>• Physicians with few malpractice claims use more facilitation, encourage patients to talk, and check understanding</td>
</tr>
<tr>
<td></td>
<td>Ambady et al,&quot; 2002</td>
<td>• Patients report harmful breakdowns in communication (insufficient information and lack of emotional support)</td>
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<tr>
<td></td>
<td>Whitlock et al,&quot; 2002</td>
<td></td>
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<tr>
<td></td>
<td>Tamblyn et al,&quot; 2007</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mazor et al,&quot; 2012</td>
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ACUTE CARE CORE COMPETENCY: DISCHARGE PLANNING

Competency Definition: Make clinical decisions to support a safe discharge plan and communicate these decisions with all members of the interprofessional team to ensure the patient receives optimal care.

Specific Expectations:

• Critically assesses patient safety (cognition/function).

• Considers patient’s life context, including: pre-hospitalization status; age; suitability of home environment; caregiver support; follow-up/transportation needs; risk factors for re-hospitalization; and economic resources.

• Assesses expectations and desires of stakeholders (e.g., patient, family, caregiver, medical team).

• Understands regulations imposed by the healthcare systems and payers.

• Determines optimal equipment needs, with consideration of reasonable and necessary standards, in context of available funding and patient’s individual circumstances.

• Determines destination, level of support, need for continuity of care in post-acute settings (rehabilitation, outpatient, home, sub-acute or other), additional services, and follow-up needs.
**WHY is my patient in the hospital?**

Medical necessity: presence of an acute condition that requires hospital-based diagnostic tests/measures, medical interventions, and/or close medical monitoring.

**WHEN will my patient discharge from the hospital?**

Discharge planning starts on hospital admission. The primary service predicts when they think the patient will be medically ready to leave the hospital. If any team member believes the discharge date is not accurate from their perspective, they should discuss this with the primary team. The primary team determines when the patient will discharge based on medical necessity.

We must avoid situations where the patient is medically ready for discharge, but remains hospitalized due to difficulty finding an appropriate setting or other social factors. Timely communication and documentation is very important.

Discharge Rounds occur daily to facilitate timely communication across disciplines and to have patients ready for discharge the day before dismissal. (Plan for day, Plan for the stay, What’s in the way?)

**NOTE:** At the time of hospital discharge, your patient’s mobility may NOT be at baseline, but continued rehab needs do not dictate medical necessity. Your job is to prioritize needs that must be addressed to facilitate discharge. Additional rehabilitation needs can be addressed outside the hospital.

**WHO is involved in discharge planning?**

Input is needed from multiple sources to determine the optimal discharge plan (patient, family, nurse, MDs, PT, OT, social worker, and insurser).

**PRIMARY SERVICE:** Estimates discharge date. Completes hospital summary with medication info, ongoing cares, (wound etc.), infection related concerns, contact info, and dismissal destination. Provides O2 prescription for transport, if needed. Completes provider-to-provider call as appropriate.

**NURSING:** Calls facility/agency on day of discharge to report: specific care needs, frequency of scheduled cares, equipment needs, and supplies needed.

**SOCIAL WORKER:** Reviews medical record for prior social work/discharge planning notes. Completes consultation with the patient/family and reviews discharge options. Coordinates patient needs in the home including: hospice, IV therapy, medical equipment, oxygen, wound VAC/PleurX, Embassy needs. Also coordinates needs outside the home including: hospital transfer, TCU/SNF, inpatient hospice. Reviews insurance coverage/criteria and provides list of Medicare-approved options, if appropriate. Sends information to facilities for assessment. Confirms acceptance at facility. Coordinates dismissal time/date with patient/family and facility. Arranges for complex air/ground transportation, as recommended by therapy, and communicates recommendations to the patient/family. Assists with financial assistance, abuse/neglect issues, and advanced directives.

**OT:** PTs assess basic cognition as it pertains to mobility, however, OTs are trained to assess higher level cognitive decisions with ADLs and IADLs (self-care, medication management, safety decisions). When there are ADL/IADL and cognitive concerns, seek the expert advice of OT and collaborate together on discharge needs with a holistic view of patient safety. (Just because the patient walked in the hallway without falling does not mean that they are “safe.”)
WHAT is my role in discharge planning?

Your role will be to help determine:

- **where** should the patient go?
- **how** will they get there?
- **who** will support them?
- **how much** support (intermittent, 24/7)?
- **what** equipment does the patient need?

“The most important factors in discharge planning identified by therapists were: the ability to transfer and ambulate, having a person at home to assist, and the patient's cognitive status. These were aptly termed, the big three…but clearly, other factors need serious consideration such as the patient's home accessibility, community resources such as availability of visiting nurses and meals on wheels, and even the patient's insurance and financial resources.”


Other factors that may influence your recommendations include:

- Patient's wants/needs
- Family/caregiver wants/needs
- Living environment/Home suitability
- Logistics (Ability to obtain services/transportation)
- Economic barriers/insurance barriers
- Facility/healthcare regulations

CONSIDER: Community-dwelling older adults (regardless of mobility ability):

- Walk and average of **900-1000 ft** during the performance of an IADL.
- **Carry** items during trips into the community.
- Have to **manage obstacles** such as stairs, curbs, slopes, and uneven surfaces.
- Need to be able to perform mobility under **multi-task** conditions/cognitive load.
- Perform postural transitions (**starts/stops, direction changes, head turning, reaching**).

Shumway-Cook et al. 2002. Physical Therapy

In EVERY therapy treatment session, discharge planning is central. You must assess the patient's evolving mobility and safety to determine/confirm/modify the discharge plan.
**Questions to ask yourself:**

Does the patient’s current status match the desired discharge destination and the available level of support? If not: Will more therapy facilitate the match? What would be the predicted time-frame for a “match” to take place? If the patient will not achieve the desired match, you will need to advocate the level of assist required.

**WHERE will my patient discharge?**

Determining the most appropriate discharge location involves determining the patient’s needs then matching their needs with potential sites of care. The severity of functional impairments, the need for assistance with activities of daily living, and safety awareness often determines whether a patient can be safely managed at home or requires care at a facility.

**DISCHARGE LOCATIONS**

**Long-term acute care hospitals (LTAC)** – More likely to take complex medical patients than IRFs, but less widely geographically distributed. Must require daily monitoring and complex medical interventions (i.e. complex wounds, chest tubes, ventilatory dependency, or multiorgan failure) with an average LOS ≥25 days.

**Inpatient Rehab Facilities (IRF)** – 75% of IRF admissions must have a specified diagnosis (stroke, SCI, congenital deformity, major multiple trauma, amputation, femur fracture, brain injury, neurologic disorders, burns, active polyarticular RA, system vascularities, severe OA in ≥2 WB joints, complex TKA/THA, or debility with Neuro or Ortho dx). Must require multidisciplinary therapy (PT, OT, Speech), be able to participate in 3 hours of therapy per day, and require ongoing physician supervision at least three days per week. Must have goals that are achievable during the rehab stay.

Patients with neuro diagnoses (brain/spine mets) can be good candidates for IRF. In addition, patients with Critical Illness Myopathy/Neuromyopathy/Neuropathy often have profound weakness (paraparesis or quadriplegia) and long, complex hospital courses that require careful medical monitoring. The target LOS for these patients at an IRF is 21 days.

The ultimate goal is to discharge home after a rehab stay and sometimes that means means from wheelchair base. The patient may not be completely independent at discharge, so the family can decide if going home is even reasonable after rehab or if it would be better to go to a skilled facility where the length of stay may be longer.

**Skilled nursing facilities (SNF)/Transitional Care Units (TCU)** – For Medicare coverage, must have a three-night hospital stay and require skilled nursing or rehabilitation for at least 1 hr/day, 5 days/wk. Benefits last 100 days without a new qualifying event. Most SNFs do not accept patients with high cost treatments (i.e. chemo). SNFs often do NOT admit on weekends. TCU’s are hospital-based, have more access to hospital-based services, and DO admit on weekends.

**Extended care facilities (ECF)** - Provide long-term custodial care reimbursed through Medicaid. In order to qualify for Medicaid, a patient must have exhausted his/ her assets, require assistance with a least three ADLs, and require skilled nursing supervision. Medicaid alone does not cover therapy services or skilled care, aside from the Medicare copayment.
Home Services – 3/4 of hospitalized patients return home at discharge. To discharge home, patients (with help from family or other caregivers) should be able to:

- Mobilize safely within the home and perform self-care activities
- Eat an appropriate diet or otherwise manage nutritional needs
- Obtain and self-administer medications
- Follow up with designated providers

Home Services can include skilled home health care, private pay services, hospice, and infusion services.

*Skilled Home Health Care* - Medicare Part A and some private insurance companies cover home care. Home health care is NEVER full-time or 24/7. Skilled PT, OT, ST and nursing services are covered at 100% with no cap or co-pay. Home health aides can be added at no charge to assist with cares, BUT care by aides only (or OT alone) is not covered. Patients cannot receive outpatient therapy services and quality for home care at the same time. A 3-day qualifying hospital stay is not required to receive Medicare Part A home care services.

**Criteria:** (ultimately the home care agency determines if the patient meets these requirements)
- acute or chronic medical condition with a *new change in function*
- services are medically necessary and ordered by a physician (written order & face-to-face documentation)
- services are skilled (not custodial)
- homebound status
  - Requires a *taxing effort* and/or assistance to leave the home. Assistance includes another person providing cognitive and/or physical assistance or the use of a gait aid/wheelchair.
  - Absences must be infrequent and short in duration; and the patient cannot drive a car. Lack of transportation alone does not qualify someone as homebound.

**Services Provided** (Typically 2-3 visits/week):
- **PT:** Fall Prevention, mobility/gait/stairs, home safety/modification, equipment recs, caregiver training.
- **OT:** ADL/cognitive assessment/training, home safety/modification, equipment recs, caregiver training.
- **Nursing:** Med management/training, diabetes, wound Care, INRs, injections, catheter care.
- **Aides:** Bathing, oral hygiene, shaving, dressing, skin care, position changes, assisting with mobility that is supportive of skilled therapy services **Meal preparation & housekeeping are not provided.**

**Hospice** - Hospice is a philosophy of care rather than a discharge destination. To qualify for hospice, a patient must have a life-threatening illness and a MD must provide a written prognosis that the patient has < 6 months to live. May receive comfort interventions, but not those with curative life-prolonging intent.

Hospice can be provided in the home or in a facility. The hospice agency does NOT provide 24/7 physical care to patients in the home, but they do provide family/caregiver training and are available to consult with 24/7. Patients typically enter/exit the home via stretcher, so the ability to ambulate or negotiate stairs is not a discharge concern. If a patient is dismissing home on hospice, then PTs will recommend equipment needed at home which is then provided at no cost by the hospice agency (for low mobility patients, this often includes a hospital bed, commode, transfer device, wheelchair).

Facility-based hospice care is a Medicare benefit, but the patient is required to pay a "room/board" fee each day (about $150-$200/day) and this can be cost-prohibitive for many patients.
## Capabilities of types of post-acute care hospital facilities

<table>
<thead>
<tr>
<th></th>
<th>Acute care hospitals</th>
<th>IRFs and LTACs</th>
<th>Medicare-certified facilities (SNFs, TCUs, subacute)</th>
<th>Extended care facilities (ECFs) Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hospital-based (TCU)</td>
<td>Community-based subacute and SNF</td>
</tr>
<tr>
<td><strong>Response to resuscitation</strong></td>
<td>Rapid</td>
<td>Rapid</td>
<td>Rapid</td>
<td>Slow</td>
</tr>
<tr>
<td></td>
<td>Equipment and trained staff</td>
<td>Equipment and trained staff</td>
<td>Hospital level</td>
<td>Limited equipment and trained staff, &quot;911&quot;</td>
</tr>
<tr>
<td><strong>Access to complex diagnostic/therapeutic modalities</strong></td>
<td>High</td>
<td>Moderate</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>Laboratory, imaging, IR</td>
<td>Radiograph, ultrasound, laboratory on site</td>
<td>Hospital level</td>
<td>Off-site radiograph and laboratory</td>
</tr>
<tr>
<td><strong>Availability of subspecialty consultants</strong></td>
<td>High</td>
<td>Moderate</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>Full range, subspecialties</td>
<td>Psych, Pain, Ortho, Neuro, PM&amp;R</td>
<td>Hospital level</td>
<td>Psych, Hospice, Ophthalmology, Dental, Podiatry</td>
</tr>
<tr>
<td><strong>Intensity of RN services</strong></td>
<td>High</td>
<td>Moderate</td>
<td>Moderate-low</td>
<td>Moderate-low</td>
</tr>
<tr>
<td></td>
<td>12 hours/patient/day (ICU)</td>
<td>Five to six hours/patient/day</td>
<td>Three to four hours/patient/day</td>
<td>Two to four hours/patient/day</td>
</tr>
<tr>
<td><strong>Intensity of MD services</strong></td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>24-hour, on-site MD</td>
<td>24-hour, on-site MD</td>
<td>24-hour, on-site MD</td>
<td>Two to three times per week, rarely daily</td>
</tr>
<tr>
<td><strong>Intensity of rehabilitation services</strong></td>
<td>High</td>
<td>High</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>All modalities</td>
<td>All modalities</td>
<td>Most modalities</td>
<td>PT, OT, speech, rarely PM&amp;R, low complexity</td>
</tr>
</tbody>
</table>

**IRF:** Inpatient rehabilitation facility; **LTAC:** Long term acute care hospital; **SNF:** Skilled nursing facility; **TCU:** Transitional care unit; **ECF:** Extended care facility; **IR:** Interventional radiology; **PM&R:** Physical medicine and rehabilitation; **PT:** Physical therapy; **OT:** Occupational therapy.

*Response to resuscitation can be interpreted as a proxy for the facility’s ability to cope with clinically unstable patients.*
CONTINUITY OF CARE VIA THE HOSPITAL DISCHARGE SUMMARY

The discharge summary is primary mode of communication between the hospital team and aftercare. (There are no Medicare requirements to provide a phone call to a facility in order for a patient to be admitted. However, when requested, a verbal handoff may facilitate a timely discharge of the patient.)

Per the Centers for Medicare and Medicaid Services, the discharge summary should include:

- the outcome of the hospitalization
- patient disposition
- follow-up care (appointments, plans for services such as hospice, home health assistance, skilled nursing)

At discharge, patients should receive literacy-appropriate instructions and education materials that are brief, focused on critical information to the patient, and primarily directed at what the patient needs to understand to manage his or her condition after discharge.

Discharge information should be reviewed with the patient/family caregivers to ensure comprehension. In one study, 40% of patients >65 years of age could not accurately describe the reason for their hospitalization and 54% could not accurately recall instructions about their follow-up appointment.

One model for patient materials developed by the National Patient Safety Foundation is called Ask Me 3:

1. What is my main problem? (ie, why was I in the hospital?)
2. What do I need to do? (ie, how do I manage at home, and what should I do if I run into problems?)
3. Why is it important for me to do this?

Teach-back is another helpful technique. The provider asks the patient or caregiver to “teach-back” the concept in the patient's own words. This allows the provider to identify and correct any misunderstandings in real time.
• 20% of Medicare beneficiaries who are discharged from a hospital readmit within 30 days. Unplanned readmissions cost $17.4 billion and represent 17% of hospital payments from Medicare. Jencks et al. Rehospitalizations among patients in the Medicare fee-for-service program. N Engl J Med. 2009

• Patients are 2.9 times more likely to be readmitted to the hospital when a PT’s discharge recommendations are not implemented, and the recommended follow-up services are not initiated. Smith et al. Physical Therapists Make Accurate and Appropriate Discharge Recommendations for Patients Who are Acutely Ill. PTJ. 2010.

• PTs are the right provider to assess and address post-hospitalization physical and functional deficits which represents a strong independent risk factor for hospital re-admission. Falvey et al. Physical Therapists’ Role in Reduction of Hospital Re-admissions. PTJ. 2016.

• Patients were 3.78 times more likely to be readmitted to the hospital when a PT was absent from the hospital interdisciplinary team. Kadivar et al. Understanding the relationship between PT participation in interdisciplinary rounds and hospital re-admission rates: preliminary study. PTJ. 2016

**RISK FACTORS THAT INCREASE THE LIKELIHOOD OF RE-ADMISSION**

<table>
<thead>
<tr>
<th>Modifiable</th>
<th>Clinical</th>
<th>Demographic/Logistical</th>
</tr>
</thead>
</table>
| - Premature discharge or inadequate post-discharge support**  
- Insufficient follow-up**  
- Medical errors  
- Adverse drug events  
- Failed handoffs  
- Procedural Complications  
- Infections, pressure ulcers, and patient falls. | - High-risk meds (antibiotics, glucocorticoids, anticoagulants, narcotics, antiepileptic medications, antipsychotics, antidepressants, and hypoglycemic agents  
- Polypharmacy (5+ meds)  
- >6 chronic conditions  
- Specific conditions (COPD, DM, CHF, stroke, cancer, depression) | - Prior hospitalization in the last 6-12 months  
- Black race  
- Low health literacy  
- Reduced social network (being alone most of the day with limited outside contact by phone or in person)  
- Low socioeconomic status |

**Functional Risk Factors for Hospital Re-admission**

<table>
<thead>
<tr>
<th>AT ADMISSION</th>
<th>Impact</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>- &gt; 3 ADL dependencies</td>
<td>42% increase in odds for re-admission vs. patients with no ADL dependencies.</td>
<td>Greysen et al. J Am Geriatr Soc. 2005</td>
</tr>
<tr>
<td>- Grip strength &lt;70% of reference values</td>
<td>500% increase in multiple hospitalization rates vs. patients with strength &gt;70% of reference values.</td>
<td>Vilaro et al. Respir Med. 2010</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AT TIME OF DISCHARGE</th>
<th>Impact</th>
<th>Reference</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>AFTER DISCHARGE</th>
<th>Impact</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Walking &lt; 4,691 steps/day in the first week after dc</td>
<td>6x more likely to re-admit vs. patients with &gt;4,691 steps/day.</td>
<td>Fisher et al. J Gerontol A Biol Sci Med Sci. 2013</td>
</tr>
<tr>
<td>- Unmet needs for ADL assistance</td>
<td>66% increase in odds for re-admission vs. those whose ADL needs were adequately addressed.</td>
<td>DePalma et al. Gerontologist. 2013</td>
</tr>
</tbody>
</table>
Model to categorize patient needs at discharge

Patient profiles are divided into four broad domains:

**Domain I: Medical/surgical issues**

**Domain II: Mental status/emotions/coping**

**Domain III: Physical functioning**

**Domain IV: Living environment - physical, social, financial**

Patient-specific elements within each domain, characterized by intensity (high-medium-low), are then determined to create a profile that can be matched to the capabilities of alternative sites of care.

**Domain I. Medical/surgical issues**

1. Clinical instability. The probability that the patient will need rapid intervention for an **Unstable Clinical Condition (UCC)**.

2. Complexity of care. The probability that the patient will need a **Complex diagnostic or therapeutic Procedure (CP)**.

3. The intensity of **Nursing services (RN)**.

4. The intensity of **Physician services (MD)**.

**Domain II. Mental status/emotions/coping**

5. The extent of **Cognitive Impairment or Depression (CID)**.

**Domain III. Physical functioning**

6. The presence of a **Window of Opportunity for Rehabilitation during which rehabilitation services are most effective and outcomes are optimal at a time when the patient has the physical capacity to participate (WOR)**.

**Domain IV. Living environment - physical, social, financial**

7. Limitations on care options due to **Medical Insurance Coverage (MIC)**.


CAREGIVER & FINANCIAL CONSIDERATIONS

Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act (FMLA) provides eligible employees up to 12 workweeks of unpaid job-protected leave in a 12 month period for one or more of the following reasons:

- the birth of a son or daughter/ bonding with the newborn child;
- the placement of a child for adoption/foster care, bonding with that child;
- to care for an immediate family member (spouse, child, or parent) with a serious health condition (but not a parent “in-law” or a sibling);
- when the employee is unable to work because of a serious health condition;
- for qualifying exigencies when the employee’s spouse, son, daughter, or parent is on covered active duty or call to covered active duty status as a member of the National Guard, Reserves, or Regular Armed Forces.

FMLA is unpaid leave. The law permits an employee to elect, or the employer to require the employee, to use accrued paid vacation leave, paid sick or family leave for some or all of the FMLA leave period. In order to be eligible to take leave under the FMLA, an employee must: have worked for the employer for 12 months and have worked 1,250 hours during the 12 months prior to the start of leave.

Costs of Care

<table>
<thead>
<tr>
<th>TYPE OF CARE</th>
<th>AMOUNT OF CARE</th>
<th>AVERAGE MONTHLY COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care</td>
<td>8 hrs/wk (44 hrs/wk)</td>
<td>$693 ($3,800)</td>
</tr>
<tr>
<td>Adult Day Care</td>
<td>40 hrs/wk (weekdays)</td>
<td>$1,500</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>24/7</td>
<td>$6,600-7,600</td>
</tr>
</tbody>
</table>

http://skillednursingfacilities.org/resources/nursing-home-costs June 27, 2016

Bankruptcy

62% of all bankruptcies in 2007 were due to medical debts. 92% of these medical debtors had medical debts over $5000, or 10% of pre-tax family income. The rest met criteria for medical bankruptcy because they had lost significant income due to illness or mortgaged a home to pay medical bills. Most medical debtors were well educated, owned homes, and had middle-class occupations. 75% had health insurance. The share of bankruptcies attributable to medical problems has risen by 49.6% since 2001. In logistic regression analysis controlling for demographic factors, the odds that a bankruptcy had a medical cause was 2.38-fold higher in 2007 than in 2001.

From Himmelstein et al. The American Journal of Medicine (2009) 122, 741-746
EXPECTATIONS OF BEHAVIOR FOR THOSE WHO SEEK TO JOIN THIS PROFESSION

Adapted from Michael Chial, University of Wisconsin

1. You show up on time, prepared, and properly attired.
2. You show up with an eager and positive frame of mind appropriate for the professional task.
3. You accept that “on time,” “prepared,” “properly,” and “appropriate” are defined by the situation, the task, and by the facility.
4. You accept that your first duty is the welfare of the persons served by the profession and is a complex mix of needs, desires, wants, ability, and capacity.
5. You recognize that professionalism means acting in ways that benefit and serve others, either immediately or in the long term. They are not about you. When you behaving as a professional, you are not the focus (not the customer, star, or victim.)
6. You respect the values, interests, and opinions of others - as long as they are not harmful to the persons you are serving.
7. You strive to serve effectively in ways that make it easier (not harder) for those around you to also accomplish their work.
8. You sign your work and properly credit others for their assistance and work.
9. You take responsibility for your actions, your reactions, and your inaction. You do not seek to defer responsibility by making excuses, blaming others, emotional displays, or by helplessness.
10. You take responsibility for expanding your knowledge, understanding, and skill set.
11. When you attempt a task again, you seek to do it better than you did the last time. You continually revise and improve the ways you approach duties, tasks, and problem solving in light of reflection, feedback, and best practice.
12. You do not accept duties or tasks for which you are personally or professionally unprepared.
13. You do what you say you will do, by the time you said you would do it, to the extent that you said you would do it, and at the level of quality expected. NO LESS.
14. You vigorously seek and tell the truth, even when those truths are not flattering to you.
15. You accept direction, feedback, and correction from those who are more knowledgeable or experienced. You, in turn, do the same for those who are less knowledgeable or experienced than you.
16. You value the resources required to assist with your professional development and in the performance of your duties/tasks – especially the time and energy of others.
17. You accept the fact that others may establish objectives for you that may differ from your own. You pursue these goals as long as they are not harmful to the persons you are serving.
18. You accept the imperfections and limitations inherent in yourself, in others and in the world, in ways that do not compromise your own pursuit of excellence in service to others.
Efficiently, effectively, and consistently, with mentored independence for both simple and complex patients:

1) SAFETY #ACUTE CARE CORE COMPETENCY#
   a. Experience with a wide variety of complex patients (with complexity domains including symptom severity, functional impairment, impaired readiness to engage, inadequate social support, complex organization of care, distrustful relationships, lack of shared language, and inadequate resources).
   b. Recognizes, prepares for, and responds to: precautions & physiologic change with safe handling and dosing techniques.
   c. Interprets all appropriate information in the medical record to determine a preliminary precautions list, communicate with other providers to clarify areas of concern, and determine the appropriateness/extent of PT services.
   d. Anticipates and plans for how movement may compound safety issues or compromise medical stability.
   e. Integrates the use of lifting technologies to maximize patient function and the safety of the patient, self, and other staff.

2) PROFESSIONALISM
   a. Maintains confidentiality of protected health information based on ethical and regulatory guidelines, including HIPAA and the APTA Guide from Professional Conduct and Code of Ethics.
   b. Serves as a professional member of the team and patient advocate.
   c. Initiates and maintains appropriate professional communication with every interprofessional team member to optimize patient care including adverse, challenging and crucial conversations –without CI prompting.
   d. Capable of managing complex/impulsive patients during sessions.
   e. Strong work ethic with efforts to maintain and manage a full caseload, offering to pick up new patients/evaluations or assist peers whenever possible without prompting from the CI.
   f. Consistently accepts feedback with eagerness and motivation to advance their practice.
   g. Manages challenging communication situations in a calm and productive manner.

3) ACCOUNTABILITY
   a. Maintains full accountability while striving to provide high quality care.
   b. Consistently and fully trustworthy, patient-centered, responsible, and hard-working.
   c. Manages potential ethical dilemmas with good judgment (stopping/holding therapy, non-compliance, etc.)
   d. Fully accountable to assignments, feedback, paging the CI, attending rounds, contacting physician services with concerns – and all responsibilities in the clinic with consistent ownership and follow-through and without prompting from the CI.
e. Maintains confidentiality of protected health information based on ethical and regulatory guidelines, including HIPAA and the APTA Guide from Professional Conduct and Code of Ethics.

4) COMMUNICATION #ACUTE CARE CORE COMPETENCY#
   a. Warm, courteous, professional, confident, and clear.
   b. Patient and encouraging/re-assuring when patients are struggling.
   c. Listens carefully and attentively to what is being said by others.
   d. Demonstrates a therapeutic sense of self (getting eye level with the patient, offering therapeutic touch).
   e. Selects optimal communication methods for patients/families (considering mood, age, learning style, cognition, culture, and communication barriers).
   f. Consistently and confidently communicates critical information with others on the care team to clarify orders, address concerns, make recommendations, advocate for patient needs, or address barriers to therapy including symptoms, medical status, and interventions/medications.
   g. Communicates clinical rationale regarding the safety/mobility of patient, referral for other services, and role of PT (including initiating, continuing, withholding or discontinuing the PT’s services).
   h. Provides clear mobility instructions to other caregivers to supplement the patient’s physical therapy care plan.
   i. Initiates and maintains professional communication in challenging and crucial situations including patients with significant concerns/barriers (poor prognosis, anxiety, refusing cares, lack of caregiver support, unsafe behaviors).
   j. Utilizes communication skills/strategies such as reflection, re-phrasing, collaborative problem-solving, and motivational interviewing to build therapeutic alliance.

5) CULTURAL COMPETENCY
   a. Experience with a large variety of patients with diverse backgrounds, needs, and preferences including patients with communication barriers (cognitive, emotional, and physiological).
   b. Values diversity and seeks to understand the multitude of influences on each patient (psych, cultural, cognitive, etc.) in order to respond optimally to their needs.
   c. Attempts to find common ground with patients for therapeutic relationship building.
   d. Deliberate and holistic when considering a patient’s life context and how it influences choices that patients/families make regarding interventions, especially at end-of-life.

6) PROFESSIONAL DEVELOPMENT
   a. Consistently demonstrates strong initiative and internal motivation to grow professionally and provide optimal care for each patient (weekly goal setting, self-reflection, self-education/research on unfamiliar diagnoses/medications, sharing new learning with CI/peers, attending noon-time in-services, etc.).
b. Completed a quality improvement project/case study/in-service.

7) **CLINICAL REASONING**  
   **#ACUTE CARE CORE COMPETENCY#**
   a. Understands the full scope of therapy management of a variety of complex patients from high to low mobility, with multiple body system impairments and with prognoses across the continuum (including end-of-life needs).
   b. Integrates the patient’s overall status, patient values/holistic needs, vitals, labs, comorbidities, medications, anticipated clinical course, and the possibility of multiple simultaneous precautions into patient management in order to predict patient presentation/needed resources, determine the role of PT, choose appropriate exam elements, assess patient response, and adjust interventions/dosage accordingly in order to optimize safe mobility and prepare the patient for discharge.
   c. Identifies the specific impairments of complex medical patients, prioritizes strategies to address them (with a focus on function), and considers tests/measures/outcome tools that would be sensitive in uncovering deficits and demonstrating progress over time.
   d. Engages patient/family collaboratively in areas of concern, intervention options, frequency/duration of care, and goals.
   e. Integrates evidence, clinical expertise, and patient preferences into treatment decisions.

8) **SCREENING**
   a. Performs triaging and screening evaluations for patients to determine if evaluation is warranted and to proceed as indicated.
   b. Screens "in the moment" for other systems (cardiopulm, neuro, etc.) based on history and initial presentation during exam.
   c. Performs safety evaluations using fall risk screening and provides immediate specific recommendations/options for safe discharge (including level of assistance/equipment required).
   d. Holistically considers multiple factors related to safety, individualized educational needs, and need for collaboration/consultation with other services (OT, SW, RN).
   e. When referral or collaboration to other services is indicated, selects the appropriate service, optional method for communication, and communicates in a confident and timely fashion.

9) **EXAMINATION**
   a. Experience with both initial examinations and periodic re-evaluations for complex patients.
   b. Includes "in-the-moment" additions based on presentation, objective measures, and systems screen of all four practice patterns.
   c. Utilizes individualized examination items for complex patients.
   d. Determines if an examination is appropriate.
   e. Obtains patient consent;
   f. Maintains patient’s physical, emotional and personal modesty and privacy.
g. Follows infection control policies and ensures safe environment for mobility;

h. Collects and synthesizes the patient history; performs screens of all four practice patterns, selects the appropriate examination components to help define the patient’s current and emerging physical therapy needs including standardized tests/measure; executes the exam in a safe, effective, and logical format; and analyzes all results to determine patient’s appropriateness for therapy as well as to guide subsequent therapy interventions.

10) EVALUATION (DISCHARGE PLANNING) **ACUTE CARE CORE COMPETENCY

a. Utilizes strong clinical decision making to support difficult discharge-related decisions with specific discussion of considerations/clinical rationale clearly evident in documentation

b. Determines if physical therapy interventions are indicated by considering length of stay, discharge destination, rehab prognosis and the level of complexity/skill of interventions.

c. Provides optimal equipment recommendations.

d. Provides optimal discharge recommendations (setting, level of support) based on patient safety (cognition, function), stakeholder expectations/desires, payer regulations, and patient life context (pre-morbid status, age, home environment, caregiver support, follow-up/transportation needs, risk of re-hospitalization, economic resources).

e. Recognizes factors to consider for different discharge options including hospice, Transitional Care Unit , SNF, home health, etc.

f. Uses sound clinical decision making to support difficult discharge-related decisions with specific discussion of considerations/clinical rationale clearly evident in documentation and confidently communicated to team members.

11) DIAGNOSIS AND PROGNOSIS

a. Able differentiate and discuss possible etiologies for patient ‘weakness’ based on history, presentation, exam, and pattern impairment (radiculopathy, myositis deconditioning, CNS lymphoma, peripheral neuropathy from DM/chemo, critical illness myopathy, etc.).

b. Experience with patients who have challenging functional prognostication (unknown medical prognosis, indefinite care plans, poor participation, transition to hospice).

c. Articulates variables (including knowledge of medical conditions/treatments) that influence both functional and overall prognosis.

d. Analyzes medical information to formulate an initial image of patient presentation to prognosticate an appropriate management strategy for communication and the role of therapy (including clinical exam, mobility interventions and discharge) based on priorities, risks and time/resource availability.

e. Continually adapts and prioritizes elements of patient management based on the patient's evolving medical status/prognosis.
12) PLAN OF CARE
   a. Establishes and progresses a prioritized plan of care with individualized goals, and multiple options for interventions with strong clinical rationale.
   b. Modifies the plan of care and discharge recommendations as needs change.
   c. Provides clear documentation of the clinical rationale of treatment decisions (linking physical impairments, functional deficits, interventions, and goals) and discharge recommendations based on the exam/evaluation findings, objective tests/measures, collaboration with other team members, and individualized discharge needs.

13) INTERVENTIONS
   a. Grades activity and prioritizes interventions for patients with limited reserves based on both their psychological/emotional and physical needs/reactions to interventions.
   b. Focuses on the most effective interventions to address needs that facilitate safe dismissal.

14) EDUCATION INTERVENTIONS
   a. Chooses prioritized relevant education topics for patients/caregivers including the rationale for education, anticipated risks/benefits, and follow-up/self-management in many areas. (i.e. preventing/combating the adverse effects of immobility, targeted dosing to optimize function and mobility, preparation for discharge to an optimal setting, energy conservation, fall risk, spine health, postural re-education, cardiovascular risks, exercise guidelines with thrombocytopenia, breathing strategies, positioning, skin care, exercises, etc.) as appropriate for each individual patient situation.
   b. Effectively adapts education to those with communication barriers such as emotional situation, cognition, sensory impairment (vision/hearing) as well as those who require significant education from multiple providers.
   c. Provides explicit and specific expectations to patients about frequency of homework and has collaborated on goals to achieve by end of week.
   d. Educates peers and departmental therapy staff.

15) DOCUMENTATION
   a. Responsible for independently managing all aspects of documentation and patient scheduling.
   b. Creates clear and defensible documentation following facility specific standards that articulates clinical decision making.
   c. Attempts to document immediately following care to establish patient medical status and facilitate healthcare provider communication.
   d. Documents all relevant aspects of the patient encounter in a manner that can be understood by all team members, and can be reproduced and continued by other PTs, including parameters that guide intervention.
e. Uses appropriate clinical judgment to determine when immediate communication beyond documentation is required for safe coordinated patient care (i.e. significant patient status changes).

16) OUTCOMES
   a. Utilizes evidence-based tests and measures to:
      i. accurately and objectively assess the patient's current status
      ii. help predict the patient’s expected level of improvement/discharge needs
      iii. demonstrate progress
      iv. accurately determine, modify, and/or update interventions and goals
      v. illustrate rehab prognosis.

17) FINANCIAL
   a. Demonstrates the ability to consistently and efficiently manage workload to achieve target productivity of at or above 80% of a staff caseload (Staff target 8-10 sessions, 20 billable units) while maintaining high quality care and completing all necessary non patient-care tasks (communications, scheduling, equipment needs, etc.).
   b. Works diligently to be efficient in all aspects of care while maintaining quality.
   c. Is fiscally responsible with the provision of skilled therapy services and with equipment considerations.

18) SUPPORT PERSONNEL
   a. Collaborates with support personnel for assistance with patient management needs (including health unit coordinators, patient care attendants, patient care coordinator nursing staff, therapy technicians, and SPT peers).
   b. Confidently and respectfully provide clear instructions, goals, and precautions to those assisting with patient care in order to optimize safety and patient performance.

CASELOAD: 1) Full caseload for staff is 8-10 treatment sessions/20 units billable average daily. New staff have 3 months to reach full caseload. 2) Student is capable of 100% of staff caseload.
Final Reflections

Assumptions
What assumptions did you have coming into this practice setting? Were they accurate?

Positives
What were the best parts? Why? What made it positive? What strategies have you used that worked well?

Challenges
What were your biggest challenges? Why? What strategies have you tried that have not worked well?

Learning
Were expectations clear? Were you sufficiently challenged? What were the pros/cons of the collaborative model?

Development
Give an example of one of the most important skills or knowledge that you gained from this experience and/or any critical learning incidents or patient examples that will stick with you. What will you “take away” from this experience and utilize to optimize patient care in your daily therapy practice (in whatever setting you might practice in)?

New Ideas and Perspectives
What ideas do you have that could make learning better for future students? What would you say to an incoming student if they asked what the “keys to success” were for this internship?

Based on your experiences here, please complete the following sentences:

“The most memorable display of unprofessionalism I observed was...”

“I hope when I am a practicing therapist I never...”

“The most memorable display of professional behavior that I observed was...”

“I hope when I am a practicing therapist, people will look to be because....”
Hello SPT NAMES!

I look forward to working together at from DATE to DATE!

Please note that this is a long message, but contains important information for your internship. Read carefully, particularly note the information for all dates that are in bold print, save this e-mail for referencing later, and print this message and the attachments – bringing them with you in a folder on day 1.

A Bit About Me:

I am a 2001 MPT graduate of the Mayo Physical Therapy Program and a 2012 DScPT graduate from the University of Maryland. I have been on staff at Mayo Clinic for 16 years working in a variety of areas including acute care, sub-acute rehabilitation, home health care, long-term care, and outpatient practices. I am a credentialed clinical instructor completing both the APTA’s Basic Clinical Instructor Program and the Advanced Clinical Instructor Credentialing Program. I also currently serve 2 taskforces for the Academy of Acute Care dedicated to enhancing and disseminating best practice strategies in acute care physical therapist education.

My greatest professional passion is developing future generations of physical therapists who are equipped to meet the complex needs of patients in acute care. Acute care is a fast-paced, inspiring, and intellectually/emotionally challenging place to be a physical therapist and I love it! Since 2010, I have been the Clinical Education Coordinator at Mayo Clinic Hospital – Methodist Campus and have had the pleasure of mentoring > 120 students in this practice. My clinical and scholarship interests include the clinical effectiveness/clinical reasoning of physical therapy students in acute care, therapeutic alliance, cancer prevention/oncology rehabilitation, and liver disease/transplant. I enjoy teaching classroom coursework for the Mayo PT program that includes these topics and enjoy working with student teams to conduct research in these areas. I am also completely fascinated by the explosion of research in the last 10 years on the human gut microbiota and the complex relationship to our brain and overall health– and the nutrition/diet implications of this relationship.

Outside of the clinic, my greatest joy is being the Mama of an awesome boy who loves Legos, science, bird walks, reading, art, sports, and making me laugh. I also enjoy getting absorbed in a great book; hiking/camping in the quiet, stillness, and beauty of nature; and advocating for social justice causes (care of orphans, sex trafficking/domestic violence, sustainable poverty alleviation).

About Mayo Clinic:

Mayo Clinic’s primary value is “the needs of the patient come first”. Our mission is to provide the best care to every patient, every day through integrated clinical practice, education and research. Mayo Clinic-Rochester registers more than 320,000 patients each year. Eighty percent of the clinic’s patients are self-referred and come from within a day’s drive.

At this internship, you will encounter obscure and difficult medical problems in people from around the world, as well as many common medical concerns. This mix of both the common and the unusual will allow you to encounter and treat people with an exceptional variety of illnesses during your clinical training. Some of the diagnoses that require physical therapy in this acute care setting are post-op surgical (including orthopedic), pre/post liver transplant, and many individuals with hematologic or oncologic disease.

Collaborative model:

We use a 3 to 1 collaborative clinical education model (1 clinical instructor to 3 students) with a team-oriented focus in learning, patient care, productivity requirements, etc.. Professionalism, individual
responsibility, open communication, collaboration, teamwork, self-directed learning/problem-solving, and flexibility are key attributes for success in this model. The collaborative model is a wonderful model for learning another as each person brings unique experiences and perspectives to the team and you have a built-in support network. I look forward to how you will work together as a team to encourage, strengthen, and enable some of the most debilitated people that you will ever encounter in your careers. You have much to learn, but also already much to offer these patients.

In addition to patient care, your time here will include frequent group/individual discussions as well as self-directed learning projects, including a research case study in-service. If you are meeting expectations for the internship, other learning opportunities which may be available include wound care training; as well as opportunities to observe other medical practices such as radiation therapy, hyperbaric medicine, medical social work, and occupational therapy.

Our team will be: SPT NAMES

**Overview of the Internship:**

**On Day 1:** Please follow the instructions for the time/location for your initial orientation that will be sent to you from the Center Coordinator of Clinical Education.

Initially, you will meet with the CCCE and all the other students across campus that are also starting internships. You will start your day with a general clinical education orientation to ensure that important basic clinical education information is communicated effectively and consistently to all. It will also provide a great opportunity for all students starting internships to meet one another and have peer support.

During the first week, we focus on orientation to the acute care practice and primarily see patients as a team. By the end of the second week, you generally will have had exposure to a variety of patients and will begin to build up your own list of patients to follow. Each week, we will continue with educational topics on Monday mornings and the clinical curriculum will include self-directed learning, hands-on training and assessment of your skills, and weekly one-on-one time for discussion of performance, goals and patient care planning.

The work hours for the student team are **8:00am to 5:00pm**. We will meet promptly at 8:00 AM each morning to review patients and any educational topics of the day. The expectation is that you are ready to treat patients immediately following our group meeting (by 8:30 AM), if you need more time to prepare, you may find it helpful to come in earlier. (On Mondays, we will meet at 8:00 am for a 1.5 hour educational session with a different topic/theme each week.) Rarely, we may have slightly different hours (such as 7am to 4pm) to accommodate life situations or the schedule of a different covering CI.

You will need to complete all patient care by **4:00pm** with the final hour used for documentation, billing, preparation for the following day, etc. On some days, I may need to leave at 4:00 and would be available by phone for assistance.

You may have the opportunity to leave early (prior to 4:30pm) if you have satisfied these guidelines: A) you have all your patient care, documentation, billing, and education projects done, B) you have offered assistance to the other students (taking a patient, or assisting with a patient), but no assistance was need, C) you have received permission from the CI, and D) you have developed the plan of care for each of your patients for the following day.

Lunch is generally over the noon hour but will flex depending on the CIs schedule that day (i.e. meetings over the noon hour), or based on patient care needs.
Students are required to wear a **blazer length lab coat** for patient care, so please bring yours on the first day. There is an employee break room with coffee pot (20 cents/cup or $3/month) and fridge/microwave, an employee cafeteria on site, as well as a few coffee/sandwich shops directly outside the hospital (Freshens, Jimmy Johns, Caribou, Starbucks). Many staff and students bring their own lunches every day and others frequently eat in the cafeteria which has a variety of options (soups, salads, deli, pizza, burrito bowls, etc.) that are fairly inexpensive (less than $5). You will be assigned a locker/lock in our therapy locker room where you can store your coats, boots, bags, etc.

**Dates away:**

You will not be working any weekends. *xxxx* is a facility-recognized holiday and you will not be working on that day.

If you anticipate having ANY potential absences during your time here, you must first have the absence approved by your program in writing (forward the e-mail to me), then contact me to discuss as soon as possible.

I am currently scheduled to be out of the clinic on *DATES*. We will discuss the details of the coverage plan closer to the date.

**Preparing for Success:**

To be successful on this internship (*and in life!*), you need primarily 3 things: 1) an eager positive attitude, 2) open communication, and 3) the desire to work hard 100% of the time (see the attachment regarding behavior expectations).

Recall that you are a doctoral level student and patients are entrusting themselves to you during some of the most difficult and vulnerable times in their lives (i.e. new cancer diagnosis, poor prognosis, etc.). It is essential that you accept your responsibility to develop therapeutic alliance with your patients, that you maintain clear and professional communications with all team members, and that you provide high quality care in all circumstances (seeking guidance/assistance as appropriate).

Recommended preparation for this internship would be to review your academic coursework and lecture notes on the following topics:

- Acute Care (in general)
- Multi-system evaluations (i.e. cardiopulmonary, neurologic, disease-specific, integumentary, musculoskeletal, etc.) – Most of your patients will be complex with many co-morbidities!
- Lab values (blood, liver, kidney, cardiac) & Pharmacology (pain, diabetes, cardiac, chemotherapy, immunosuppressant, anti-coagulant, oxygen)
- Clinical Fall Risk Assessments (i.e. gait speed, Berg, Tinetti, mini-BEST, timed sit<>stand,)
- Physical performance, dyspnea, fatigue, depression, and cognitive assessments/outcome measures
- Fitting and choosing optimal gait aides for gait training/ wheelchair fitting
- Transfer training and gait training (including neuro facilitation and rehab)
- Communication skills: collaborative goal setting, motivational interviewing
- Oncology, Hospice, and End-of-Life issues
- Organ Transplant (especially liver disease and transplant)
- Orthopedic Rehabilitation following surgery (TKA, THA, TSA)
- ICU assessment and mobility
**Excellent References:**

I will be sending an additional e-mail invitations to you to join Dropbox and access my account where I have many resources for this internship. Please begin to skim over the files (especially the **Introduction** folder), so that you are aware of the resources there to help you prepare and while you are here. It is not always necessary to read every article/file. Students come to this setting with different strengths/weakness, worries, experiences, knowledge levels, and skill sets – so depending on your needs you may only utilize particular resources and not others.

The textbook “Acute Care Handbook for Physical Therapists” by Jaime C. Paz and Michele P. West is an excellent resource for this affiliation. In addition, the textbook "Pathology" by Goodman, Boissonnault, and Fuller; and the textbook "Cancer Rehabilitation" by Stubblefield and O'Dell are fabulous references for understanding the patients that we care for at this setting. I have all of these at my desk which you are welcome to utilize, but if you have your own copies of any of these, I would bring them. Also, any cardiopulmonary texts that you have would be very helpful (Frownfelter or Hillegass).

You will have access to our outstanding online Library resources while you are here. I highly recommend utilizing “Up-to-Date” to quickly research any unknown diagnosis/topic rather than using Wikipedia or whatever shows up on your Google search. If you are unfamiliar with this resource, let me know and I will be sure to show you how to access and use it while you are here.

**What you need to do NOW:**

I have attached **3 documents for your initial review**.

1) **EXPECTATIONS FOR BEHAVIOR FOR THOSE WHO SEEK TO JOIN THIS PROFESSION:** commit to these professional traits.

2) **QUANTITATIVE ANALYSIS OF ACUTE CARE:** Read it, reflect on it, and self-assess. **By DATE**, send me your written reflections. Particularly compare and contrast the specific skills and knowledge mentioned in the article to your self-perceived strengths and areas for growth.

3) **ENTRY-LEVEL COMPETENCIES FOR ACUTE CARE:** Read it, reflect on it, and self-assess. **By DATE**, send me at least 2 written goals (SMART format) from each competency category (Clinical Decision Making, Communication, Safety, Discharge Planning, and Patient Management) that you will complete in your first 2 weeks here (10 goals total). We will continue to utilize this document as you write personalized goals for the affiliation each week.

If you have any questions or need additional information, please let me know. My contact information is listed below, or after hours, I can be reached at **XXX-XXX-XXXX** (mobile).

I really look forward to welcoming you in person and working with you in the acute care practice! It is a challenging practice where the stakes are very high. It really takes 1-2 years in this practice to have the knowledge, experience, and confidence to navigate all complex situations, but I know that in your 12 weeks here, you will learn so much and be stretched outside of your comfort zone in so many ways. Come with a resilient growth mindset and an eagerness to rise to the challenges and opportunities ahead. I have high expectations, and will be with you each step of the way.

Thank you,

Melissa Hake, PT, DScPT | Clinical Education Coordinator | Physical Medicine and Rehabilitation
|Rochester Methodist Hospital, Eisenberg 2D | Phone: 507-266-8721 | Pager: 127-00381 | Email: hake.melissa@mayo.edu. Mayo Clinic | 200 1st St. SW | Rochester, MN 55905 | [www.mayoclinic.org](http://www.mayoclinic.org)
## Acute Care Competencies for Entry-Level Practice: Self-Assessment

### Clinical Decision Making

*Deliberate about a course of action within a specific context and with an ability to anticipate outcomes guided by a framework of previous experiences and knowledge of best evidence. Integrate patients’ health conditions, vital signs, lab values, co-morbid conditions, medications, possible adverse drug events, anticipated clinical course, and the possibility of multiple simultaneous precautions.*

<table>
<thead>
<tr>
<th>Task</th>
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<th>Confident in simple scenarios</th>
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<tr>
<td>Observe the details of the patient’s history, physical examination and the complex environment.</td>
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<td>Integrate information from multiple sources and distinguish what is relevant to physical therapy diagnosis and impairments.</td>
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<td>Predict patient presentation and anticipate needed resources</td>
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<td>Screen the medical record to determine the role of physical therapy services at that point and time, and then clearly communicate the clinical rationale to the medical team.</td>
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<td>Choose appropriate examination and intervention elements at onset and throughout the session.</td>
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<td>Assess the patient in the moment and adjust intervention choices and dosage based on patient response.</td>
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<td>Identify and differentiate underlying health conditions, body and system impairments, contextual factors, activity limitations, and participation restrictions to address the impact on the patient’s function.</td>
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<td>Critically reflect on information, knowledge, experience and evidence to create a comprehensive physical therapy care plan that is individualized and focused on patient and caregiver goals and circumstances.</td>
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<td>Utilize evidence-based practice to predict the patient’s expected level of improvement in order to accurately determine goals, discharge needs and rehab prognosis.</td>
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<td>Prioritize and optimally dose specific interventions to improve function, safe mobility and quality of movement and to prepare the patient for discharge.</td>
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<tr>
<th>Communication</th>
<th>Not confident</th>
<th>Confident with simple scenarios</th>
<th>Confident &amp; consistent for simple and complex patients</th>
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<tr>
<td>Select the most appropriate communication method/style, with consideration of the patient’s age, learning style, cognition, culture and communication needs, communicating for understanding by both the patient and the patient’s family.</td>
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<td>Clearly communicate the PT’s clinical decisions, with supporting data as available, in regard to: the patient’s safe mobility status; the need for ongoing therapy services in the acute environment; referral for additional services (OT, speech, social work, ortho, neuro, chaplain, psych, patient liaison, etc.); needed assistance from the interprofessional team; and future physical therapy needs.</td>
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<tr>
<td>Implement an evidence-based care plan and communicate it in a manner that advocates and represents the PT’s independent clinical judgment in order to determine initiating, continuing, withholding or discontinuing the PT’s services.</td>
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<td>Collaborate with the interprofessional team to create an environment that eliminates barriers to the patient accessing physical therapy services and promotes safe and effective care. This includes using communication strategies such as: SBAR; briefs/debriefs; curbside consults, rounds, as indicated.</td>
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<td>Educate members of the interprofessional team of the patient’s circumstances that impact the therapy plan of care, including safe mobility status, tolerance of activity and coordination of therapy services with medical interventions and medications.</td>
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<td>Provide clear instruction to support personnel and other members of the interprofessional team in order to supplement the patient’s physical therapy care plan.</td>
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<td>Communicate aspects of the patient’s care through formal and informal conferencing in a manner that respects regulations, team members, the patient’s needs/wants and the PT’s best clinical judgment.</td>
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<td>Initiate and maintain professional communication with every team member at all times, including adverse, challenging and crucial conversations.</td>
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Notes:
**Safety**

*Continually create and maintain a safe environment and plan of care in medically complex situations.*

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<th>Confident &amp; consistent for simple and complex patients.</th>
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<tr>
<td>Respond to any emergent situation by identifying needs, keeping the patient safe, activating emergency response systems, communicating with responders, and being ready to assist as needed.</td>
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<td>Integrate information from the medical record to determine a preliminary precautions list and plan. Consider: past medical history, current medical status, lab values, medication, patient’s mental status, fall risk, risk of further deterioration, and systems review.</td>
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<td>Interpret information obtained from medical record, patient self-report and vital sign monitoring to communicate to the team: the appropriateness, extent, and timing of PT services; the recommended mobility schedule outside of therapy, and the appropriate monitoring parameters for the patient.</td>
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<td>Consider, anticipate, and plan for: possibilities whereby movement might compromise medical stability, and how medical conditions or medications might affect physiological responses to movement or compound safety issues. Be able to discuss these considerations with the interprofessional team.</td>
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<td>Determine the need for and don/doff personal protective gear prior to, during and after the physical therapy session to protect the patient, the PT, and the environment from infection transmission. Follow hospital protocols for infection control.</td>
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<td>Utilize and manage common hospital equipment, including: beds; commodes; air mattresses; alarms; call bells; gait aids, lifting devices, and wheelchairs. Seek help prior to use, if unfamiliar.</td>
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<td>Prior to mobility, survey the patient and the environment to address all movement barriers and optimize safety: lock moveable objects; don non-slip footwear; apply gait belt and any bracing devices, clear space sufficient for maximal mobility (&amp; prepare for minimal mobility); position beds and chairs optimally; and locate all lines, tubes and monitoring equipment.</td>
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<td>Identify the role of each line/tube and any specific precautions related to it. Pre-position and ensure security before/during mobility. Decide: “I can manage;” “I need help managing;” or “I need further training to manage.”</td>
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<td>Independently seek assistance for managing patients that require intensive monitoring when deemed necessary for the safety of the patient.</td>
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<td>Integrate the use of lifting technologies to maximize patient function and the safety of the patient, the therapist, and other staff.</td>
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## Discharge Planning

*Make clinical decisions to support a safe discharge plan and communicate these decisions with all members of the interprofessional team to ensure the patient receives optimal care.*

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<th>Activity</th>
<th>Not confident</th>
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<tr>
<td>Critically assess patient safety (cognition, function).</td>
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<td>Consider patient’s life context, including: pre-hospitalization status;</td>
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<td>age; suitability of home environment; caregiver support; follow-up/</td>
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<td>transportation needs; risk factors for re-hospitalization; and economic</td>
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<tr>
<td>resources.</td>
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<td>Assess expectations and desires of stakeholders (e.g., patient, family,</td>
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<td>caregiver, medical team)</td>
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<td>Understand regulations imposed by the healthcare systems and payers.</td>
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<td>Determine optimal equipment needs, with consideration of reasonable and</td>
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<td>necessary standards, in context of available funding and patient’s</td>
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<td>individual circumstances.</td>
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<td>Determine destination, level of support, need for continuity of care in</td>
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<td>post-acute settings (rehabilitation, outpatient, home, sub-acute or</td>
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<td>other), additional services, and follow-up needs.</td>
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<th>Patient Management</th>
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<th>Confident &amp; consistent for simple and complex patients.</th>
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<tr>
<td>Maintain confidentiality of protected health information based on ethical and regulatory guidelines, including HIPAA and the APTA Guide from Professional Conduct and Code of Ethics.</td>
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<td>Gather and interpret medical information to determine the appropriateness of therapy in the context of potential medical instability and unpredictability (right patient, right time and right setting).</td>
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<td>Articulate clinical rationale to referring provider when mobilization is not indicated or more information is needed on the basis of available chart information and communication.</td>
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<td>Analyze medical information to formulate an initial image of patient presentation to prognosticate an appropriate management strategy for communication, clinical exam, mobility interventions and discharge based on priorities, risks and time/resource availability.</td>
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<td>Create clear and defensible documentation – consistent with facility specific standards – that articulates clinical decision making.</td>
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<td>Document immediately following care to establish patient medical status and facilitate healthcare provider communication.</td>
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<td>Document all relevant aspects of the patient encounter in a manner that can be understood by all team members, and can be reproduced and continued by other PTs, including parameters that guide intervention.</td>
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<td>Use clinical judgment to determine when immediate communication beyond documentation is required for safe coordinated patient care.</td>
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<td>Determine if an examination is appropriate and select the appropriate examination components to help define the patient’s current and emerging physical therapy needs.</td>
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<td>Execute the examination in safe, effective, logical, and efficient manner.</td>
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<td>Determine if physical therapy interventions are indicated by considering: the patient’s length of stay, discharge destination, probability of significant improvement in a reasonable time frame; the level of complexity and sophistication of interventions; and/or if the establishment of a functional maintenance program is warranted.</td>
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Weekly Self-Assessment & Learning Objectives Worksheet

Record all patients seen each week in the table below (adding rows as needed). In the Comments section, record your learning (esp. related to Professionalism, Communications, Clinical Reasoning, Interventions/Outcomes, Discharge Planning.) Please note any specific requests for feedback from the CI.

<table>
<thead>
<tr>
<th>Pt</th>
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<th>Eval?</th>
<th>Comments</th>
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OVERALL REFLECTION: What stands out in your mind or has made an impact on you?

SKILLS ASSESSMENT: How are you doing in these key acute care skills?

- Collecting & analyzing medical information
- Continual assessment & dosing
- Communications with pts/families
- Collaboration with team/prof. role
- DC Advocacy
- Documentation

Things I feel comfortable performing independently:

Things that I need more confidence with:

Things that I find unclear/confusing:
PERSONAL LEARNING OBJECTIVES:

Progress I have made toward last week’s learning objectives:

1. 
2. 
3. 

Learning Objectives for the upcoming week: *(specific, measurable, time-based)*

<table>
<thead>
<tr>
<th>Learning Objectives for the upcoming week: <em>(specific, measurable, time-based)</em></th>
<th>Action Plan:</th>
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<td>2.</td>
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<td>3.</td>
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FOR THE CI:

Questions that I have:

Specific ideas for how the CI can help me:

CI SUMMARY: Student is meeting expectations for this week? YES NO

CI COMMENTS:

I have met with the CI and discussed my performance, clinical expectations, skills assessment, and learning objectives.

---

CI signature date PT Intern signature date