

# Enhancing Pediatric Education for Physical Therapy Students Through the Development of Community Partnerships to Facilitate Experiential Learning: A Case Report

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**Background and Purpose.** Doctoral physical therapy (DPT) programs are expected to provide students with educational experiences in classroom and in clinical settings and with all age demographics, including pediatrics. There is significant discrepancy in the delivery and assessment of pediatric content in DPT programs. One effective and evidence-based strategy to address this discrepancy and deliver pediatric content is experiential learning (EL). Our case report illustrates how EL with a symbiotic community partner can enable DPT programs to effectively address the current limitations in direct contact hours and clinical experiences in pediatrics.

**Case Description.** We formed a structured and formal partnership with a local community fitness and gymnastics facility to provide our students with pediatric EL opportunities outside of the classroom and

traditional clinic settings. Each student is required to engage in structured and focused play-based interactions with typically and atypically developing children 1 hour per week for two 8-week EL periods under direct supervision of a certified pediatric clinical specialist.

**Outcomes.** Students demonstrated appropriate professional behaviors, increased self-efficacy, achievement of the pediatric course learning objectives, and attainment of 3 Academy of Pediatric Physical Therapy essential core competencies. With our community partner, 87% of the children demonstrated improvement in their gross motor skills.

**Discussion and Conclusion.** Our case report details an innovative approach to use EL to increase the number of direct contact hours with the pediatric population through a symbiotic community partnerships that positions our students to reach entry-level competency with the pediatric population upon graduation.

**Key Words:** Experiential learning, Pediatrics, Symbiotic community partnerships.

## BACKGROUND AND PURPOSE

The American Physical Therapy Association (APTA) and the Commission on Accreditation in Physical Therapy Education (CAPTE) mandate that physical therapy graduates possess entry-level competency to treat patients throughout the life span, from infancy to late adulthood.<sup>1,2</sup> Therefore, entry-level doctoral physical therapy (DPT) programs are expected to provide students with educational experiences in classroom and in clinical settings and with all age demographics, including pediatrics.

Currently, there is significant discrepancy in the delivery and assessment of pediatric content in entry-level DPT programs across the United States.<sup>3</sup> In 2011, Schreiber et al<sup>3</sup>

highlighted these substantial discrepancies with pediatric education hours ranging from 0 to 170 didactic hours, 0 to 126 laboratory hours, and 0 to 70 direct contact hours. Although DPT programs require pediatric didactic content throughout the curriculum, Kenyon et al<sup>4</sup> found that only 2.5% of all programs surveyed ( $n = 158$ ) required a formal pediatric clinical experience. Furthermore, of the DPT programs surveyed ( $n = 130$ ), only 8% of all available clinical sites were pediatric specific.<sup>4</sup> These findings reinforce that many DPT programs in the United States have a deficit in both pediatric didactic hours and pediatric-specific clinical experiences.<sup>3,4</sup>

Given the current discrepancies within pediatric education and the limited formal clinical learning opportunities to work and interact directly with children, physical therapy students may not be prepared to meet CAPTE's expectations of entry-level competency in pediatrics. This is significant not only for physical therapy students who plan to practice in pediatrics but also for all graduates as physical therapists who practice primarily in an outpatient or hospital-based setting and will still spend, on average, 10–15% of their clinical time treating patients younger than 18 years.<sup>5</sup> The limited opportunities for students to work directly with the pediatric population may also result in an insufficient number of competent graduates ready to meet the future employment demands in the key area of pediatrics.

To address these significant variations in pediatric education, the Academy of Pediatric Physical Therapy (APPT) established five essential core competencies that represent the knowledge and skills that are vital for all DPT graduates regardless of their interest or intent to provide physical therapy services for children after graduation (Table 1).<sup>6</sup> These essential core competencies were also designed to provide DPT programs with guidelines, direction, and information to assist in educating students to a consistent level of competency in pediatrics upon graduation.<sup>6</sup> The APPT's essential core competencies include

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**Table 1. List of Academy of Pediatric Physical Therapy Essential Core Competencies<sup>7</sup>**

<b>Academy of Pediatric Physical Therapy Essential Core Competencies</b>	
1. Human development	Includes all domains of development, but with an additional emphasis on motor development, especially at key transition points throughout the life span
	<ul style="list-style-type: none"> <li>• Integrate knowledge of human development across all domains and at life span transition points with clinical decision making</li> </ul>
	<ul style="list-style-type: none"> <li>• Analyze the development of movement skills across the life span</li> </ul>
	<ul style="list-style-type: none"> <li>• Apply knowledge of psychosocial, cognitive, and communication developmental level to effectively interact with individuals across the life span</li> </ul>
2. Age-appropriate patient/client management	Effective application of the patient/client management model to children and their families
	<ul style="list-style-type: none"> <li>• Perform developmental screening for the identification of potential growth and motor delay/impairments</li> </ul>
	<ul style="list-style-type: none"> <li>• Conduct an appropriate interview/history with the child and/or parent (including systems review)</li> </ul>
	<ul style="list-style-type: none"> <li>• Gather information on the child's play/recreation/preferred activities, participation, educational setting/level, and family unit</li> </ul>
	<ul style="list-style-type: none"> <li>• Select appropriate tests and measures on the basis of the child's age, interview/history and systems review, and setting</li> </ul>
	<ul style="list-style-type: none"> <li>• Conduct appropriate tests and measures and gather data: in most cases, this will minimally include gait/mobility, postural control, motor development, pain, range of motion, muscle performance (strength), sensation, self-care, physical fitness, and activity endurance</li> </ul>
	<ul style="list-style-type: none"> <li>• Interpret examination findings to determine impairments in body structure and function, activity limitations, and participation restrictions.</li> </ul>
	<ul style="list-style-type: none"> <li>• Develop an age-appropriate and developmentally appropriate plan of care to address participation restrictions/activity limitations/impairments of body structure and function</li> </ul>
	<ul style="list-style-type: none"> <li>• Solicit input on goals and service delivery from parents/primary care providers and from the child when appropriate (on the basis of age, communication, and cognitive ability)</li> </ul>
	<ul style="list-style-type: none"> <li>• Select age-appropriate and developmentally appropriate procedural interventions, including play/recreational activities, natural environment, toys, and equipment</li> </ul>
	<ul style="list-style-type: none"> <li>• Implement age-appropriate and developmentally appropriate procedural interventions, including play/recreational activities, natural environment, toys, and equipment</li> </ul>
3. Family-centered care	Key characteristics: positivity, responsive, collaborative, sensitive
	<ul style="list-style-type: none"> <li>• Consistently collaborate with families throughout the patient/client management process in all settings where intervention is provided</li> </ul>
	<ul style="list-style-type: none"> <li>• Address family priorities in the plan of care</li> </ul>
	<ul style="list-style-type: none"> <li>• Identify the role of the family in all aspects of care under the IDEA, Parts B and C</li> </ul>
	<ul style="list-style-type: none"> <li>• Understand the focus on the family's needs in the IFSP and the focus on the child's needs in the IEP</li> </ul>
	<ul style="list-style-type: none"> <li>• Describe the influence of a child with special needs on the family system</li> </ul>
	<ul style="list-style-type: none"> <li>• Describe the factors of the family system that influence the development of the child</li> </ul>
4. Health promotion and safety	Specific considerations for child vulnerability include environmental factors, age-specific safety, screening of healthy populations, fitness and health promotion, and recreation
	<ul style="list-style-type: none"> <li>• Determine the need for referral to other health care professionals</li> </ul>
	<ul style="list-style-type: none"> <li>• Develop a plan to address age-appropriate health and wellness for all children, including those who are typically developing and those with special needs</li> </ul>
	<ul style="list-style-type: none"> <li>• Educate caregivers about age-specific and developmentally appropriate environmental safety considerations</li> </ul>
5. Legislative, policy, and systems	Related to environmental factors of the ICF, IDEA, state and federal regulations, and mandatory reporting of child abuse and neglect
	<ul style="list-style-type: none"> <li>• Understand requirements related to mandatory reporting of suspected child abuse and neglect in one's state</li> </ul>

**Table 1. List of Academy of Pediatric Physical Therapy Essential Core Competencies<sup>7</sup> continued**

	Academy of Pediatric Physical Therapy Essential Core Competencies
	<ul style="list-style-type: none"> <li>• Discuss the major tenets of IDEA; know how to access and share information about IDEA, Medicaid, and other public programs related to care for children</li> </ul>
	<ul style="list-style-type: none"> <li>• Identify the required elements of an IFSP and IEP and work with the team to write appropriate family-focused IFSP goals and educationally relevant IEP goals</li> </ul>
	<ul style="list-style-type: none"> <li>• Describe appropriate care settings available to extend pediatric rehabilitation services</li> </ul>

Abbreviations: IDEA = Individuals with Disabilities Education Act; IFSP = individualized family service plan; IEP = individualized educational program; ICF = International Classification of Functioning, Disability, and Health.

(1) Human Development, (2) Age-Appropriate Patient/Client Management, (3) Family-Centered Care for All Patient/Client and Family Interactions, (4) Health Promotion and Safety, and (5) Legislation, Policy, and Systems.<sup>6</sup>

To assess outcomes related to achieving the essential core competencies, the APPT developed “entrustable professional activities” (EPAs). Entrustable professional activities are specific examples of learning experiences (didactic or experiential) that give students the opportunity to achieve competency in working with pediatric patients (ie, laboratory experiences with typically and atypically developing children and parent panels).<sup>6</sup> Doctoral physical therapy programs have difficulty providing EPAs that involve students working directly with a pediatric patient. Paper and video case studies, observation hours, and practice on student peers are also listed as possible EPAs; however, these activities are “hands off” and subsequently may not fully prepare students for pediatric clinical practice.

### Experiential Learning in Physical Therapy Pediatric Education

In physical therapy education, students typically learn clinical evaluation and intervention techniques by “practicing” on their adult peers. When it comes to pediatric education, this “practice” on adults cannot directly translate to pediatric patients due to the developmental differences between children and adults, for example, the smaller body size and immature musculoskeletal and neurologic systems. An adult cannot realistically model as a child due to the additional challenges of a child’s behavior, cognition, motivation, and the parent, child, and physical therapist interactions. Schreiber et al<sup>7</sup> reported that “physical therapy with children often requires implementation of unique strategies to effectively communicate with, engage, and motivate children” to improve the health outcomes for the child. Due to the complexities of pediatric patients, the traditional model of learning by “practicing” on adult peers and expecting transference to children is impractical and ineffective.<sup>8</sup>

One effective and evidence-based strategy to deliver pediatric content to achieve the APPT’s essential core competencies is experiential learning (EL).<sup>7</sup> Schreiber et al<sup>7</sup> characterizes EL “... as a form of practice-based education that provides exposures and opportunities for students to explore the work, roles, and identities they will encounter as future professionals.” Incorporating appropriate EL into the DPT curriculum increases students’ ability to apply didactic coursework to real-life situations, while simultaneously improving confidence in their clinical capabilities.<sup>7,9</sup> In a DPT program, structured and focused EL in pediatric education has been shown to improve student learning and pediatric patient health outcomes.<sup>8,10</sup> The EL model developed by Wyncarz and Pelletier<sup>11</sup> found that more than 90% of students enhanced and expanded their learning of pediatric content as a result of structured EL with community partners. Furthermore, EL increases students’ confidence to interact and perform hands on skills with the pediatric population.<sup>10</sup>

The purpose of our educational case report is to illustrate how the use of EL with a symbiotic community partner can enable DPT programs to effectively address the current limitations in direct contact hours and clinical experiences in pediatrics and help students reach entry-level competency with the pediatric population.

### CASE DESCRIPTION

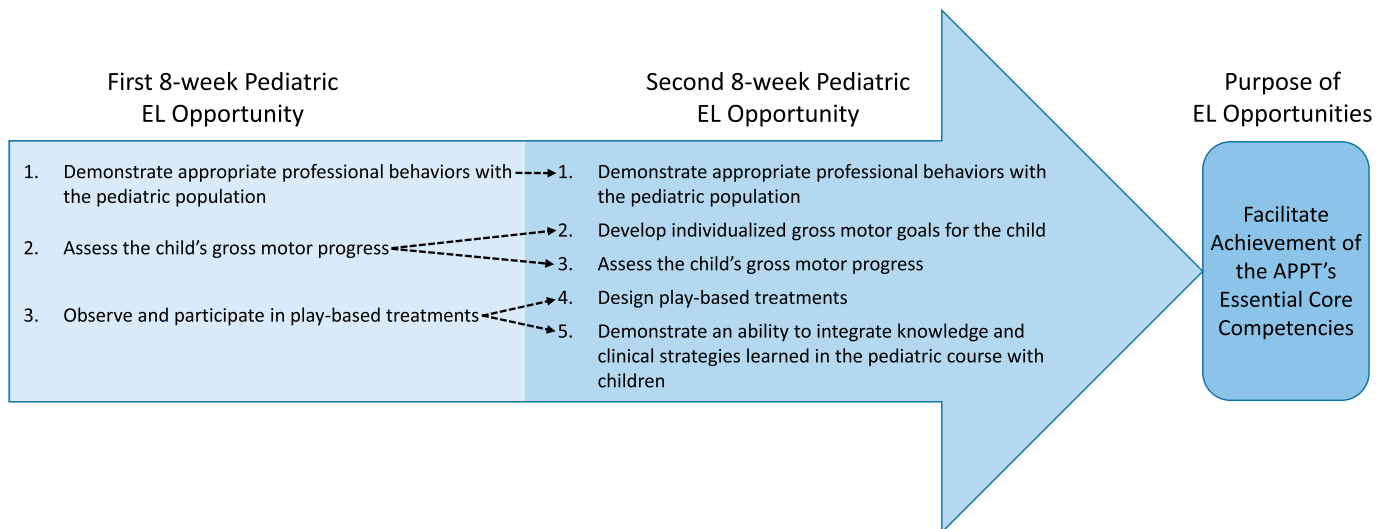
Within the University of Jamestown Physical Therapy (UJPT) Program, EL in pediatrics is prioritized to enhance student learning and facilitate students’ achievement of the APPT’s essential core competencies. The essential core competencies and EPAs suggest numerous activities to maximize student learning; however, most involve direct contact with children.<sup>6</sup> Due to the limited number of pediatric sites, formal clinical experiences are difficult to obtain. In order to offer each of our students opportunities for direct contact with children and assess achievement of the APPT essential core competencies, our DPT program looked beyond the classroom and clinic settings.

To ensure that each of our students had direct contact with children, we formed a structured and formal partnership with a local community fitness and gymnastics facility (TNT Kids Fitness) to provide our students with an additional 16 hours of direct contact with children outside of the classroom and traditional clinic settings. TNT Kids Fitness is a local nonprofit organization that provides adapted one-on-one programming for children with special needs, competitive gymnastics, and recreational and adaptive fitness classes. TNT Kids Fitness serves children of all ages and abilities. TNT Kids Fitness facility has a large multipurpose gymnastics gym, sensory room, and gross motor equipment that is fun and motivating for children, and subsequently, they were the ideal community partner for UJPT.

At the TNT Kids Fitness, each student is paired with a child who has an individualized education program (IEP) and assists that child throughout the adapted fitness class. The adapted fitness class activities are preplanned by the staff at the TNT Kids Fitness and include structured stations with emphasis on various aspects of development including gross motor, object manipulation, social, and educational activities. The students provide support (physically or for encouragement) as needed for the children to be successful in completing all the required stations. Depending on the needs of each child, the physical therapy student will assist with transfers, positioning, gait, interactive play, and completion of task. For example, a student will provide minimal assistance and encouragement while a child with Down syndrome navigates a difficult obstacle course.

Integrated within our DPT curriculum, each student is required to engage in structured and focused play-based interactions with typically and atypically developing children 1 hour per week for two 8-week EL periods (8 hours in semester 5/8 and 8 hours in semester 7/8) under direct supervision of a certified pediatric clinical specialist (Figure 1). The UJPT Program’s EL opportunities with the community pediatric population ensure that all students have the opportunity to work and learn directly with

**Figure 1. Progression of Student Learning Objectives**



a child. From these paired interactions with children, outcomes expected for the students include (1) demonstration of appropriate professional behaviors, (2) increased self-efficacy, and (3) achievement of the pediatric course learning objectives.

### First 8-Week Pediatric Experiential Learning Opportunity

The first 8-week pediatric EL opportunity at the TNT Kids Fitness is incorporated into a required community experience course in our DPT curriculum (spring semester 5/8) with the following student learning objectives: (1) demonstrate appropriate professional behaviors with the pediatric population, including successful interactions with children, school teachers, and paraprofessionals, (2) assess the child's gross motor progress, and (3) observe and participate in play-based treatments (Figure 1).

To determine if the student meets these learning objectives, 2 assessment approaches are used: (1) faculty assessment of the student and (2) student self-assessment.

**Faculty Assessment of the Student.** During the faculty assessment of the student, the certified pediatric clinical specialist who supervises students during their pediatric EL opportunity formally assesses all students' professional behaviors using a rubric of documented behaviors, including professionalism, communication, participation, documentation, and safety (Appendix 1, Supplemental Digital Content 1, <http://links.lww.com/JOPTE/A54>).

Students' learning from the first pediatric EL opportunity is also assessed through students' completion of the pediatric Goal Attainment Scale (GAS). The GAS measures children's progress toward individualized

goals and detects clinically significant changes in children's gross motor skills.<sup>12-14</sup> Prior to the first EL opportunity, students are trained on the administration and scoring of the GAS. On 2 separate occasions during the students' first 8-week pediatric EL opportunity, the students rate the child's performance on a preexisting goal using the GAS. By rating a child using the GAS, students are learning to actively observe gross motor skills and objectively determine the child's current level of gross motor progress. Following each students' completion of the GAS, the supervising pediatric clinical specialist reviews the GAS scoring for accuracy. The results of the GAS are then shared with TNT Kids Fitness.

**Student Self-Assessment.** Before and after the students' paired interactions, students self-assess their professional attributes of communication and therapeutic handling with children through the voluntary completion of the Pediatric Communication and Handling Self-Efficacy Scale (PCHSES).<sup>10</sup> The PCHSES is distributed as an electronic questionnaire via Survey Monkey, with up to two reminder emails when applicable. Descriptive statistics and a paired-sample, 2-tailed *t* test (significance level of  $\alpha \leq 0.05$ ) were used to determine the change in physical therapy students' professional attributes of communication and therapeutic handling.

Each student also completes a written reflection assignment at the end of the first pediatric EL opportunity on how direct contact with children has improved their confidence in working with the pediatric population.

### Second 8-Weeks Pediatric Experiential Learning Opportunity

The second 8-week pediatric EL opportunity at the TNT Kids Fitness is integrated with the

concurrent stand-alone pediatrics course in our DPT curriculum (fall semester 7/8) with the following student learning objectives: (1) demonstrate appropriate professional behaviors with the pediatric population, (2) develop individualized gross motor goals for the child, (3) assess the child's gross motor progress, (4) design play-based treatments for a specific child, and (5) demonstrate an ability to integrate knowledge and clinical strategies learned in the pediatric course with children (Table 2).

To determine if the student meets the five student learning objectives, two assessment approaches are used: (1) faculty assessment of the student and (2) student self-assessment. During the second pediatric EL opportunity, students are trained on the development, psychometrics, and administration of the GAS. Students are then taught how to use their clinical observation skills to identify impairments and functional limitations in children during their initial session at the TNT Kids Fitness. Once a specific impairment or functional limitation is identified, each student develops an individualized goal using the GAS. To meet the GAS guidelines, a GAS goal is required to be clinically relevant, have clinically equal intervals, change only one variable per interval, and provide a specific period for achievement of that goal.<sup>15</sup> Once developed, the GAS goal is reviewed for accuracy by the supervising pediatric clinical specialist, and then, the student is given appropriate feedback on the goal (Appendix 2, Supplemental Digital Content 2, <http://links.lww.com/JOPTE/A55>). Following feedback, students' revise the GAS goal prior to using the goal with the child they are paired with.

Once the GAS goal is approved, each student works with the child to achieve that goal

**Table 2. Faculty Assessment of Second Pediatric EL Opportunity Student Learning Objectives and Alignment With APPT's Core Competencies**

Experiential Learning Opportunity Student Learning Objectives	EL Opportunity Assessments (Semesters 5/8 and 7/8)	Pediatrics Course Assessments (Semester 7/8)	Alignment with APPT's Core Competencies
1. Demonstrate appropriate professional behaviors with the pediatric population	Professional behaviors Rubric	Professional Behaviors Rubric	2. Age-appropriate patient/client management
2. Develop individualized gross motor goals for the child	GAS goal development	Evaluation and documentation for typically and atypically developing children	1. Human development 2. Age-appropriate patient/client management
3. Assess the child's gross motor progress	Assessment using the GAS goal	Evaluation and documentation for typically and atypically developing children	1. Human development 2. Age-appropriate patient/client management
4. Design play-based treatments	Assessment using the GAS goal and interactions with children	Evaluation, documentation, and presentations for typically and atypically developing children	1. Human development 2. Age-appropriate patient/client management 4. Health promotion and safety
5. Demonstrate an ability to integrate knowledge and clinical strategies learned in the pediatric course with children	Assessment using the GAS goal and interactions with children	Evaluation, documentation, and presentations for typically and atypically developing children	1. Human development 2. Age-appropriate patient/client management 4. Health promotion and safety

Abberivations: APPT = Academy of Pediatric Physical Therapy.

throughout the remaining 8 weeks. The students are asked to assess the child's gross motor progress at each TNT Kids Fitness session and formally record a measurement twice during the 8-week EL opportunity. Based on the assessment of the child's gross motor progress, students then design play-based treatments to meet the child's GAS goal. During the development and interactions with the child during the play-based treatments, each student is expected to integrate knowledge and clinical strategies learned in the concurrent pediatric course to purposefully help the child reach his or her GAS goal.

The GAS goals developed by the students continue to be used by the next cohort of students in their first 8-week pediatric EL opportunity to assess the same child. The child's total progress, using the GAS goal, is recorded at the end of the child's school year (approximately 9 months; spring), and the results are given to TNT Kids Fitness.

Similar to the students first 8-week pediatric EL opportunity, the certified pediatric clinical specialist continues to assess students' professional behaviors, including professionalism, communication, participation, documentation, and safety (Appendix 1, Supplemental Digital Content 1, <http://links.lww.com/JOPT/A54>). In addition, before and after the students' paired "one-on-one" interactions, the students continue to self-assess their professional attributes of communication and therapeutic handling using the PCHSES.<sup>10</sup> Descriptive statistics and a paired-sample, 2-tailed *t* test (significance level of  $\alpha \leq 0.05$ ) were used to determine the change in students' professional attributes of communication and therapeutic handling for the second pediatric experiential learning opportunity. Following the second EL opportunity, the students complete a written reflection assignment that discusses how direct contact with children has improved their learning and application of pediatric course content.

**Concurrent Pediatrics Course.** In order to integrate and apply the knowledge and skills learned in the pediatric EL opportunities and in the pediatrics course, the students evaluate one typically developing child and three atypically developing children within the classroom setting. In small groups ( $n = 6$ ), the students perform a standardized evaluation with a (1) typically developing child, (2) child with cerebral palsy, (3) child with myelomeningocele, and (4) child with a genetic or chromosomal syndrome (ie, Down syndrome, Prader-Willi syndrome). Upon completion of each standardized evaluation, all students are required to document findings and develop an oral presentation for classmates and faculty in order to provide evidence of students' progression toward entry-level competency with the pediatric population (Appendix 3, Supplemental Digital Content 3, <http://links.lww.com/JOPT/A56>).

**Table 3. Changes in Students' Mean Self-Efficacy Rating by Time**

	Time			
	Pre First 8 weeks (SD)	Post First 8 weeks and Pre Second 8 weeks (SD)	Post Second 8 weeks (SD)	F(2, 63)
Communication self-efficacy rating	6.07 (1.67)	7.38 (1.08) <sup>a</sup>	8.02 (1.24)	32.16 (P < .001)
Therapeutic handling self-efficacy rating	5.60 (2.01)	6.75 (1.41) <sup>a</sup>	8.30 (1.18) <sup>a</sup>	41.89 (P < .001)

One-factor within-subjects analysis of variance; *n* = 32;

<sup>a</sup>Sidak post hoc analysis, *P* < .01

**Outcomes**

**Student and Physical Therapy Program Outcomes.** Upon completion of both pediatric EL opportunities, students (*n* = 32) had significant increases in their professional attributes of communication (*P* < .01) and therapeutic handling (*P* < .01) as measured by the PCHSES (Table 3).<sup>10</sup>

From the students' 4 evaluations, documentation, and oral presentations, 100% of students (*N* = 72) "agreed" or "strongly agreed" that they were able to meet the learning objectives for the pediatric course. In addition to achieving the course learning objectives, the pediatric EL opportunities also allowed the UJPT faculty to directly assess our students' clinical competencies with the pediatric population (Table 2).

The combination of the pediatric EL opportunity with the concurrent pediatric course provided evidence of the achievement of the APPT's essential core competencies of Human Development (1), Age-Appropriate Patient/Client Management (2), and Health Promotion and Safety (4) (Table 2). Through the students' paired interactions during the first and second 8-week EL opportunities, 100% of our students (*N* = 72) demonstrated appropriate professional behaviors, developed an individualized GAS goal, assessed a child with that GAS goal, and interacted directly with a child for two 8-week periods.

**DISCUSSION AND CONCLUSION**

**Academy of Pediatric Physical Therapy Essential Core Competencies**

In 2014, the Section on Pediatrics of the APTA (now the APPT) developed the essential core competencies to "provide a framework for understanding the most important aspects ... unique to working with children."<sup>6</sup> Our findings highlight how a DPT program can successfully develop a pediatric EL opportunity with a symbiotic community partner to provide direct contact hours with children

and enable students to achieve three of the APPT's essential core competencies: Human Development (1), Age-Appropriate Patient/Client Management (2), and Health Promotion and Safety (4) (Tables 1 and 2).

First, for the APPT core competency of Human Development (1), our purposeful pediatric EL opportunities allowed our students to "analyze the development of movement skills across the life span," "integrate clinical decision-making," and "apply knowledge of psychosocial, cognitive, and communication developmental level to effectively interact with individuals across the life span."<sup>6</sup> Second, for the APPT core competency of Age-Appropriate Patient/Client Management (2), our students "performed developmental screening," "gathered information on the child's play," "selected appropriate tests and measures," "interpreted examination findings," and "developed an age-appropriate ... plan of care."<sup>6</sup> Third, for the APPT core competency of Health Promotion and Safety (4), our students "developed a plan to address age-appropriate health and wellness for all children."<sup>6</sup>

Our EL opportunities did not directly align with the APPT's essential core competencies of Family-Centered Care (3) and Legislative, Policy, and Systems (5). Although our EL opportunities allowed for students to directly interact with a child's teacher or caregiver/paraprofessional, students were not "collaborating with families throughout the patient/client management process."<sup>6</sup> Our EL opportunities did not allow for any purposeful engagement with legislative, policy, or health systems actions, as listed in the APPT essential core competency Legislative, Policy, and Systems (5).<sup>3</sup> Currently, in our DPT program, the APPT essential core competencies of Family-Centered Care (3) and Legislative, Policy, and Systems (5) are taught and assessed as part of the stand-alone pediatrics course. We are considering how to develop pediatric EL opportunities that integrate APPT essential core competencies 3 and 5 into students learning experiences at the TNT Kids Fitness.

Through the integration of the pediatric EL opportunities with the stand-alone pediatrics course, student learning objectives and assessments align with all APPT essential core competencies and provide our students with additional direct contact hours with children to achieve those competencies. Accordingly, our students can be expected to provide high-quality primary care to the pediatric population and achieve the APPT essential core competencies.

**Goal Attainment Scale and TNT Kids Fitness**

The development and assessment of the GAS goals was an important element of our students learning. The GAS goals provided a framework for our students to observe, assess, and diagnose impairments and activity limitations while purposefully engaging in play-based activities with the children. The majority (87%) of children on an IEP who participated with our students during the pediatrics EL opportunities showed improvements toward or achieved their individualized GAS goal. The assessment of the children's progress was shared with the leadership at the TNT Kids Fitness following each EL opportunity and has been used as evidence for grant funding groups to continue to fund TNT Kids Fitness.

**Student Learning with Experiential Learning Opportunities**

In DPT education, emphasis has been placed on developing physical therapists who are knowledgeable, demonstrate appropriate professional behaviors during patient interactions, are effective communicators, and possess competent therapeutic handling skills.<sup>1,16,17</sup> Improved self-efficacy in communication and therapeutic handling has been reported to improve the health outcomes for pediatric patients.<sup>16</sup> Consistent with Silberman et al,<sup>16</sup> our outcomes provide evidence of an innovative method for improving students' self-efficacy.

## CONCLUSION

Our case report details an innovative approach to use EL to increase the number of direct contact hours with the pediatric population through a symbiotic partnership with a local community organization. Our structured partnership expanded the opportunities for each student to achieve the pediatrics course student learning objectives, attain three APPT essential core competencies, and be positioned to reach entry-level competency with the pediatric population upon graduation.

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