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Clinical Ladders in Physical Therapy

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CLINICAL LADDERS IN PHYSICAL THERAPY

by

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This Independent Study, submitted by Stonewall E. Gessner, in partial fulfillment of the requirements for the Degree of Master of Physical Therapy from the University of North Dakota, has been read by the Chairperson of Physical Therapy under whom the work has been done is hereby approved.

(Chairperson, Physical Therapy)

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Title	Clinical Ladders in Physical Therapy
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ABSTRACT

The clinical laddering system as it pertains to physical therapy is described. The history, purpose, benefits, and development of clinical ladders is presented. The benefits include improved recruitment and retention of professional physical therapy staff.

A clinical ladder in a physical therapy department may be very beneficial, but the decision to develop it should be considered carefully. Developing a clinical ladder system is a time consuming and costly undertaking and other alternatives should be considered first.

CHAPTER I

INTRODUCTION

Clinical laddering is a concept that is being used by the nursing profession and is well documented in literature.[1,2,3,4,5,6,7,8,9,11,13,14,16,17,18,19,20,21,22,24,25,26] Clinical ladders should not be confused with career ladders. Career ladders allow advancement vertically to different job categories, while clinical ladders allow lateral movement in clinical care.[1] A clinical ladder can be defined as a hierarchy of criteria intended to provide a means of evaluation and/or development of therapists providing direct care to patients.[2] Although nursing has been using clinical ladders for some time, it is a relatively new concept in physical therapy. The rationale for developing a clinical ladder in nursing is similar to the need for its implementation in physical therapy.

The first proposal for a clinical ladder in nursing was presented by Zimmer in 1972.[3] It was designed to address the failure of traditional nursing organization and structure to: 1) provide a working environment that would nurture and challenge professional growth, and 2) recognize excellence in clinical practice. Zimmer contended that failure to provide such an environment created a work place void of incentives for achieving higher levels of competencies or for

pursuing careers in direct bedside care. She predicted that a system of clinical advancement that recognizes and rewards excellence in nursing practice "will result in a higher rate of retention of nurses in careers in nursing and will secure a higher level of expertise in the delivery of nursing to patients and families".[3] Zimmer predicted outcome addresses two different needs: (1) the professional's need for growth and recognition, and (2) the institution's need for a stable, experienced nursing staff. The same needs and desired outcomes, as addressed by Zimmer, can be related to the field of physical therapy.

Clinical excellence has not been rewarded in the traditional system, which has rewarded longevity only. This traditional system has been credited for the attitude that direct patient care is a dead-end job and has lead to high turnover rates (up to 46% in some nursing departments).[1] Advancement was limited to management positions, which meant clinicians had to leave direct patient care to advance.[4] Clinical ladders provide for lateral mobility in career development. Benefits of clinical ladders for the clinician are salary increments, opportunity to explore and expand job possibilities, and organizational recognition of advancement.[4] The primary objective of clinical ladders for hospitals is retention and recruitment of qualified physical therapists. If this purpose is served, physical therapists will benefit also from increased salary, expanded job responsibilities and recognition of excellence. Clinical

ladders should reward excellence, reward therapists who prefer direct patient care, direct initiative, and sustain superior clinical skills. Although most ladders are geared to reward educational achievements, equitable standards for advancement need to be established. These would include tenure, continuing education, formal education, committee work, teaching, and performance as criteria. Measurable performance levels must be developed, and a point system devised to objectively evaluate each candidate.

Clinical ladders should not be looked at as a "quick fix" remedy for departmental staffing problems.[4] It must be implemented into a long-range plan. Hospital administration and fiscal services must approve the concept and be involved in its development. The concept should not be initiated at a time when other major changes are taking place in the department or hospital. There are many different types of clinical ladders. The type chosen should be unique to the institution and meet the specific needs of the department.

The purpose of this study is to present the concept of clinical ladders. Clinical ladders will be presented as they pertain to the physical therapy profession in the hospital setting. The benefits and drawbacks of clinical ladders will be presented. Rationale for the development will be discussed. It is hoped that clinical laddering can be shown to be an effective way to improve staff morale, improve patient care, and increase retention of qualified physical therapists.

CHAPTER II

REVIEW OF LITERATURE

Clinical laddering in physical therapy has been slow to develop and, therefore, much of the literature on clinical ladders is from professions other than physical therapy. Nursing was one of the first to develop the concept of clinical ladders, and most of the documentation comes from that profession. Literature involving clinical ladders in nursing dates back to the 1970's.

Literature varies on the means of implementation of clinical ladders, but there is nearly unanimous agreement as to why clinical ladders are developed. The shortages of allied health professionals, and the need to recruit and retain qualified professionals while rewarding and promoting clinical excellence, are repeatedly stated as the reasons for considering and implementing a clinical ladder.[1,2,5,7,9,16,17,18,19,20,21,22,23,24,25,26] Sanford[5] states that clinical ladders are the single answer to two problems; recognition for clinical excellence, and retention of stable work force. Davis[6] describes clinical ladders as effective recruitment and retention tools. Opperwell[7] states that although the purpose of most clinical ladders is to reward the nurses at bedside, the retention and recruitment of nurses along with promotion of clinical excellence added

to their attractiveness. Kuitse[8] states that a clinical ladder is helpful to address staff recruitment and retention problems.

Benefits of a clinical ladder, as stated by Lamperski[9], include:

1. Improved retention of staff.
2. Development of a good recruitment tool.
3. Upgraded quality care.
4. Career growth for staff other than administrative.
5. Senior clinicians to educate staff.
6. Increase skill level of the department.
7. Job enhancement flexibility.
8. Increase staff self-esteem.
9. Self-satisfaction.

Harvey[10] lists perceived benefits of a clinical ladder as:

1. Definition of standards of performance.
2. Staff recognition.
3. Organizational program development.
4. Staff incentive.
5. Staff development.
6. Recruitment and retention.

Means of implementation of clinical ladders vary. Kuitse[8] states that his facility formed a committee, which included the department director, a human resources representative, and clinical managers to work with a management service consultant in developing and implementing their

ladder structure. Merker, Mariak and Dwinnells[11] state in their book that before developing a clinical ladder, a department must assess itself in its environment to determine what it can feasibly do and not do within the extent of its resources. Nearly all authors recommend the formation of a committee or task force to work on implementing a clinical ladder. Lamperski[9] emphasizes the importance of the first step, which is approval from administration. He states that with the efforts of hospitals to cut costs, the benefits of decreased money and time required for recruitment and efficiency of physical therapy, development of new programs and specialty areas, and increased job satisfaction of physical therapy staff, must be emphasized.

Opperwell[7] reports a 30% turnover rate for RN's at Sinai Hospital of Detroit, which translates into 129.6 FTE's. Recruitment and orientation costs for the budgeted year 1987 were $1.3 million. She estimates retention costs through a successful clinical ladder for that same number of positions would have been $524,500, a savings of $776,000.

Problems to consider before implementing a clinical ladder system include determining the need for such a program. Does the staff want such a system? What are the economic implications of a clinical ladder system to the health care facility? What are the organizational changes that must occur? What are the potential effects on personnel? What are the potential effects on patient care? Harvey[10] recommends a three-step approach for development

and implementation of a clinical ladder: 1) Administrative support, 2) Staff involvement, 3) Implementation and application.

The structure of clinical ladders varies with facilities. Sterneck[12] describes a three-level structure for physical therapy. Level one is a staff therapist who is competent in the standards of practice and performs in a manner appropriate to the profession. Level two is a senior therapist who has added level of knowledge and expertise allowing contributions in the area of education, quality improvement, clinical practice, program development, and department participation. Level three is a clinical coordinator who has the added responsibility of organizing, coordinating, developing, and implementing all educational activities. Level three also coordinates and implements new programs, reviews and revises existing programs as necessary in the area of responsibility, including development of policy procedure, which impacts patient care in a specified area.

Huey's[13] comparison of several clinical ladder systems for nurses found that most systems describe four clinical levels. Gassert, Holt and Pope[14] had five levels in their clinical ladder system. Physical therapy clinical ladders listed by the Health Care Advisory Board also lists five levels,[15] however, the top two are administrative. Components for the levels have been identified by such factors as job knowledge, judgment, and responsibility.[22,23]

Measurable levels of performance need to be established to objectively judge candidates.

Application to begin a clinical ladder is completed by the candidate and reviewed by a peer review committee.[24] To validate maintenance of critical factors in each ladder, clinicians should be reviewed every two years.[25]

An integral part of the evaluation process of a clinical ladder is to ask staff professionals whether it is working to meet their needs.[26] Literature on the effectiveness of clinical ladders is essentially nonexistent because of the relative newness of the concept, especially in physical therapy. Documentation that does exist describes clinical ladders as useful and consistent with the stated program goals.[6,7,16,22,23,26] Nearly all of the assessments of clinical ladders in literature are subjective. Very little information is available that objectively assesses the outcome of a clinical ladder system.

CHAPTER III

BENEFITS OF A CLINICAL LADDER

The potential benefits of the clinical ladder are numerous. If the ladder is properly developed and implemented, the institution, clinician, and the consumer, will benefit.

A criteria-based clinical ladder and performance appraisal system offers an objective mechanism to annually review a therapist's performance at the time of salary adjustment (annual merit appraisal) as well as to determine an individual therapist's eligibility for promotion to a higher clinical level.[27] Criteria in both the job description and the performance appraisal are defined in behavioral terms so that the content of the therapist's assessment is objectively based. This results in a sense of fairness on the part of the staff regarding the appraisal process and the salary recommendations that follow.

The ultimate benefits of a successful clinical ladder system would include:

- Promotion of the delivery of optimal patient interventions.
- Criteria-based performance appraisals are developed which meet JCAHO standards for evaluating and assuring therapist's competence.
- Clear standards of clinical practice are delineated.

- Clinical excellence and a sense of clinical challenge are fostered.
- A mechanism for career growth within the clinical setting is created.
- Financial compensation is tied to the level of performance.
- The scoring system that accompanies the performance appraisal provides an objective means to determine salary recommendations built upon employee performance.
- This objective means of assessing performance and determining salary results in a sense of fairness on the part of the staff about these often sensitive issues.
- A system is developed which should prove to be a major recruitment and retention management tool.
- Enhancement of the research and quality assurance components of the department.

The two components of clinical research and quality assurance are currently areas of major emphasis within the field of rehabilitation.[27] Incorporating them in a department offers the opportunity to promote improvements in patient care, promote more efficient usage of short supply professional resources, and promote the growth of professionalism and pride among the staff.[11,27,28]

CHAPTER IV

DEVELOPING AND IMPLEMENTING A CLINICAL LADDER SYSTEM

Phase I: Forming a Task Force and Collecting Data

The first step in developing a clinical ladder is to begin collecting data for assessing the feasibility of a ladder system.[11] The reason why such a system should be implemented needs to be identified. The organization needs to decide if a clinical ladder system will address the specific goals of the organization. To do this, a task force should be formed to explore the possibility. The task force should include professional physical therapy staff members. The greater the extent of participation by staff, the more precisely the ladder system can be structured to incorporate those programs and benefits beneficial to both staff and management.[27]

It is important to review all the data in a sequential process by identifying how the department functions now to accomplish its identified goals and objectives and who, both inside and outside the health care system, interacts with the department and influences daily and long-term operations.

The philosophy, organizational structure, and goals of the department that direct the implementation of programs for professional practice and delivery of patient care should be documented, as therein lies the foundation for building an

advancement program.[11] If the advancement program is not congruent with the philosophy of the organizational structure of the department, role disparity will occur due to the lack of reinforcement in the actual practice environment.

If staff believes job satisfaction is determined by salary and vacation time rather than the scope of professional practice roles and expanded skills which is the premise held by the manager, role disparity occurs and the program will fail.[2] Any program, in order to be a success, must meet the needs of a grassroots group who identifies with the program and believes in its advantage. Information on staff perceptions of their needs may be obtained by meeting with the staff, or through surveys, questionnaires, or interviews.[27]

Review of the resources available for a clinical ladder program need to be looked at from the perspective of dollars and cents, not only for the year of implementation, but for each succeeding year. Questions needing answers include: How many dollars are currently allocated to the operational budget for yearly salary increments? Who decides how to allocate the budget for the department? What organizational policies exist in reference to monetary increases for longevity and satisfactory behavioral performances?[11]

Ultimately, administration of the hospital must give its approval and support for establishing a clinical ladder system. In these days of cost containment, a good case for its approval would be financial. It would be very beneficial

to be able to demonstrate that although the implementation of a ladder system may initially cause increased expense, the long-term cost to the hospital may be reduced. The fiscal department should be involved in the initial stages of feasibility and budgeting for the program. The human resources department must also be involved, since restructuring of job descriptions and performance appraisals will be part of the development of the system.[11]

Once all the data has been collected and organized into a sequential format, it is necessary to analyze the data through an objective framework for evaluation and decision making. If, after review of all the data, it is decided to proceed with a clinical ladder system, the next step is to convert the assembled data into a formal structure and develop an organized program.

Phase II: Determining the Structure and Levels of the Ladder

The clinical ladder system must be customized to the individual department's needs. Just because a specific system worked for one department does not necessarily mean it will be best suited for another. The number of levels in the ladder system is determined by the needs and resources of the particular department. An example of a three-level ladder would be the inexperienced therapist (I), the intermediate therapist (II), and the advanced therapist (III).[27,28] Qualifications for the different levels may include years of experience, and competency. Competency

requirements for the major clinical areas can be established for application to another level. Clinical areas may include acute care, rehabilitation, cardiac, orthopedic inpatient and orthopedic outpatient.[27] Each clinical area should have a list of required knowledge and skills that have been identified, and that can be attained by the laddering therapist.

Phase III: Job Descriptions and Performance Appraisals

The outlined drafts for clinical job descriptions represent an initial effort which will need to be critically evaluated for compliance with personnel policies, standards already established for job performance, and expectations of management for differentiation of physical therapists' behavior between clinical levels. Job descriptions for advanced staff therapists' roles should include the primary concepts considered essential for the goals stated for implementing a clinical ladder system.

The criteria in each job description could be grouped into four major sections of responsibility: clinical duties, administration or organizational duties, teaching duties, and educational responsibilities.[3,11,14,27] Each job description lists in behavioral terms the criteria for each of the four sections.

The job descriptions for the clinical levels should lead the therapist to gain progressively sophisticated skills. Each level of clinical practice builds upon the skills gained and refined during the previous clinical

level. All behaviors of the job description should be measurable by objective performance.[11] It is important that once the content of each job description has been determined, the staff therapists are given the opportunity to also become thoroughly familiar with the clinical levels and the requirements at each level as these will form the basis of their job expectations.

Objective performance appraisals need to be established for each clinical level and each is different as it correlates to that level. Criteria for performance at each level needs to be developed for the major clinical areas including clinical duties, administration/organizational duties, teaching duties, education responsibilities, and professional behaviors.[27] A rating scale should be used to score points achieved by the therapist in each of the five sections. This scoring allows for an objective means to quantify performance and determine if the therapist is performing at standard, below standard, or above standard performance levels. A salary system can be adapted into the clinical ladder system and tied to the scoring system. This establishes a pay for performance system that encourages the therapists to feel that their efforts to achieve clinically are being recognized in the appraisal, and rewarded financially. These same therapists also realize that those therapists who do not work as hard to achieve do not receive positive appraisals nor an equivalent salary adjustment.

Promotion into the clinical ladder system is achieved by meeting the minimum eligibility requirements noted for the job descriptions for each clinical level. The philosophy of promotion should be that while upward movement to clinical levels will be encouraged by the manager, the primary responsibility for clinical advancement rests with the individual therapist. Therapists should be encouraged to know the eligibility requirements, to document their activities throughout the year, and to seek out opportunities that are required for their consideration for promotion.[11]

Phase IV: Implementation

Before implementation of the clinical ladder system, approval must be obtained from the hospital management and the board of directors.[4,11,12,17] Announcement of the program and explanation of its intent and effects need to be presented to the other hospital departments and medical staff.

Meetings with the physical therapy staff need to be scheduled so that the program can be explained and questions can be answered. The professional physical therapy staff are the individuals who will be directly involved with the changes, and who will have the most numerous and detailed questions. It is important to detail all information during these meetings so that there are no misunderstandings later that will diminish support for the program.

Evaluation and placement of all professional staff needs to be an initial phase of implementation.[11] This evaluation process should occur during a distinct, designated time period. The clinical level for placement will be documented at that time. A procedure should also be established for placing newly hired staff into specific clinical levels. Once staff are placed, a mechanism must be devised for the therapist to advance to the next level. It is essential that such a promotional system and review process be established. One method for evaluation of candidates is to utilize the the process of peer review.[11] Through peer review, the practice of an individual therapist is evaluated through self-appraisal and by practice colleagues.

Once the clinical advancement program has been established and implemented, the manager may mistakenly think that the daily schedule will become less focused on the program and sit back with a sigh of relief. A clinical advancement program requires continual evaluation and administrative direction just as with any clinical program.[11] Once the implementation phase has been completed, the manager should be responsive to feedback received both from candidates for promotion and other participants in the clinical ladder program, and look for ways to incorporate revisions and modifications into the original format as necessary.

CHAPTER V

SUMMARY AND CONCLUSION

Before the decision is made to develop a clinical ladder system, the purpose or objectives for implementing it must be considered carefully. Several questions need to be answered. What is preventing the organization from achieving the objectives with its present system?[2] Is the reason for not obtaining these objectives lack of staff, lack of standards, or lack of management skills? Will a clinical ladder change any of these?[2] The objectives need to be realistic. If increased recruitment is the objective, the available market needs to be identified. If the fair share of the market is already being recruited, then the ladder system may not affect recruitment objectives. If decreased turnover is the objective, the organization must compare its turnover rate to that of the standard for the area. It may be that a ladder system will not affect the turnover rate enough to make the effort worthwhile.

Although a clinical ladder can be a beneficial program for a physical therapy department, those considering one must be cautious. The clinical ladder is a cumbersome superstructure imposed on existing systems for reward and evaluation. It is not a panacea for other organizational problems such as low pay or rigid administrative practices.

Other alternatives such as bonuses, contracts, improved benefit packages, and changes in management styles should be considered before implementing a clinical ladder. Developing and implementing a clinical ladder is a tremendous expenditure of resources and psychic energy, and unless the achievement of the intended objectives is highly probable, the clinical ladder may turn out to be an embarrassing and costly failure.

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