Educational Goals & Objectives
Physical and Occupational Therapies are an important part of patient care. The Physical Therapy rotation, under the supervision of the Director of Rehabilitation, is a one day experience designed to provide the resident with an overview of Physical and Occupational therapy modalities and appropriate integration of these services in the inpatient and outpatient setting. Focus will be on understanding common use of various modalities, appropriate ordering of therapy, and appropriate indications for referral.

Resident will learn independently in addition to scheduled didactics. Learning is centered on the 6 core competencies as follows:

Patient Care and Procedural Skills
I. Residents will use their knowledge of therapy services to positively impact patient care in the inpatient and outpatient setting.

II. Residents will be introduced to the mechanics of ordering physical and occupational therapy.
   • Specific Meditech orders and sequence, signature requirements, and Medicare compliance requirements will be reviewed.
   • The resident will understand necessary details to be included in therapy orders, such as restrictions, weight bearing status, and other specific orthopedic related restrictions or requirements.

III. Residents will become familiar with important information included in therapist documentation, including whether the patient is a rehab candidate, and if so, the plan of care (required therapy, frequency, duration) and outcome goals.

Medical Knowledge
I. The resident will become familiar with a brief overview of the physical modalities and procedures available to physical therapists, including
   • Physical Modalities (e.g. hydrocollator/hot packs, cold packs, ice massage, electrical muscle stimulation (high volt, biphasic, interferential, Russian), mechanical spinal traction, iontophoresis
   • Manual therapy: spinal or joint mobilization, grade 5 spinal mobilization (manipulation), soft tissue mobilization
   • Therapeutic Exercise
   • Gait Training
   • BPPV evaluation and intervention, vestibular therapy
   • Lymphedema massage and compressive bandaging
   • Wound Care
   • Splint and bracing evaluation and application

II. The resident will be exposed to the current physical therapy approach for musculoskeletal and postoperative problems, with a focus on patient evaluation and
plan of care, including precautions, limitations, and plan for progressive mobilization for commonly performed surgeries.

III. The resident will be exposed to the current Occupational Therapy approach for musculoskeletal and postoperative problems, including evaluation of the patient’s specific functional limitations of Activities of Daily Living and adaptive training.

Practice-Based Learning and Improvement

I. Residents should be able to access current clinical practice guidelines (https://www.orthopt.org/content/c/international_classification_of_functioning_and_disability) and apply evidence-based strategies to the patient care.

I. All residents should learn to function as part of a team, including the primary care physician and physical and/or occupational therapist, to optimize patient care.

II. All residents should respond with positive changes to feedback from members of the health care team.

Interpersonal and Communication Skills

I. Residents must demonstrate organized and articulate communication skills with patients, families, and therapy staff, to facilitate goals set by therapists and promote patient behavioral change.

Professionalism

I. All residents should be able to interact with patients and their families in a manner respectful of gender, cultural, religious, economic, and educational differences.

Systems-Based Practice

I. Residents should understand the impact of insurance status on patient access to therapy services and be aware of the availability of resources to maximize care.

Teaching Methods

I. Residents will attend the above didactic program but gain most of their practical experience in the clinical setting, interacting with therapists.

II. Independent study
   • Residents will be provided with an information sheet during the session (Appendix A)
   • Online educational resources
     • Agency for Healthcare Research and Quality www.guideline.gov
     • American Physical therapy Association https://www.orthopt.org/content/c/international_classification_of_functioning_and_disability
     • Up To Date
• Clinical Key

Evaluation
I. Director of Rehabilitation will provide verbal feedback to the resident and Program Director.
II. 360 Evaluation

Rotation Structure
I. Residents should contact the Director of Rehabilitation the day prior to confirm start time and location.
II. Residents should notify the Director of Rehabilitation and their Program Director promptly if they cannot attend at the assigned time.
III. Residents will be involved in discussion of patient cases as time permits during the didactic day, a process that will be fostered by multidisciplinary rounds in the hospital and electronic and verbal communication with therapists in the outpatient setting.
IV. Residents have noon conferences and should be excused in a timely fashion to attend.
Appendix A

Rehabilitation Services Curriculum for a One Day Medical Residency Rotation

1. High level overview of how to order physical or occupational therapy: On Meditech “Order Entry” select “PT Consult” and/or “OT Consult. The therapist determines the plan of care and the report is entered into the physician signing queue. The plan of care must be signed by the ordering physician per a Medicare compliance requirement. The orders for PT Consult or OT Consult should be accompanied by specific orders for any restrictions and include the weight bearing status, as well as any other specific orthopedic related restrictions or requirements.

2. The physician doesn’t need to know the extensive list of specific modalities and procedures, the therapist will write a plan of care and outcome goals. The Therapist will determine what is needed to accomplish the goals and frequency of therapy (qday or b.i.d.). (For example: therapists apply state of the art strategies for THA and TKA patients) The therapist will assess if the patient has sufficient rehabilitation potential, if the patient is not a rehab candidate, the order will be cancelled and the physician notified via documentation in Meditech EMR (Rehab notes under “Other Reports”). If a patient is deemed to have rehab potential, therapy is initiated. If a patient receiving therapy attains the rehab goals and no new goals are indicated before discharge from the hospital, the therapist will complete the therapy orders and discontinue therapy, per documentation in a therapy daily progress note in the EMR.

3. However for edification purposes the gross list of physical modalities and procedures available to physical therapists include the following:
   a. Physical Modalities (e.g. hydrocollator/hot packs, cold packs, ice massage, electrical muscle stimulation (high volt, biphasic, interferential, Russian), mechanical spinal traction, iontophoresis)
   b. Manual therapy: spinal or joint mobilization, grade 5 spinal mobilization (manipulation), soft tissue mobilization
   c. Therapeutic Exercise
   d. Gait Training
   e. BPPV evaluation and intervention, vestibular therapy
   f. Lymphedema massage and compressive bandaging
   g. Wound Care
   h. Splint and bracing evaluation and application

4. The current Physical Therapy approach for musculoskeletal and postoperative problems involves an evaluation of the patients functional limitations due to pain, hypomobility, weakness, and neurological impairment. Then a plan of care is written with interventions to improve the functional limitation(s). This approach is applied to all orthopedic and neuro-surgery patients postoperatively.
   a. **Total Hip patients:** Caution is taken to check HCT/HMG levels to determine if patient is ready for standing at bedside. Surgical hip joint precautions are taught, and patient mobilization begins the next morning after surgery unless the orders specify same day (e.g. Dr. Mazurek). Standard THR range of motion exercise for the L.E., plus isometric exercises taught and done each day with patient. Progressive mobilization from bed transfer to standing to ambulation with weight bearing as tolerated or full weight bearing usually with a walker.
b. **Total Knee patients**: Caution is taken to check HCT/HMG levels to determine if patient is ready for standing at bedside. Then standard knee exercises taught. Progressive mobilization from bed transfer to standing to ambulation with weight bearing as tolerated or full weight bearing usually with a walker.

5. Other orthopedic post-surgical approach varies based on the surgery, site, and the physician confidence in the stabilization of the site by the surgical hardware. The Current Occupational Therapy approach for musculoskeletal and postoperative problems involves an evaluation of the patients specific functional limitations of Activities of Daily Living (especially as it applies to the upper extremity and includes feeding using the U.E.; due to pain, hypomobility, weakness, and neurological impairment.

   a. **Total Hip patients**: Adaptive training for dressing, toileting, and transfers bed to commode, etc.

   b. **Total Knee patients**: Adaptive training for dressing, toileting, and transfers bed to commode, etc.

   c. Other orthopedic post-surgical approach varies based on the surgery but usually includes adaptive training for dressing, toileting, and transfers bed to commode, etc.

---

*Gary Laub, PT, DOR*

*Director of Rehabilitation; glaub@cmhshealth.org; 805-652-5410*