American Physical Therapy Association

AC
Board of Directors Meeting
Minutes

January 21, 2013
San Diego, Hilton Bayside, Indigo A

Present:

Leslie Portney, DPT, PhD, FAPTA	President
Terry Nordstrom, PT, EdD	Vice President (President elect)
David L Somers, PhD, PT	Secretary
Nancy B. Reese, PT, PhD, MHSA	Treasurer
James R. Carey, PhD, PT	Director
Susan S. Deusinger PT, PhD, FAPTA	Director
Diane U. Jette, PT, DSc	Director
Thomas P. Mayhew, PT, PhD	Director
Stephanie Piper Kelly, PT, PhD	Director elect
Barbara Sanders, PT, PhD, SCS, FAPTA	Director (Vice President elect)
Rick Segal, PT, PhD, FAPTA	Director elect
Barbara A. Tschoepe, PT, PhD	Secretary elect
Kathryn Zalewski, PT, PhD, MPA	Director elect

Guests:

Janet Bezner, PT, PhD	Vice President, Education and Governance, APTA
Josh D'Angelo	President, Students Assembly
Maggie Donahue, PT	President, FSBPT
Mandy Frohlich	Senior Director, Government Affairs, APTA
Jodi Frost, PT, DPT, PhD	Lead Academic Affairs Specialist, APTA
Mary Jane Harris, PT, MS	Director, CAPTE
Corrie J. Odom, PT, DPT, MS, ATC	Co-Chair, CESIG, Education Section, APTA
Paul Rockar, PT, DPT, MS	President, APTA
Libby Ross, MA	Director, Academic Services, APTA
Shawne E. Soper, PT, DPT, MBA	Speaker of the House
Holly Wise, PT, PhD	Academic Council Global IOM Representative

Staff:

Lisa McLaughlin	Executive Director, APTA Academic Council

A regular meeting of the Academic Council (AC) Board of Directors was called to order by President Leslie Portney at 8:08 AM (Eastern Time).

ESTABLISHMENT OF A QUORUM

Nine of nine board members attending, a quorum was present.

CESIG CONSORTIUM FORMATION

Corrie Odom presented the outcome of initial discussions that have occurred about the formation of a Clinical Education Consortium within the AC. These included the possibility of representation from clinical instructors who may not be APTA members (e.g. each institution may be represented in the consortium by the DCE and one identified clinical faculty member who may or may not be an APTA member).

It was concluded that the bylaws of the AC will need to be revised should the AC move to component status in June of 2013 and those bylaws will have to be consistent with APTA standards. These standards may prevent non-APTA members from participating in governance and voting within the consortium, but perhaps not from participating in consortium discussion and activities. While the idea of the consortium was favorably viewed, it would be helpful if the proposers would clearly articulate a purpose to help guide the discussion about the consortium and the bylaws that will be germane to it.

BYLAW AMENDMENTS

A bylaw amendment has been drafted specifically to establish the American Council of Academic Physical Therapy (ACAPT) independently from any bylaw amendments affecting governance changes. The APTA BOD is the sponsor of this bylaw amendment and the Education Section has been approached to be an additional sponsor (i.e. the APTA BOD and Education Section are acting as one). The Education Section could alternatively decide to co-sponsor the amendment, a sponsorship that does not require the BOD and Education Section to be of one voice. To date one question has been raised about the use of the word Council which also appears elsewhere in APTA structure. Having two different types of councils was not perceived as problematic because bylaw changes to specifically define a singular entity of "council" was believed to be premature. The anticipated issue of concern will be institutional membership.

One issue that emerged during the discussion was a precise definition of institutional member. The proposed bylaw amendment was based upon the approved standing rules for the organization. The relevant page has been attached (Attachment 1). Those rules indicate an institutional member is an accredited physical therapy program within an institution of higher education. A single institution of higher education with multiple accredited physical therapy programs (not expansion programs) may have multiple institutional members in the Council.

Shawne reiterated that it is the responsibility of the APTA BOD to strongly bring the amendment forward. However, the AC should be strong advocates promoting success of the motion. Consequently, the AC board members were assigned caucus meetings to attend at CSM 2013 and specific talking points for these and future discussions were decided upon:

- Why do we need ACAPT?
    - Producing excellence in doctoral education

  - Effectively deal with issues of higher education and communication between institutions.
  - Advising and providing input to APTA about educational issues.
  - Taking independent positions that provide consistency in physical therapy education.
  - Collaborating between and strengthening the academic community.
  - Communication with external stakeholders.
- Why does ACAPT need to be an institutional-based component within the APTA as opposed to the previous structure of AASIG or outside the APTA?
  - Unlike AASIG, ACAPT provides a defined structure of membership and voting for making, documenting and distributing decisions regarding academic physical therapy.
  - The institution is as defined above, indicating the Council has influence over its members which are the programs rather than individual people.
  - Staying within the APTA, rather than forming an independent group as most professional organizations have done, is because of APTA's strong support and largely consistent vision. It always remains a possibility for ACAPT to move outside of the APTA, but the early working relationship has been very successful.
- Does ACAPT also include accredited PTA programs?
  - ACAPT is for physical therapist programs.
  - Institutions with PTA are often (but not always) at different types of institutions, the degree granted is different and the concerns of PTA institutions are at a different level. These differences make one council for both professions not feasible.
  - A parallel, independent organization for PTA accredited programs is certainly welcome or PTA participation as a Sub Council within ACAPT could be envisioned, but both are dependent upon PTA programs discerning what they would like to do.
- How many member institutions are in the current AC?
  - 204/212 accredited programs are members of the AC.
  - 145 of these members currently pay the voluntary assessment.
  - A few of the 145 schools paid slightly lower than the $2500 assessment.
  - Once AC becomes ACAPT the assessment will be considered dues and be mandatory.
- What is the impact on APTA budget?
  - The AC has been totally self-sustaining.
- What has the AC accomplished?
  - Institute of medicine (IOM) global education.
  - Exercise physiology task force.
  - Diversity task force.
  - New website.
  - Clinical education summit.
  - Standardization of prerequisites.
  - Benchmarks of excellence task force.
  - Great enthusiasm of membership reflected in deep volunteer pool.

Barb Sanders is updating information on chapter delegates so that board members can be assigned to a particular chapter for communicating about this issue. Board members will speak to the chief delegates and bring back any concerns they are hearing. Lisa McLaughlin will compile a list of delegates who are AC representatives.

CAPTE SEPARATION FROM APTA

Mary Jane Harris and Paul Rocker/Shawne Soper discussed the views of this issue from CAPTE and the APTA BOD, respectively. Both indicated they want what is best for the profession. The APTA BOD will make the final decision and, like CAPTE, very much wants feedback from the communities of interest. A summary of CAPTE and APTA positions appear in Attachment 2.

The issue will be discussed as part of the open forum during the business meeting tonight. The BOD will generate an opinion following that exchange.

PTA MOBILIZATION AND POSITION OF AC

FSBPT included joint mobilization in its PTA licensing exam based on a survey of practitioners, its customary process for revising the exam. In response, CAPTE adopted a position in 2012 (Attachment 3) that permits, but does not require, PTA education in grade 1-2 peripheral joint mobilization. The American Academy of Orthopedic Manual Physical Therapists objects to this position and to the linkage of grade 1-2 peripheral joint mobilization as kindred to passive range of motion because of the safety and quality issue for the patient. They have asked the AC for a response/opinion.

The issue will be discussed as part of the open forum during the business meeting tonight. The BOD will generate an opinion following that exchange.

WEBSITE DEVELOPMENT

The team from Openarc presented the scope of the website project, defining each of its functionally related component parts. Software to be used does not have licensing fees so that the website can be flexible and low-cost in the future. The project is presently completing the design phase and will be moving to the interface design phase. A presentation will occur at the business meeting tonight (can be viewed at: acaptapreview.org). A new person from the BOD will be assigned to be the contact person for open arc after Dave steps down.

FLEXIBLE, SHARED VISION OF CLINICAL EDUCATION (SUMMIT)

Dave summarized the process that is being used, introduced our consultant Dr. Susan Meyer and where we are in the process. The call for proposals is presently written and under review by the coeditors of JOPTE. There will be four different position paper manuscripts published as an independent issue in JOPTE (since our meeting the editorial board of the Journal approved the publication of an independent issue). The position papers will be followed with webinars

that will give rise to topics on which Summit attendees will vote. These positions can then be taken before the AC as motions or positions.

Steps in the process and tentative timeline still to be accomplished include:

- Distribution of call for position papers (mid-February, 2013).
- Decision on position paper authors (late April or early May, 2013).
- ELC 2013 discussion session on enriching the collaboration between academic and clinical components of education (information will be used to augment webinar see below).
- Submission of manuscripts by authors (at the latest January 1, 2014).
- Review/revision complete (March 1, 2014).
- Release of PDFs (June 1, 2014).
- Webinars (June, July and August, 2014).
- Summit (before or after ELC, 2014).

APTA, Education Section and FSBPT are co-funders of the summit and a meeting will occur to increase the involvement of these co-funders in the planning process from here forward. A replacement board member will be identified for Dave. Several people were suggested as potential co-chairs.

TREASURERS REPORT

Please note the treasurers report (Attachment 4) is unaudited and only completed through November 2012. The financial state of council is good with revenues exceeding expenses. It was also noted that revenues in excess of expenses is placed into reserve at the end of the fiscal year. Budgets may not propose to spend out of the reserves. Therefore, to use the reserves deficit spending must occur. The figures on the attachment (through November) will be altered by about $28,000 as Openarc received its first payment in December 2012. It was believed to be very important in presentations to the constituency to indicate that reserves will be used to support major initiatives (e.g. the summit) and will occur through deficit spending. The funding of Consortia will be a topic of discussion for the first conference call after CSM.

TASK FORCE UPDATES

Reports were provided on the diversity and exercise physiology taskforces. Lisa McLaughlin distributed a listing of people serving on all task forces which has been attached (Attachment 5).

GLOBAL INSTITUTE OF MEDICINE (IOM) FORUM

Holly Wise reported on her service as our representative on the Global IOM forum. Her report is attached (Attachment 6). At the end of the three-year grant supporting this initiative, the IOM global forum is to produce a white paper on innovation of health professions education. One area for this report is interprofessional education and validating its effectiveness. Holly agreed to write a newsletter article on this topic.

As an extension of this issue, the board believed a task force to investigate what is presently being done in interprofessional education within physical therapist education would be beneficial.

FINAL – PASSED (Jette)

V-1 That a task force be established to investigate where we are as an educational community on interprofessional education and to use that baseline information to produce recommendations/suggestions/ideas for use in physical therapist education.

Support statement:
This has become a priority for all health professions and investigating our status as a profession is necessary. The task force will be comprised by Holly, and people who were interested in serving as the IOM representative from AC will be contacted for their interest in serving on the task force.

APTA GOVERNMENT AFFAIRS

Mandy Frohlich reported on government affairs. Mandy broadly reviewed issues for the profession instead of focusing on only issue specific to education. These included a fiscal cliff update, MPPR taking effect on April 1, alternative payment system (to begin January 1, 2015), direct access, implementation of healthcare reform legislation, Medicare reform, reintroduction of the student loan repayment and the higher education act.

STUDENT ASSEMBLY

Josh D'Angelo reported on the Student Assembly which elected its most recent board at the student conclave in November. Their three goals are to continue and improve their already established initiatives, solidify their communication network (core ambassadors and faculty representatives), and organize and improve accessibility of opportunities and develop new opportunities for members. The assembly was invited to make a regular submission for the AC newsletter.

STRATEGIC PLAN UPDATE

The discussion was deferred to the next conference call meeting.

CONSORTIUM APPROVAL (ATTACHMENT 7)

FINAL – PASSED (Sanders)

V-2 That the early assurance BS/DPT program consortium be approved.

Support statement:
The application has met the criteria for formation of consortium within the AC.

BOARD LIAISONS AND APPOINTMENTS

New appointments for liaisons are listed in Attachment 8. Historically, our liaisons with sections were started to open the communication regarding entry-level education recommendations that frequently emerge from sections, but have broadened to include other communications. One example is motions related to education that should perhaps best be considered by the AC.

BENCHMARKING TASK FORCE

The task force met and will be meeting again during CSM. The benchmarking will be divided into two categories: demographics and "to be essentials". The former will be done in collaboration with CAPTE (using the AAR). Should there be any motions emerging from this group they will be forthcoming by the July 1 deadline for the October AC business meeting.

BUSINESS MEETING AGENDA

The agenda for the business meeting was altered from that distributed in the board packet to ensure adequate discussion time for the two open forum issues. Dropped from the agenda were reports on the IOM global forum (Holly will be asked to submit something for the newsletter), PTE 21 study (to be included if there is time), annual PT exam (from HOD task force; will go in newsletter) and benchmarks for excellence reports. Added to the agenda were reports on our task forces (diversity, exercise physiology and a new interprofessional education task force).

NEXT MEETINGS

Board of Directors

Conference call(s)	TBD	
Annual Conference	January 27, 2013	12:00 noon-
ELC	October 3, 2013	4:00 p.m.-8:00 p.m.
	October 6, 2013	11:00 a.m.-2:00 p.m.

Respectfully submitted,

Dave Somers
Secretary

ATTACHMENT 1

Membership

A) APTA members who represent institutions of higher education located in the United States of America with a physical therapist education program that is accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE) may be designated as Council members by such an institution.

B) The institution will be represented by one academic administrator or other designated full-time core faculty member (as defined by CAPTE) in the program.

   1) Institutions with an accredited physical therapist education program that offer one or more expansion programs shall have one institutional representative selected by the Institution.

   2) Institutions with two separately accredited physical therapist education programs may have one designated representative for each of those accredited physical therapist education programs.

   3) The individual designated to represent any institution must be a member in good standing of the Association.

   4) The institution must continue to maintain a program that is accredited by CAPTE. An institution whose program has lost accreditation shall regain the right to designate a representative to the Council if its program regains accreditation from CAPTE.

   5) If a designated representative ceases to be an academic administrator or other full-time core faculty member in the program, then he/she shall cease to be a member of the Council. In such cases institutions are encouraged to designate a new representative within three months.

ATTACHMENT 2

FORUM ON SEPARATION OF CAPTE FROM APTA: Background Information from CAPTE

Differing Roles/Missions of CAPTE and APTA:

CAPTE is a regulatory agency, not a member service. Its role is to establish and enforce minimal standards for educational quality and not necessarily to promote an educational or practice agenda for the profession (that is APTA's role). Formal separation of these organizations would provide greater distinction between these respective roles and still allow mechanisms for strong collaboration.

Control over CAPTE resources:

- To maintain recognition as a specialized accrediting agency by the U.S. Dept. of Education (USDE) and the Council for Higher Education Accreditation (CHEA), CAPTE is expected to demonstrate autonomous control over its resources. CHEA has a new criterion which expects the accrediting agency to have *"independent authority and capacity to deploy resources in the service of its mission."* They will begin enforcing compliance with this criterion in 2015; CAPTE is uncertain whether it will meet the expected intent of this criterion in its current operational situation.
- In addition, CAPTE's inability to carry over its revenue surpluses from year-to-year has limited its ability to set aside funds that may be invested in future activities related to its mission. Given that these revenues come from educational programs, not APTA members, it seems that these resources should be used to serve their interests, not APTA's.
- As an entity within APTA, all of CAPTE's records, databases, evaluative criteria, position statements, and other intellectual property are currently owned by APTA. CAPTE believes that it should own its intellectual property and have independent control over access to its information and records.
- As a separate agency, CAPTE would develop its own governing board to ensure its fiscal accountability and solvency, as well as provide oversight for, and counsel to, its staff (particularly the executive director). CAPTE's Governing Board would include a representative from the Academic Council as well as other communities of interest. Given the planned retirement for Mary Jane Harris at the end of 2014, this Board would assume responsibility for the search for her replacement; currently this search process would be conducted by APTA.

- CAPTE acknowledges program directors' fears that it will have to raise accreditation fees to meet increased operational costs. However, CAPTE's fiscal projections have been based on scheduled fee increases that have already been publicized. In addition, other revenues sources are being explored.

Preserving CAPTE's integrity by eliminating any real or perceived conflicts of interest:

- A recent review of literature on this topic indicates a growing concern about conflicts of interest between accrediting bodies and professional associations. CAPTE is one of the largest accrediting agencies, yet is among a small percentage that still functions under its professional organization.
- Perceptions of conflicts of interest between CAPTE and APTA have been communicated both formally and informally by several program directors and academic administrators. There is a persisting perception that educational programs are "APTA-accredited," particularly when accreditation fees and correspondence go through APTA. Furthermore, when CAPTE positions or actions conflict with APTA policy, as in the recent debate over PTA education in peripheral joint mobilization, accreditation staff (who are employees of APTA) are placed in a tenuous position.
- CAPTE creates a risk management issue for APTA in that regulatory decisions made by CAPTE could potentially jeopardize member assets if CAPTE is held liable for an adverse decision. Consider the above example related to CAPTE's position statement on PTA education and joint mobilization: If

ATTACHMENT 2

CAPTE prohibits programs from teaching content that will be on the licensure exam and a candidate fails that exam based on these particular items, could CAPTE be held liable for that failure? Although CAPTE has been fortunate to avoid many lawsuits in the past, the kind of decisions it makes poses a greater liability risk for APTA than most of its other entities. And as the USDE tightens its control over accrediting bodies, CAPTE is likely to be forced to make a greater number of adverse decisions.

ATTACHMENT 2

FORUM ON SEPARATION OF CAPTE FROM APTA: Background Information from APTA

CAPTE and APTA – an overview:

CAPTE and APTA share a number of common interests, including both wanting what is best for the physical therapy profession. In addition we both acknowledge that CAPTE's status quo is unacceptable for both groups and recognize the importance of CAPTE remaining financially viable and adequately staffed and resourced as it transitions into a new model of operation.

APTA's current interests:

- Protect the public by maintaining high standards in PT education through the accreditation process. This interest involves ensuring that CAPTE has the necessary resources to "survive" financially, which is especially important to the Board in performing their fiduciary duties.
- Maintain the mutually beneficial aspects of the relationship between APTA and the accreditation process. The APTA Board believes that physical therapy education and practice are stronger when the domains are combined. CAPTE helps APTA keep a strong focus on education.
- The Board believes that APTA's influence plays an important role in maintaining the system of checks and balances related to discussions pertaining to physical therapy educational criteria.

Where things stand:

- Representatives from CAPTE and APTA met for a weekend in October in Pittsburgh; two models of operation were proposed:
- A ***Hybrid model*** of operation. This model would address concerns about accountability and establish a business unit model within APTA. CAPTE would retain surplus revenues and carry them forward, and CAPTE would have significantly increased decision making authority under APTA's CEO. CAPTE would develop its own business & strategic plan and be held accountable for it.
- An ***Independent model*** of operation. This would provide CAPTE with increased autonomy in decision-making and resource allocation, would avoid perceived conflicts of interest, and would be classified as a 501c3. CAPTE's Central Panel would still exist along with a to be determined governance plan. Under this model CAPTE's new revenue streams could potentially compete with APTA.

Next steps:

- Additional data are being collected regarding governance models in comparable accreditation agencies, current finances, projected finances in the proposed models, and input from key stakeholders. All of the information informing this decision will be represented in a report to the APTA Board of Directors in the first half of this year and the APTA Board will make a decision.

ATTACHMENT 3

PTA EDUCATION AND JOINT MOBILIZATION

As the preferred extender of physical therapy services, physical therapist assistants (PTAs) are educated and licensed to deliver physical therapy interventions within the plan of care designed by the physical therapist (PT). To safely and effectively fulfill this role, the PTA must possess knowledge of the rationale for all components of the treatment plan and their expected outcomes, as well as the psychomotor skills needed to perform components of the treatment plan as directed by the physical therapist. The Commission on Accreditation in Physical Therapy Education (CAPTE) believes that the knowledge of the entry-level PTA should include the rationale for manual therapy procedures such as soft tissue and non-thrust joint mobilization techniques. Furthermore, the Commission believes that it is not inappropriate to train PTAs to perform soft tissue mobilization or to manually assist the PT in the delivery of peripheral joint mobilization procedures (i.e., assist with patient positioning, stabilization, or grade 1-2 movements). CAPTE does not support the inclusion of educational objectives or learning experiences in the entry-level PTA curriculum that are intended to prepare the PTA to perform grades 3-5 (thrust) procedures.

(Adopted by CAPTE April 2012; Revised November 2012)

Update Regarding Position Statement (updated 12/4/2012)

On November 2-7, 2012, the Commission on Accreditation in Physical Therapy Education met to discuss its recent position statement on the education of physical therapist assistants as it relates to peripheral joint mobilization. The Commission considered all the feedback it has recently received, both in support of and in opposition to this position statement during its deliberations. Although it was the Commission's intent that this statement apply only to peripheral joint mobilization, this wording was only explicit in the supporting rationale which individuals responding to the position may or may not have seen. The Commission wishes to remind its communities of interest that its position statement is not intended to imply that PTA programs must teach this content nor does it endorse any specific point of view related to practice patterns. This statement merely indicates to programs that they will no longer be found out of compliance with CAPTE's current evaluative criteria should they choose to include this content in their curricula. Programs that do choose to address peripheral joint mobilization in their curricula will be expected to provide evidence that they are teaching the appropriate level and standards related to these intervention techniques and that they are assessing student competence. Furthermore, CAPTE reminds physical therapist educational programs that they are responsible for teaching appropriate decision-making as it relates to the direction and supervision of the interventions they choose to assign to physical therapist assistants.

Following its discussion, CAPTE made three changes to the position statement: the title was changed, emphasis was added to stress the role of the physical therapist in the determination of what interventions are directed to the PTA, and the word "peripheral" was added for clarification of CAPTE's original intent. In summary, CAPTE's position statement only relates to the application of its evaluative criteria and does not necessarily advocate for any changes in professional policy regarding the utilization of PTAs in clinical practice. CAPTE welcomes comments from its constituents. We respectfully ask that these comments be directed to accreditation@apta.org, and not sent to individual commissioners.

ATTACHMENT 4

American Physical Therapy Association
Program 40 - Activity 6
Academic Council
For the Eleven Months Ending November 30, 2012

	2012 YTD Actual	2012 YTD Budget	2012 YTD Pct of Budget	2012 Annual Budget
444 - Miscellaneous	360,000	$166,750	144.00%	250,000
451 - Registration fees	70,997	$28,348	167.05%	42,500
455 - Sponsorship	17,950	$5,336	224.38%	8,000
Total revenue, gains and other support	**448,947**	**195,098**	153.49%	**292,500**
600 - Salaries	18,258	$16,675	73.03%	25,000
602 - Employee benefits	5,359	$4,950	72.20%	7,422
603 - Payroll taxes	1,974	$1,334	98.70%	2,000
611 - Xeroxing / copying	0	$83	0.00%	125
613 - Occupancy	947	$626	100.96%	938
614 - Stationery / supplies	1,741	$83	1,392.80%	125
616 - Postage and shipping	573	$167	229.20%	250
620 - Printing (general)	140	$250	37.33%	375
625 - Audiovisuals	6,638	$5,670	78.09%	8,500
630 - Travel expenses (staff)	2,038	$667	203.80%	1,000
631 - Travel expenses (member)	24,656	$22,345	73.60%	33,500
632 - Travel expenses (non-member)	748	0	748.00%	0
635 - Meeting services	34,966	$20,677	112.79%	31,000
636 - Honoraria	6,638	$3,335	132.76%	5,000
640 - Professional fees	3,329	$2,335	95.11%	3,500
698 - Bank processing fees	0	$917	0.00%	1,375
Total expenses	**108,005**	**80,113**	**89.92%**	**120,110**
Change in net assets	**340,942**	**114,984**	**197.77%**	**172,390**

ATTACHMENT 5

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ATTACHMENT 5

Exercise Physiology Content Task Force

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Diversity in Student Recruitment & Retention Task Force

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ATTACHMENT 6

Global Forum on Innovation in Health Professional Education (IHPE)
iom.edu/Activities/Global/InnovationHealthProfEducation.aspx

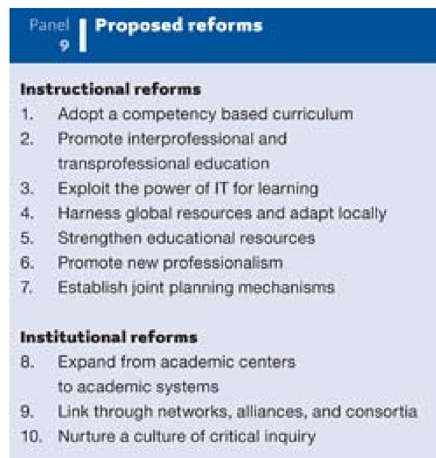
Background Information: Institute of Medicine (IOM)

The Institute of Medicine (IOM) is an independent, nonprofit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public. Established in 1970, the IOM is the health arm of the National Academy of Sciences, which was chartered under President Abraham Lincoln in 1863. Nearly 150 years later, the National Academy of Sciences has expanded into what is collectively known as the National Academies, which comprises the National Academy of Sciences, the National Academy of Engineering, the National Research Council, and the IOM.

The IOM aim is to help those in government and the private sector make informed health decisions by providing evidence upon which they can rely. Each year, more than 2,000 individuals, members, and nonmembers volunteer their time, knowledge, and expertise to advance the nation's health through the work of the IOM. Many of the studies that the IOM undertakes begin as specific mandates from Congress; still others are requested by federal agencies and independent organizations. While our expert, consensus committees are vital to our advisory role, the IOM also convenes a series of forums, roundtables, and standing committees, as well as other activities, to facilitate discussion, discovery, and critical, cross-disciplinary thinking.

2011

The Josiah Macy Foundation awarded a $225,000 three-year grant to the IOM in October 2011 to support the establishment of the IOM Global Forum on Innovation in Health Professional Education (IHPE). The principal investigator is Patrick W. Kelley, MD, DrPH, Director of the Board on Global Health and African Science Academy Development at IOM. This grant took it's inspiration from the 2010 *The Future of Nursing: Leading Change, Advancing Health*, a joint effort of the IOM and the Robert Wood Johnson Foundation, and the 2010 Lancet Commission's report, which discussed interdependent health professional education for the 21st century.


Panel 9 **Proposed reforms**

Instructional reforms

1. Adopt a competency based curriculum
2. Promote interprofessional and transprofessional education
3. Exploit the power of IT for learning
4. Harness global resources and adapt locally
5. Strengthen educational resources
6. Promote new professionalism
7. Establish joint planning mechanisms

Institutional reforms

8. Expand from academic centers to academic systems
9. Link through networks, alliances, and consortia
10. Nurture a culture of critical inquiry

ATTACHMENT 6

The IHPE aims to apply an ongoing, multi-national, multi-disciplinary/professional approach to exploring promising innovations in health education. The Forum brings together stakeholders from a variety of disciplines/professions and sectors to engage in dialogue and discussion to illuminate contemporary issues in health professional education. The members of the forum will be drawn from US and foreign government agencies and programs; leaders of US and foreign professional associations; foundations with a stake in health and higher education; WHO, UNESCO; medical, dental, pharmacy, and public health schools; relevant researchers; nursing, medical, dental, and public health student leaders; industry stakeholders; and include representatives from each major region of the world.

The Forum provides an ongoing, innovative mechanism to cultivate new ideas through global, multi-disciplinary/professional collaboratives, which represent formal partnerships between university-based health institutions that are undertaking recommendations put forward in either the 2010 Lancet Commission report or the Future of Nursing report. The four innovation collaboratives are located in Canada, India, South Africa, and Uganda.

- The Canadian Interprofessional Health Leadership Collaborative focuses on developing a learner-focused and competency-based educational model focused on collaborative leadership for health system change.
- The Public Health Foundation of India partnership with the Symbiosis College of Nursing (Pune) and the Datta Meghe Institute of Medical Sciences (Sawangi) is identifying interdisciplinary health care leadership competencies relevant to the medical, nursing, and public health professional education in India, and developing and piloting an interprofessional training model to cultivate leadership skills relevant for the 21st century health system in India.
- Makerere University in Uganda, a partnership involving schools of medicine, public health, and nursing, is dedicated to interprofessional training to develop competencies and skills in health professional ethics and professionalism.
- A South African collaboration involving Stellenbosch University, the University of the Western Cape, and the University of the Free State is working to identify and build capacity in relevant competencies required for transformational and shared leadership in health teams, and designing and implementing competency-based, interprofessional skill building for teamwork in the community and primary health care setting

Two Lancet report Commissioners, Jordan Cohen, MD and Afaf Meleis, PhD, co-chair the IHPE Forum. Dr. Cohen is on the faculty of the George Washington University School of Medicine and was President for 12 years of the Association of American Medical Colleges, and Professor Meleis, PhD is Dean of the University of Pennsylvania School of Nursing. The Forum will be to hold several workshops per year and the projected **"end-product" will be a white paper on innovations in health professions education.**

Organizational Sponsorships
Dr. Kelley has sought financial sponsorships with a 3-year commitment to support the activities of the Forum. Originally, there were six founding sponsors but the number of sponsors has rapidly grown (47+). Each sponsor is requested to make a 3-year commitment to the Forum to get the activities up and running with a level of certainty about finances. After the academies receive funds

from a sponsoring organization, IT automatically loads the name of the sponsoring organization onto the appropriate website.

Note: Some organizations have requested a designated alternate be named. The alternate is not formally recognized by the Academies but when the primary member cannot attend the alternate a meeting the alternate is automatically put into the vacant seat. Designated alternates are included on all our mailings except those that involve voting because that is only one vote per organization. The expectation is that the primary Forum member will discuss the voting options with his/her alternate and organization before voting.

Some organizations like to request a designated alternate while others prefer to keep their options open regarding who might fill their seat when they cannot attend a meeting. One advantage to having a designated alternate is they stay more abreast of the issues but really it is up to the member and his/her organization to decide how they would like to handle it.

2012

Two workshops and two planning meetings were held in Washington DC in 2012. All presentations are available at the Forum website. One planning meeting (March 8th) and Workshop 1: Educating for Practice: Improving Health by Linking Education to Practice using IPE (August 28th-29th) were held prior to Academic Council of the APTA (ACAPTA) membership. In the fall, ACAPTA agreed to become a Forum sponsor and I represented ACAPTA at the second planning meeting on November 28th and Workshop 2: Educating for Practice: Learning how to improve health from interprofessional models across the continuum of education to practice held on November 29th–30th. The planning meeting determined that the topic(s) for the 2013 workshops which will focus on IPE/P assessment and interprofessionalism.

Highlighted Presentations/Discussions from the November Workshop:

- **National Center for Interprofessional Practice and Education**
  In September 2012, HRSA awarded the University of Minnesota $4 million over five years to establish a national coordinating center for interprofessional education and collaborative practice. The Josiah Macy Jr. Foundation, Robert Wood Johnson Foundation, Gordon and Betty Moore Foundation and The John A. Hartford Foundation have also committed $8.6 million to the center. to brainstorm how to join forces and resources most effectively.

  This center creates an extraordinary opportunity to rigorously align the needs and interests of education and practice communities. We have named the new center "*National Center for Interprofessional Practice and Education.*" As we move forward, we will engage education and health systems in a *"nexus"* to incubate and innovate ideas, define the field and guide program development and research. The *"nexus"* is the shared ground, shared conversation and shared language necessary to create true collaboration between practice and education necessary to achieve our shared goals. 10 universities have been identified as "incubator sites" and have been invited to a 3-day March 2013 conference to begin planning the next step. I am part of the team representing the Medical University of South Carolina (one of the 10 sites) at this meeting.

  Initial materials are posted at www.ahceducation.umn.edu/nexus-ipe. If you would like to

be on the mailing list click, "to receive news and announcements".

- **Canadian Interprofessional Health Leadership Collaborative (CIHLC)**
  CIHLC is a multi-institutional and interprofessional partnership that is led by the University of Toronto and includes the University of British Columbia, the Northern Ontario School of Medicine, Queen's University and University Laval. The goal of the CIHLC is to develop implement, evaluate, and disseminated an evidence-based curriculum for *collaborative leadership*. The curriculum will be targeted to health are leaders, practitioners, and students. Over the next year, the CHIHL will be completing its environmental scan to understand the competencies that underlie *social responsibility*, best practice approaches to developing *community-engaged* medical education, and the principles that define collaborative leadership, and the principles that collaborative leaders should apply in their own social accountability or that of their organization.

- Other Topics/Discussion: Team OSCEs, Public Health competencies for all health professions students (population health), etc.

2013
Global Forum Activities to be held in Washington DC:
May 13: Forum meeting
May 14-15: Forum workshop
Oct. 9-10: Forum workshop

Related Activities:
March 20-22 National Center for Interprofessional Practice and Education Planning Meeting Phoenix, AZ
June 12-14 Collaborating Across Borders (CAB) IV Vancouver, Canada

If you have any questions, please do not hesitate to contact me. I can be reached at as follows:

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ATTACHMENT 7

APPLICATION FOR THE FORMATION OF A CONSORTIUM
Academic Council of the APTA

General Information

1. Name of proposed consortium:

~~*Dual Degree BS/DPT Program Consortium*~~
Early Assurance BS/DPT Program Consortium

2. Membership: Who will this consortium represent?

This consortium represents the faculty and admissions coordinators from DPT programs that are currently listed as "Freshman Entry" in the CAPTE directory of programs.

3. What is the estimated number of institutional members?

The CAPTE directory of programs currently lists 36 programs under its "Program admits students at the freshman level" category. Thus faculty and staff from these and other interested programs could participate in this consortium.

4. Purpose of the proposed consortium:

Programs that incorporate an undergraduate course of study leading directly into the DPT degree have unique issues and needs in the areas of admissions, student outcomes, curriculum design and development, faculty workload, and data collection. The purpose of this consortium would be to share and collaborate on these issues in an effort to further both institutionally driven and council goals of academic excellence within physical therapy.

5. Objectives of the proposed consortium:

I. *To have a venue to share issues related to the structure and functions of a dual degree program*
II. *To caucus on issues that come before the academic council that impact on the dual degree programs*

6. Meetings:

a. When will the Consortium meet, e.g. CSM, ELC, separate time?

The consortium would meet at a minimum one time each year prior to prior to the Educational Leadership Conference (ELC) in the fall.

b. How will the Consortium meet, e.g. teleconference, Web-based, in-person.

The fall meeting of the consortium would take place in person for those attending the ELC. Other meetings of the consortium would likely occur using a virtual meeting format (web-based).

Governance and Leadership

7. A Consortium must have at least a Chairperson and a Secretary. Will this Consortium have any additional leadership or governance structures?

☒ No (Skip to question 8)
☐ Yes (Continue to question a)

(a) What will be the leadership structure (e.g., board of directors, additional officers, etc.)?

8. All Consortium participants must be affiliated with an institutional representative of the Academic Council. Will there be any other qualifications to hold office in the Consortium?

☒ No (Skip to question 9)
☐ Yes (Continue to question a)
(a) What is/are those qualification(s)?

9. What would be the terms of office for the Offices within the Consortium?

The terms of office for the offices would be 2 years (staggered for the two officers of the consortium) with no term limit.

10. A Consortium must have a designated liaison to the ACBoD. If that liaison will be someone other than the Chairperson, who will that Liaison be and how will they be designated?

The liaison would be the chairperson.

Academic Council-Consortium Relationship and Support

11. Dues: At this time, Consortium may not charge dues. Does the Consortium anticipate charging dues in the future? If so, please describe what those dues would be used for?

We do not anticipate a dues structure for this consortium

12. What support does the Consortium anticipate needing from the AC for it to be successful? Examples might be Website links and access, financial support, staff support, meeting planning, teleconference call access, web-based conference access. Please provide as much information as possible about these needs.

Web-based conference access

Signed by at least 5 AC Representatives from Institutions participating in this Consortium:

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Gail Stern, PT, PhD, NCS	American International College
Diane M Heislein, PT, DPT, MS, OCS	Boston University
Ivan J Mulligan, PT, DSc, SCS, ATC, CSCS	Saint Francis University

ATTACHMENT 8

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PPS Internships TF		Randy Rausch	
FSBPT		Barb Sanders	
CAPTE		Barbara A. Tschoepe	
Acute Care		Kathryn Zalewski	
Research		Rick Segal	
Neurology		Susie Deusinger	
Aquatics		Susie Deusinger	
Caridopulmary		Kathryn Zalewski	
Sports		Barbara A. Tschoepe	
Clinical Electro		Rick Segal	
Women's		Barbara A. Tschoepe	
Education		Stephanie Piper Kelly	
Pediatrics		Stephanie Piper Kelly	
Federal		Barb Sanders	
Orthopaedics		Barb Sanders	
Geriatrics		Jim Carey	
Home Health		Jim Carey	
Oncology		Terry Nordstrom	
Hand		Terry Nordstrom	
PPS		Nancy Reese	
HP & A		Nancy Reese	
Fianance Committee		Nancy Reese	
Cultural Transformation		Susie Deusinger	
Excellence		Barbara A. Tschoepe	
		Jim Carey	
Board Appointment Committee		Nancy Reese	
		Kathryn Zalewski	
		Rick Segal	
Integrated Community		Terry Nordstrom	
		Tom Mayhew	
IOM Forum		Holly Wise	
Exercise Phys TF		Kathryn Zalewski	
Diversity TF		Jim Carey	
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ELC 2013	Barb Sanders		
Flexible shared vision	???		
Website	Stephanie Piper Kelly (not lead the initiative, just contact to BOD)		