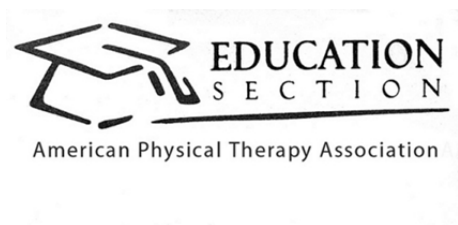


American Council of Academic Physical Therapy Clinical Education Summit

October 12-13, 2014, Kansas City, MO

Summit Report and Recommendations

Summit Supporting Organizations



Executive Summary

Clinical education in physical therapy will have a common culture of teaching and learning based in strong partnerships with shared responsibility for preparing all students to enter and progress through their clinical education experiences prepared for practice. Participants in the American Council on Academic Physical Therapy (ACAPT) Clinical Education Summit October 12-13 in Kansas City shaped this shared vision through two intense days of collaboration among representatives from 202 of the nation's 212 academic programs along with clinicians and an array of other vital stakeholders.

To make this vision a reality, summit teams drafted 15 recommendations that the ACAPT board will prioritize, consistent with ACAPT's strategic plan, for further exploration and implementation, moving toward a request for full adoption and implementation by ACAPT members. Eleven of these recommendations call for harmonizing the best practices programs will exemplify; four recommendations propose innovative research and pilot initiatives to further strengthen clinical education. As the summit ended, representatives were asked to express their level of commitment to enact the harmonization recommendations: 54 institutions said they are enthusiastic advocates and ready to act; 84 institutions said they are ready, willing and just need approval to proceed; and 42 institutions said there are enough implications to require them to move cautiously into implementation. No institutions indicated these changes are too hard to attempt.

Summit preparation and dialogue began well before October. Following discussions at the Education Leadership Conference in 2012 in which key clinical education issues were identified, ACAPT commissioned seven journal articles to explore structures and processes for strengthening clinical education. Six webinars were held over the summer of 2014 to discuss how these different proposals might contribute to quality clinical education. The journal articles, webinar recordings and chat transcripts are available for review on the ACAPT website.

Through this preliminary work, possible areas for best practices were identified and grouped into either changes in curricular structures or partnering processes. Jan Gwyer PT, PhD, Valerie Teglia PT, DPT, NCS, and Jody Cormack PT, DPT, MS Ed, NCS facilitated the action learning teams exploring curricular structures. Scott Euype PT, DPT, Corrie Odom PT, DPT, and Stephanie Kelly PT, PhD facilitated the action learning teams exploring partnering processes.

Summit lead facilitator Marsha Rhea, CAE, president of Signature I, LLC, designed a large-scale action learning and visioning process to discover and define a shared vision for best practices in clinical education and identify the recommendations needed to lead these changes. In the first step on day one of the summit, table teams generated meaningful questions that challenged assumptions and led to critical thinking, fresh perspectives and innovative solutions. In the second step that day, the teams expressed their desired outcomes and guiding principles for implementing any changes. What was notable was the degree of harmony around the guiding principles. They can be seen as a guide for navigating the changes ahead. The facilitation team analyzed the first day's discussion output and

proposed a slate of potential recommendation areas that could lead to the desired outcomes. On the second day, summit participants volunteered to work on recommendation drafting teams based on their interests. The summit concluded with the opportunity for institutions to publicly express their level of commitment to the proposed harmonization recommendations.

SUMMIT VISIONING PROCESS



This summit report includes the following elements:

- Guiding principles defining the key qualities or attributes needed to achieve a shared vision for clinical education best practices.
- Harmonization recommendations proposing concrete actions ACAPT and the clinical education community will take to create a strong culture of teaching and learning based in strong partnerships to achieve student readiness.
- Innovation recommendations that organize the clinical education community to research and pilot new directions to strengthen clinical education.
- Desired outcomes that are an expression of the shared vision and intent of the summit participants.
- Conclusion and next steps that outline how ACAPT and its members, the academic and clinical faculty, will work together in the months ahead to achieve these changes.
- Appendix: Action learning questions the summit teams developed to explore and analyze areas of opportunity for new approaches to clinical education. Summit Steering Committee members. Agenda and Participant Preparatory Materials.

Guiding Principles

Summit participants developed guiding principles at multiple tables within either the Curricular Structures or Partnering Processes action learning teams. They defined these key qualities or attributes needed to achieve a desired outcome and guide how solutions are designed and implemented. Both action teams proposed similar guiding principles, reflecting a high degree of harmony around how any changes should be developed and implemented.

Evidence-based: Congruent with published guidelines (ie. Guide for Physical Therapist Practice [Guide], Commission on Accreditation in Physical Therapy Education [CAPTE], etc), best educational practices.

Stakeholders as partners: All stakeholders are defined, included, in agreement, and accountable; stakeholders have ongoing education and communicate with each other; national consensus is achieved with shared values, common goals; transparency and trust; students and patients are included as stakeholders.

Assessment: Continuous improvement through data collection and analysis, benchmarking and transparency in these areas:

- Psychomotor/clinical skills
- Affective skills
- Leadership
- Professionalism – core values and behaviors

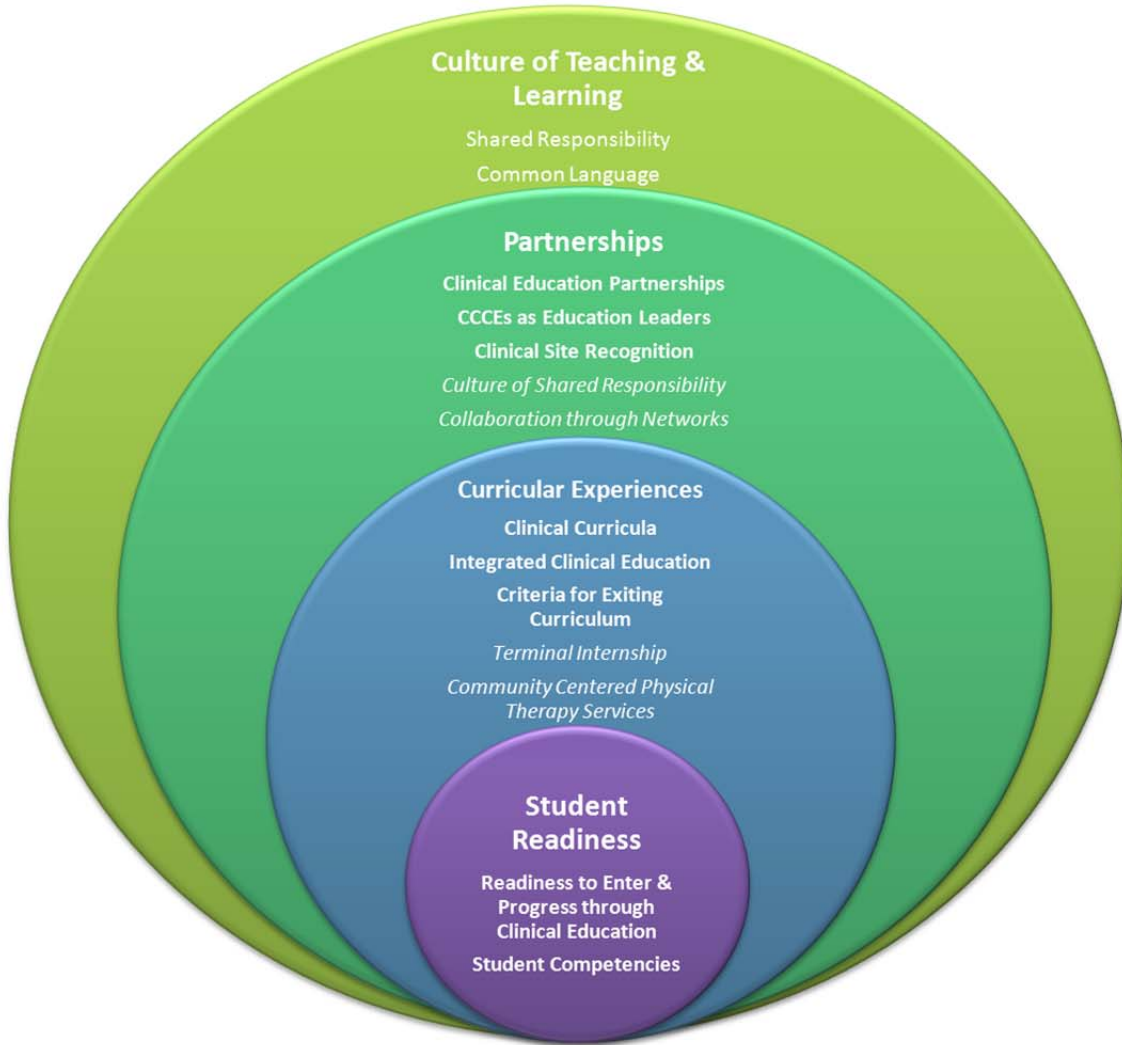
Clear, Explicit Plan: Simple, consistent, deliberate, explicit and efficient plan with operational definition of terms and an ethical framework.

Forward thinking: Considers current and projected needs and is unconstrained by current models and practices.

Interprofessional: Learn from other disciplines and adopt consistency of language across the professions.

Responsible & Sustainable: Sustainability; equitable and effective use of human and financial resources.

Harmonization Recommendations



Recommendations Diagram Note: The proposed recommendations offer a systemic and interconnected approach to strengthening clinical education. A culture of teaching and learning will be the basis of strong partnerships and quality curricular experiences that achieve student readiness. The harmonization recommendations appear in **bold**; the innovation recommendations are in *italics*.

I. Common Language for Communication

Recommendation: Academic and clinical faculty will develop, disseminate, use, and periodically review standard terminology and definitions for physical therapy education (As a model, think the National Medical Library’s MeSH – Single *acceptable*, resource).

Rationale: Being able to communicate consistently between academic and clinical facilities (or anyone, really) is essential to effective and efficient best education practice.

Relevant Guiding Principles: All described above, with attention to using existing evidence-based literature.

Proposed Implementation Steps: ACAPT will develop a task force including: regional consortia, the National Consortium of Clinical Educators (NCCE), American Physical Therapy Association (APTA) Education Section and Special Interest Groups, CAPTE, and other disciplines. It should draw upon any existing support documents, i.e., CAPTE, Clinical Performance Instrument (CPI), Guide. This work may also result in templates and models to support clinical education, such as placement request forms and student information forms. This recommendation also relates to other recommendations defining different aspects of clinical education.

II. Clinical Education Partnerships

Recommendation: Academic and clinical institutions will partner to provide best practices in clinical education.

Rationale: Partnerships foster culture and values promoting clinical education excellence. All stakeholders will value education as a component of their physical therapist (PT) professional identity. Partnerships will be mutually beneficial to optimize benefits to all stakeholders (students, institutions, patients, clinical sites).

Relevant Guiding Principles: Stakeholders as partners, evidence-based, responsible & sustainable

Proposed Implementation Steps: Establish formal partnerships and mutual sharing of information among clinical, academic, and administrative leaders engaged and contributing to curricular development. These partnerships can be flexible and customized for each institution and partner. Provide multiple options/opportunities for engagement (webinars, surveys) that are inclusive and flexible enough to serve both major medical institutions and smaller facilities, such as small clinics and community-based sites. Acknowledge the Center Coordinator of Clinical Education (CCCE)/ institution/practice through possible joint positions or faculty appointment. (See also related Harmonization Recommendation, Clinical Faculty Preparation/Development and Innovation Recommendation, Collaboration through Networks.)

III. Clinical Faculty Preparation/Development

Recommendation: Academic and clinical sites will partner to engage in continual development and support of clinical educators.

Rationale: Clinical education is a critical and valued component of education; recognition of clinical instructors (CI) as role models and central members in developing clinicians, furthers the

culture of learning in the clinical sites and is important to sustain a highly qualified pool of clinical instructors.

Relevant Guiding Principles: Evidence-based. Also create a culture and training for CI development early in academic programs.

Proposed Implementation Steps: Enlist resources from APTA to revamp CI training (web-based, cost effective). Make judicious use of simulation and other technology. Bring clinical educators in as consultants to help develop clinical teaching training programs. Evaluate CI's through new means such as a post-affiliation survey. Make training for clinical teaching more accessible for CI's. For those not APTA members, give library access. Determine evaluative criteria for CI's. Institutions collaborate with clinical sites to engage in research. Workshops for CPI training need to be more user friendly (not just web-based version). Revamp CPI (for use with multiple students, etc.). Offer more informal learning/mentoring via use of technology. Offer clinical education models where more advanced students mentor first year students. Establish a two-way communication model between institutions and clinical sites. Create CI specialty certification. Broaden roles of CI's to do more within the academic program- teaching, etc. Create a "CI for a day" experience.

IV. CCCEs Education Leaders

Recommendation: ACAPT will evaluate, enhance and promote the role of the CCCE as an educational leader in his or her respective organization.

Rationale: Clinical education program constituents are acutely aware that the role of the CCCE as the leader of the clinical education facility is paramount to a successful clinical education partnership between the site and academic institution. Directors of Clinical Education (DCE) and academic faculty wish to strengthen the role of the CCCE within their organizations in order to increase efficiency in the clinical education program. CCCEs should be the leaders of their respective clinical education facilities. They should possess clinical education expertise and be closely partnered with academic physical therapy institutions. They should be prepared to lead, promote and effectively mentor clinical faculty, and be empowered to effectively manage clinical education programs.

Relevant Guiding Principles: Stakeholders as partners, interprofessional, forward thinking. Also clear communication of roles and responsibilities, ongoing mentoring and advocacy.

Proposed Implementation Steps: The following strategies could be used to elevate the CCCE as education leaders: provision of time and resources to support the role of the CCCE, mentorship programs, education programming, professional certification, pooling of network resources, and partnership & communication enhancement.

V. Clinical Sites Recognition/ Credentialing

Recommendation: Centers of excellence in physical therapy clinical education will be recognized to best serve society's/patients' needs.

Rationale: Increase recruitment and visibility for sites by future employees, facilitates a bridge between academic programs and clinical educators; helps ensure quality of clinical education; demonstrates commitment to clinical education; creates a community of practice that supports clinical education; improves/supports the role of the CCCE; offers recognition as a "center of excellence" benefitting all (including administrators).

Relevant Guiding Principles: Stakeholders as partners. Also must set minimum criteria across the board and the criteria must be reasonable based on organization size.

Proposed Implementation Steps: Using existing documents such as Guidelines for CI's/CCCEs, determine markers of excellence. Strive to make this scalable and voluntary. Investigate the Texas exemplary site award as a possible model. Set an implementation timeframe with a progressive path. With different tiers of excellence, rewards from academic institutions might increase. The Credentialed Clinical Instructor Program (CCIP) may need different models of delivery to accommodate part-time CI's and others who may have difficult attending the traditional two-day course.

VI. Clinical Curricula

Recommendation: The physical therapist program should have clinical curriculum that develop a generalist, not constrained by setting or length. We recommend a model for tiered clinical education experience with specific objectives and outcomes via collected data to maximize efficiency and effectiveness.

Rationale: Defining objectives and outcomes for different levels provides a common language, expectations, while still allowing flexibility as to how exactly the structure might work. Goal of curriculum should be generalist with residency / fellowship for post-graduation. Do need to explore minimum total combined length for achievement of entry-level.

Relevant Guiding Principles: Evidence-based practice; assessment; clear, explicit plan

Proposed Implementation Steps: The total number and total combined length of clinical experiences need to be explored through funded research in order to define a current minimum standard. Examine existing models including how the 30 hour minimum requirement from CAPTE was established. Technology and simulation could be used to implement and/or achieve competencies.

VII. Integrated Clinical Education (ICE)

Recommendation: All programs will offer goal oriented, diverse active-learning experiences that are developed in collaboration with invested stakeholders and embedded within the didactic curriculum, prior to terminal experiences.

RATIONALE: ICE allows student to develop cognitive, psychomotor, and affective behaviors for successful terminal experiences. Given current differences in existing models and practices of ICE, the recommendation establishes baseline expectations to be met by invested stakeholders working collaboratively.

Relevant Guiding Principles: Evidence-based, stakeholders as partners, sustainability, interprofessional, assessment

Proposed Implementation Steps: Consider multiple models including addressing online, part-time and simulations. Definitions are needed to clarify concepts within ICE. Some elements should be common to all ICE experience. Perhaps ICE could be competency-based with each program having the flexibility in how competencies are taught. However, ICE should be managed and structured by academic programs and partner clinic sites.

VIII. Terminal Internship

Recommendation: Terminal internship models focus on the graduation of generalists who meet entry level criteria.

Rationale: While there are many questions related to length, setting and relationship with residency/fellowship (see Terminal Internship innovation recommendation III.), there is agreement that increasing the consistency in terminal internships graduating generalists is important to our profession.

Relevant Guiding Principles: Evidence-based, responsible and sustainable. Also include enough variability to meet needs of different programs.

Proposed Implementation Steps: Identify/define what the minimum expectations are for a generalist ready to enter the profession. What is a competency-based level of performance for the generalist?

Note: Recommendations IX, X and XI are interrelated and will need to be developed in concert. Because three separate teams developed these recommendations, they are reported here as distinct recommendations to preserve the fullness of their proposal.

IX. Student Readiness to Enter and Progress through Clinical Education

Recommendation: Develop a requisite core set of knowledge, skills, attitudes and professional behaviors to move into early, intermediate and final fulltime clinical experiences.

Rationale: To optimize learning and provide for safe, effective and efficient patient care and to increase clarity for all stakeholders (academic programs know what needs to be developed, clinical sites will be assured of a core set of knowledge/skills/attitudes and professional behaviors regardless of program, prospective and current students will have more clearly defined expectations before they enter the clinical environment). A common foundation of student readiness will allow for improved clinical experiences for students and clinical instructors.

Relevant Guiding Principles: Evidence-based, stakeholders as partners. Also common language and not setting/patient population/duration based.

Proposed Implementation Steps: Since it is important to include the right stakeholders, regional clinical consortiums could collaborate in developing this, working with the guidance of an ACAPT liaison or coordinating task force. Once a tool is developed, we need to do the research to ensure the tool is validated as an evidence-based assessment method.

X. Student Competencies

Recommendation: Establish a process for identifying how and if students meet clinical core performance competencies upon entering each level of full-time clinical experience.

Rationale: Clinicians are asking for a level of similar understanding of student preparation across academic programs – what skills and knowledge the student will have at each level. This should include standardized preparation across certain cognitive/psychomotor/affective abilities to be able to start a clinical experience prior to beginning a clinical level. It must be consistent across academic institutions for clinical experience. Ultimately we need to be sensitive to clinician time efficiency to streamline clinical instructor preparation requirements and to ensure patient safety.

Relevant Guiding Principles: All

Proposed Implementation Steps: We need to identify levels and competencies to have consistency and common language among universities; perhaps we can define three to four levels of performance competency to maintain uniformity for clinicians (e.g., defining early, intermediate and final fulltime clinical experiences). Define these levels with input from all stakeholders, particularly polling clinicians to determine language, criteria and competencies. Academic institutions can examine their curricular design and deliver content consistent with clinical partner needs.

XI. Entry-level Criteria for Exiting Curriculum

Recommendation: Commission a work group to explore and articulate a profession-wide definition of entry-level graduate competence, which is contemporary and adaptable to a changing health care environment.

Rationale: There is not an accepted definition of “entry-level” which might be better labeled “graduate competence”. The question is whether we want or need to change the current definition of “entry level.” Current definitions are driven by the CPI, rather than driving the CPI. We would suggest that an accepted definition of graduate competence underlies initiatives and discussion related to length and setting of terminal internships. A common definition would assist us to develop evidence about optimal length and setting of internships.

Relevant Guiding Principles: Evidence-based, assessment, stakeholders as partners, forward-thinking

Proposed Implementation Steps: Conduct a nationally standardized employer survey – with discussion around skills and competencies related to practice management and leadership. Explore best practice in other professions especially other doctorally prepared professions. This initiative may lead to adding competencies and behaviors to the CPI and using competency based assessments.

INNOVATION RECOMMENDATIONS

I. Culture of Shared Responsibility for Clinical Education – Administrative Levels

Recommendation: In an effort to move academic and clinical sites toward a culture of shared responsibility, the physical therapy profession and ACAPT will do the following: 1. A group of academic and clinical leaders will develop, define and facilitate a model for bidirectional relationships between clinical organizations and academic institutions in order to communicate, educate and assess the benefits of sustainable clinical education for all stakeholders. 2. Form a shared commitment to assess the value of clinical education for all stakeholders through aggregation of current evidence and further research.

Rationale: To develop more closely aligned and mutually beneficial relationships between academic and clinical partners.

Relevant Guiding Principles: Evidence based, stakeholders are partners, responsible and sustainable, interprofessional, assessment. Also consider underserved areas.

Proposed Implementation Steps: ACAPT and APTA will support research to study shared responsibility models. The research will identify data sources and determine existing data /

literature. The study should examine clinical sites inclusive of size and underserved regions. The research would develop business models and conduct cost-benefit analyses. Resources to enhance communication are also needed.

II. Collaboration through Networks

Recommendation: Establish demonstration projects to explore possible models for networks that create grassroots partnerships of teaching between clinical learning environments and academic institutions to promote excellence in clinical teaching, coordinated models of placements, sharing of information and resources and aligning academic and clinical curricula.

Rationale: There are many potential benefits for sharing rich data, facilitating CI development, supporting stronger DCE and CCCE roles, enhancing individual relationships with clinics and programs; improving efficiency/fit of matching process, promoting flexibility and responsiveness to health care changes; developing a richer culture of clinical education with equal input from all stakeholders; developing placement opportunities, expanding placement opportunities in a variety of settings and geographic areas (i.e., rural and underserved), promoting higher level connections (e.g. admin) between academic institutions and clinical learning environments, reducing the number of contracts – however, we need more information and exploration of models to move collaboration through networks forward.

Relevant Guiding Principles: Stakeholders as partners, evidence-based, interprofessional, clear and explicit plan, responsible and sustainable, forward thinking and assessment. Also consider characteristics of network beyond geography.

Proposed Implementation Steps: ACAPT will fund demonstration projects in different regions/groups.

III. Terminal Internship

Recommendation: Explore, develop and test models for terminal internship that consider competency vs. time based structures, minimal length of experience to meet entry-level requirements that includes practice management, impact of length of internship on clinical sites / CI's, settings (e.g. trauma hospital vs. community hospital vs. private practice), advantages/disadvantages of licensure, stipends.

Rationale: We still have many unknowns, many ongoing questions related to implementation of the terminal internship, lack of agreement on definitions within profession and between ACAPT and CAPTE, many professional models, unclear connection and interaction with residency / fellowship programs.

Relevant Guiding Principles: Evidence-based, assessment, responsible and sustainable, interprofessional, partners as stakeholders

Proposed Implementation Steps: Conduct research and test models to clarify models and options: experience vs. internship; minimal internship time; achievement vs. time based; result in entry-level or beyond entry-level; relationship to residency; seminar interspersed within terminal internship; impact on students and their preferences as to length, variability, timing, licensure, cost; meeting the needs of practice for a doctoring profession. Examine any existing models that may be addressing these questions.

IV. Innovative Community-Centered Physical Therapy Services

Recommendation: Building on current models, discover, develop and test innovative community-centered physical therapist services that can be integrated into physical therapist professional education to meet societal needs.

Rationale: There are significant unmet contemporary societal needs and we have capacity and talent; we have a core value of social responsibility; this will create a more prominent role for this practice through clinical education.

Relevant Guiding Principles: Stakeholders as partners, responsible and sustainable, evidence-based, and interprofessional. Also the Triple Aim, cultural competence, advocacy, health continuum, person-centered.

Proposed Implementation Steps: These clinical education experiences could be directed at individuals, groups and populations by working with a range of stakeholder partners such as health care providers, faith-based groups, engineers, city planners and politicians. The focus could be on personal and public health priorities like flexibility and mobility across the lifespan/health continuum and safety and risk management. These efforts would adhere to state and federal laws and ethical standards without limiting the opportunity for innovation.

Desired Outcomes

The Partnering Processes and Curricular Structures action learning teams concluded the first day's summit work with an exploration and expression of desired outcomes. The recommendations above grew out of this emerging sense of shared vision. This is a brief summary of what almost 40 table teams explored as the best strategic direction for the future of clinical education.

The physical therapy profession will embody a strong culture of teaching and learning as a component of each physical therapist's professional identity. All PT graduates will possess the knowledge, skills and attitudes to serve as effective educators including clinical instruction. This is the foundation for creating a comprehensive system to educate and mentor all stakeholders in clinical education.

The physical therapy clinical education community will develop effective communication and shared language, including operational definitions regarding experience level, curricular content, and academic preparedness of the students. Clear communication among all stakeholders will help reduce variability between programs and enhance efficiency of education.

Clinical educators will be prepared, supported and recognized through academic and clinical partnerships. CCCEs will be the leaders of their clinical education sites and possess the clinical education expertise to manage, promote and mentor clinical faculty.

Clinical education sites will be recognized for meeting defined evidence-based characteristics and having the relationships and infrastructure required for quality clinical education. Academic institutions will share resources to collaborate with and support clinical stakeholders.

Clinical sites and academic institutions will be closely aligned through partnership networks. These networks will facilitate and incentivize the exchange of expertise and resources among academic and clinical partners to maximize overall efficiency of student learning and patient outcomes. These networks will use technology to optimize and leverage the current capacity of clinical education experiences and build and sustain strong partnerships.

Curricula and clinical experiences will be structured to ensure students are ready to progress through clinical education. An evidence-based set of competencies will be developed to clarify what is entry-level, what differentiates generalists from specialists and what skills are required for specific patient populations and conditions. Academic institutions will use a common assessment to certify each student's level of mastery of a defined set of competencies. All stakeholders have consistent expectations for student readiness along the developmental continuum for early, intermediate and final clinical experiences.

Physical therapy will have a consensus statement on standards for physical therapy curriculum that will graduate students ready to integrate, adapt and lead the delivery of care within new healthcare delivery models that address societal and professional needs.

Physical therapy will develop a sustainable clinical education model that prepares students for fulltime clinical experiences and effectively manages their placement needs. All students will participate in integrated clinical education that fits the variety of needs and assets of the educational and clinical environment. Clinical education stakeholders will agree on a minimum and maximum fulltime clinical experience that leads to entry level expectations.

Next Steps for Review, Adoption & Implementation

These recommendations are an ambitious program of work for ACAPT, its member institutions, and the larger professional community.

ACAPT encourages all stakeholders to continue the summit dialogue around these proposed changes. Institutions are encouraged to bring all stakeholders together to discuss what their role might be in pursuing these recommendations.

If you indicated your institution is ready and willing to move ahead and just needs to seek approval, you can use these stakeholder dialogues to facilitate understanding.

If you indicated you will need to move cautiously, these dialogues can help you better understand your challenges and what you can do together to overcome them.

For those of you who are already strong advocates of this path forward, ACAPT urges you to continue championing this vision throughout the community. ACAPT will need the expertise of all institutions already working on any aspect of these recommendations.

The ACAPT board will review and approve these recommendations in early 2015. The board plans to prioritize these actions and incorporate them into ACAPT's strategic plan and current initiatives and resources. The proposed recommendation implementation steps provide helpful guidance for developing follow-up action steps that might take a variety of forms:

- Collaborative Task forces
- Support / Collaboration with current initiatives
- Funding of research studies
- Initiation of pilot projects

ACAPT's goal for the clinical education visioning process was to reach agreement on best practices for clinical education in entry-level physical therapist education and to strengthen the relationship between academic and clinical faculty. These recommendations demonstrate a tremendous first step toward achieving these goals for our profession. These recommendations arose from individuals who demonstrated intellectual courage and a collaborative spirit throughout the entire process – from the call for papers which resulted in highly collaborative authoring teams – to the many perspectives voiced by the full array of summit participants. Continued demonstration of these qualities will be essential for the hard work ahead executing this vision of a common culture of teaching and learning based on strong partnerships and shared responsibility for preparing all students to practice as Doctors of Physical Therapy.

APPENDIX

Action Learning Questions

The summit action learning teams first developed meaningful questions to take a deeper look at the possibilities for strengthening clinical education.

Partnering Processes Questions:

- Can we develop a way to reward and recognize clinical instructors and sites that model best practice?
- What if academic partnerships were more collaborative and focused on meeting the needs of the community (i.e. expanding and developing programs)?
- What would it be like if there was a broad cultural change in the profession that clinical teaching is an essential role of the professional?
- Could we explore and develop a business model for physical therapy clinical education that considers return on investment?
- Can we engage payers and providers to determine effective ways to balance financial interests that impact curriculum design and practice needs?
- What if we could use strengthened partnerships to advance excellence in practice?
- How could we partner to share expertise within the classroom and clinical facility? (ie. Teaching and research)
- Could we have collaboration between clinical and academic partners to identify a skill set for student readiness?
- How do we build consortia around the country growing from existing partnerships?
- How could the Physical Therapist Education Network (PTEN)/Regional Core Network (RCN) enhance placement and support processes for clinical education?
- How do we use technology to support our outreach and increase capacity?
- What are the most valued incentives for the CI that can be provided by the school, facility and profession?
- How can we standardize clinical education verbiage, including experience level, and curricular content/academic preparedness?
- How do we credential clinical settings to ensure excellence with clinical education?
- What types of expertise could academic institutions offer clinical sites and vice versa?
- How do we engage the consumer in seeking providers that value education and student teaching?
- Could we develop a mentoring system for new CI/CCCEs?
- What resources (other than DCE's and/or physical therapy education programs) are available for CI's to communicate with other CI's?
- What if we develop data that shows clinical sites students are cost effective and not cost prohibitive?

- Can partnering processes provide a bank of available rotations in a region to enhance collaboration and diminish competition between programs? Can partnering processes provide opportunities to work across regions?
- How would our jobs (DCEs and CCCEs) be different if RCN existed?

Curricular Structures Questions:

- Student readiness/competencies/entry level criteria for exiting clinical education:
 - Can student readiness be determined at multiple points across the education process?
 - How does each stakeholder determine and communicate student readiness?
 - Does the definition of entry level change based on length of internship?
 - What are the criteria for now and 10 years from now?
 - Should we be graduating generalists (current criteria) or specialists (may need to develop new criteria)?
 - Are there key competencies/proficiencies that all graduating PTs should have across settings and patient populations?
 - What are the conceptual frameworks common to all practice settings that underlie professional competence?
 - What are the benchmarks for student readiness?
 - Can we define the skills needed by students at the outset of fulltime experiences regardless of setting?
 - What are the critical competencies that transcend the current and future practice?
 - What would clinical education research look like if we could standardize readiness and competence?
- Terminal Internship:
 - What is the evidence that indicates how long a terminal internship should be? Should the length be standardized?
 - Should competency dictate length of final internship?
 - Is the one-year internship the most effective format for a terminal internship?
 - What is the Impact of the terminal internship on residency?
 - What does a clinical site believe is the ideal length of a clinical rotation from a staffing and management perspective?
- Integrated clinical education (ICE):
 - What does integrated clinical education encompass?
 - What is the best model/construct to use to integrate ICE into the curriculum?
 - What novel ideas can we use/classify as ICE?
- Clinical experiences that address societal needs:
 - How do we define diverse settings?
 - How do we explore models of how this can be better done?
 - How can we influence and develop new practice models?
 - How can we implement nontraditional clinical education experiences, e.g. simulation, telehealth, advocacy, etc.

- How can we work within regulatory and reimbursement environments to provide optimal learning experiences?
- How can we maximize the power of technology in clinical education?
- Can we expand supervision of PT students to include other disciplines?

Clinical Education Summit Steering Committee

Stephanie Kelly, PT, PhD, (Co-Chair, ACAPT Board)

Jody Cormack, PT, DPT, MS Ed, NCS (Co-chair, DCE)

Leesa DiBartola, EdD, DPT, PT, MCHES, (DCE)

Scott Euype, PT, DPT, (CCCE, CESIG Co-Chair)

Jan Gwyer, PT, PhD, (JOPTe)

Corrie Odom, PT, DPT, (DCE, CESIG past Co-Chair)

Valerie Teglia, PT, DPT, NCS, (DCE)

CONSULTANT MEMBERS

Susan Meyer –Dean of Pharmacy, Univ of Pittsburgh

Peggy Gleeson – Past President Education Section

Janet Bezner, PhD, (Former VP Education and Governance, APTA)

Mark Lane, (Federation of State Boards)

For a list of all summit participants, see the ACAPT Clinical Education summit website.

Summit Agenda and Participant Preparatory Materials

The following summit agenda, frequently asked questions and webinar summary were provided as preparation to summit participants. This document offers important background information and context for understanding the summit and its decisions described in this report.

**CLINICAL
EDUCATION
SUMMIT**

OCTOBER 12 – 13, 2014
KANSAS CITY, MISSOURI

Agenda

10/12/2014

Sunday, 8:30 am-9:00 pm

7:30 a.m.	Continental Breakfast Meet & Greet Colleagues
8:30-9:15 am	Summit Welcome & Charge (Century C) The Charge & Expected Outcomes--Terry Nordstrom Vision for Physical Therapy--APTA Vice President Sharon Dunn 5 Minute, Triad Exchange of Participant Aspirations Introduction of Summit Steering Committee & Facilitator (Stephanie Kelly and Jody Cormack) Recognition of Clinical Education position paper authors Overview of Summit Agenda and Action Learning Process (Facilitator, Marsha Rhea)
9:15-10:00 am	Opportunity Presentation: See Webinar Summary (Century C)—webinar facilitators panel, organized & facilitated by M Rhea <ul style="list-style-type: none"> ● A Shared Sense of Direction & Promising Opportunities ● Framing the Options <ul style="list-style-type: none"> ○ Curricular Structures (i.e. integrated clinical education; mix of settings & patient types; student readiness; terminal experiences). ○ Partnering Processes (i.e. standardization and support for clinical instructors, collaboration networks - physical therapy education network, regional core network).
10:00-10:30 am	Break & Move into Curricular Structures (Century A) & Partnering Processes Action Teams (Century B) Breakouts <i>(Choose any numbered table at this time – you will keep your table number through all summit breakouts)</i>
10:30 am-12:00 pm	Action Learning Teams: Questioning Curricular Structures Team (Century A - GREEN) or Partnering Processes Action Teams (Century B – GOLD) Kickoff Instructions: <ul style="list-style-type: none"> ● Creating meaningful questions ● Balancing harmonization & innovation Teams develop and post 5 critical questions for harmonization & 5 for innovation Assemble questions
12:00-1:00 pm	Lunch Boxed lunch will be provided in Century Ballroom Foyer. Utilize chairs in Century C.

Sunday, October 12 (Cont'd)

1:00-2:00 pm	<p>Switch to the Other Team's Room: Prioritizing the Questions</p> <p>Curricular Structures Action Team moves into Century B (GREEN)</p> <p>Partnering Processes Action Team moves into Century A (GOLD)</p> <p><i>Go to your corresponding numbered table in the other inquiry group's room</i></p> <ul style="list-style-type: none"> ● Review the critical questions for harmonization and innovation ● Discuss the questions as a team and identify the top 5 questions for each
2:00-2:15 pm	<p>Break (Century Ballroom Foyer)</p>
2:15—4:00 pm	<p>Design Principles & Desired Outcomes</p> <p><i>Teams Return to Their Original Team Room Locations</i></p> <p>Curricular Structures Action Team is back in Century A (GREEN)</p> <p>Partnering Processes Action Team is back in Century B (GOLD)</p> <ul style="list-style-type: none"> ● Review Prioritized Questions/Agree or Disagree ● Teams Propose Desired Outcomes & Design Principles ● Full Group Shares & Agrees on Desired Outcomes & Design Principles <p><i>(Place on PPT slides for full group sharing)</i></p>
4:15-4:30 pm	<p>Break (Century Ballroom Foyer)</p>
4:30 pm – 5:45 pm	<p>Recap—Design Principles & Desired Outcomes (Century C)</p> <p><i>Full group plenary room</i></p> <ul style="list-style-type: none"> ● Inquiry Group Presentations—Curricular Structures & Partnering Processes ● Reflections on Emerging Themes for Shared Vision ● Summit Participant Questions ● Instructions for our purposeful networking reception
5:45-7:00 pm	<p>Unscheduled Time</p>
7:00-9:00 pm	<p>Vision Discovery & Best Practices Scouting Reception (Union Station Kansas City – Sprint Festival Plaza)</p> <ul style="list-style-type: none"> ● Please bring your conference badge ● Begin in your regional conversation cluster ● Choose Your Role & Ribbon: Scout, Advocate, Stakeholder Perspective, Provocateur, Innovator, Visionary ● Mix & Mingle with charge to speak with all types during the evening

October 13, 2014

Monday, 7:30 am-3:00 pm

7:30 a.m.	Continental Breakfast (Century Ballroom Foyer)
(7:30 -8:15 am)	<i>(Summit Steering Committee Facilitators Only: Check-in & Key Themes for Next Session)</i> (Presidents)
8:30-9:30 am	<p>Summit Reconvene & Check-In (Century C)</p> <p><i>Panel of Facilitators: What we've learned in Day One:</i></p> <ul style="list-style-type: none"> ● Where are the promising opportunities & potential for easy wins? ● What may be more challenging? <p><i>Instructions for Today's Action Learning—M. Rhea</i></p>
9:30-9:45 am	Break (Century Ballroom Foyer)
9:45-10:30 am	<p>Recommendations & Strategies for Leading Change</p> <p><i>Go to Curricular Structures Team (Century A - GREEN) or Partnering Processes Action Team (Century B - GOLD) as Assigned</i></p> <ul style="list-style-type: none"> ● Identify Potential Recommendations ● Make team assignments for recommendation drafting ● Discuss and draft your assigned recommendation
10:30-11:15 am	<p>Coordination & Revision of Recommendations (Remain in Your Action Team Room)</p> <ul style="list-style-type: none"> ● Share draft recommendations with your inquiry group ● Refine & agree on recommendations
11:15-11:30 am	Break (Century Ballroom Foyer)
11:30 am—12:15 pm	<p>Recommendations & Strategies for Shared Vision (Century C)</p> <ul style="list-style-type: none"> ● Team presentations by recommendation advocates ● Distribute draft recommendations ● Any questions for clarification
12:15-1:15 pm	<p>Lunch Caucus</p> <p>Boxed lunch will be provided in Century Ballroom Foyer. Utilize tables and chairs in Century A and B.</p> <p><i>Please sit with delegates from your institution and other critical partners to review the proposed path forward</i></p>
1:15-2:00 pm	<p>Organizing to Take Action (Century C)</p> <ul style="list-style-type: none"> ● Program representatives place your institution on the poster that best expresses your current position on the proposed recommendations: <ul style="list-style-type: none"> ○ <i>Enthusiastic Advocate & Ready to Act</i> ○ <i>Ready, Willing & Need Approval</i> ○ <i>Enough Implications to Move Cautiously</i> ○ <i>Hard Change, Hard Choices Ahead</i> ○ <i>No Change, No Way Forward</i> ● Review lists & invite program representatives to comment on their positions as time permits
2:00—3:00 pm	<p>Leading Change (Century C)</p> <ul style="list-style-type: none"> ● Stretch Break to Exchange Contact Info/Schedule follow-up calls/meetings ● ACAPT's next steps—Stephanie Kelly ● Your Next Job: Change Leadership—M Rhea ● Closing Words of Appreciation—Jody Cormack

Other Important Details:

Will there be internet access? Complimentary Wi-Fi will be available in the meeting space of the hotel. The access code is APTA14.

Will this event be live streamed? Portions of the summit will be live streamed and available for viewing on the [CE Summit web page](#); the link will go live the morning of October 12. Live stream video will capture the plenary events in Century C; break-out sessions will not be available on live stream.

Will virtual participation be possible? A Twitter handle has been created for the summit. As you watch the live stream, let us know what you think - @ClinEd14

Do we need a laptop? A laptop will not be necessary for participation in the summit. However, participants are encouraged to have access to the position papers during the summit (electronic or hard copy), as hard copies of these will not be provided.

Will I be able to make a flight out on Monday evening? Yes, the summit will promptly conclude at 3:00pm as scheduled. We are aware that many individuals will wish to depart for the airport shortly after the time and are working with the hotel to ensure ample availability of taxis.

Will meals be provided? As you can see on the summit agenda, breakfast and lunch will be provided for all participants on Sunday and Monday. The Westin Kansas City at Crown Center is encompassed by Hallmark's Crown Center, which offers 85 acres of shops, restaurants, and attractions.

Appropriate Dress? Attire is business casual.

Are CEU's available for summit participants? We are seeking approval to issue CEU's for attendance at the summit. More information will be available soon.

Is there a sign-in / registration? Summit badges will be available for pick-up starting on Saturday at ELC, for those who are attending both meetings. Badges will also be available for pick-up all day Sunday at the registration area located outside of the Century Ballroom.

How will I be assigned to a priority area of "Changes in Curricular Structures" or "Partnering Processes"? Stakeholder participants will be pre-assigned to one of the designated areas. The two representatives from each academic program will be allowed to self-select the assignment group; however, academic representatives will be expected to have one representative in each group, and should be prepared to declare their assignment group before the first break-out session starts on Sunday at 10:00 am.

What should I do to prepare? Summit participants should read the position papers and participate / listen to the discussion webinars. Copies of the articles, an article discussion board, and webinar transcripts can all be found at the ACAPT website: <http://www.acapt.org/index.php/full-events-list/event/23-clinical-education-summit>.

ACAPT Clinical Education Webinars Discuss Potential Best Practices

The American Council on Academic Physical Therapy (ACAPT) is convening the Clinical Education Summit October 12-13 in Kansas City to advance collaboration and consensus building among the profession's more than 200 academic programs. ACAPT commissioned seven journal articles to explore structures and processes for strengthening clinical education and then conducted six webinars this summer to discuss how these different proposals might contribute to quality clinical education. The journal articles, webinar recordings and chat transcripts are available for review on the ACAPT website (<http://www.acapt.org>). This summary, developed by Marsha Rhea, president of Signature i, LLC who is serving as the summit facilitator, is intended to begin framing some of the important questions summit participants will address.

Quality clinical education depends on strong partnerships between academic and clinical programs. Academic programs trying to secure sufficient clinical sites now average 458 clinical education affiliations. Clinical sites want to support clinical education yet are challenged by increasing demands for delivering patient care. Changes are needed to ensure better integration between academic and clinical education, quality learning experiences for clinical instructors and students, and effective use of everyone's time and resources to prepare the next generation of physical therapists.

Standardize Qualifications and Support Clinical Instructors

Webinar participants generally agreed with the need for universal baseline qualifications for clinical instructors (CI). The development of a standard set of CI teaching skills, through both currently available mechanisms like CI credentialing, and yet to be developed processes was thought to be a key component of essential qualifications. There was much concern that patient productivity requirements impinged on quality clinical instruction, although evidence was limited and dated. It was pointed out that any changes in clinical education models should anticipate future shifts to outcomes-based care delivery models. A number of clinical education programs are experimenting with different instructor to student ratios and supervisory and mentoring practices to leverage the time of their clinical instructors. There was some interest in exploring financial models to better support clinical education, such as reimbursing clinical instructors or securing reimbursement for student provided patient care. Caution was expressed that the implementation of standards and qualifications not discourage capable physical therapists from becoming clinical instructors.

Establish Student Competence/Readiness for Clinical Education

The majority of webinar participants voiced support for a standardized level of student readiness for clinical education. The most popular ideas were a formal examination or standardized patient assessment; however, there was a clear need to clarify and agree on what knowledge and behaviors constitute readiness. It was also suggested that students should specifically be taught to be clinical instructors in their academic program to become more effective learners. In addition, more emphasis could be placed on teaching students to add value as student physical therapists in their clinical sites.

Offer a Diverse Mix of CE Settings and Experiences

The majority of the webinar participants voiced support for conducting clinical education experiences across a variety of setting and patient types, including most common employment settings, such as outpatient facilities, hospitals and skilled nursing facilities. However, there was also interest in ensuring students were able to

manage patients and clients with common conditions. Simulations were viewed as possible viable options for providing experiences that cannot be accessed through clinical sites.

Embrace Integrated Clinical Education

Most participants agreed integrated clinical education (ICE) is consistent with best practice for transfer, application and reinforcement of didactic and skill-based learning. Disagreement existed regarding whether ICE should be required and the degree to which ICE should be standardized. For example, where in the curriculum should these experiences occur and how many contact hours should there be? The webinar participants were realistic about the implementation challenges in integrating and coordinating periodic clinical experiences throughout the academic curriculum.

Experiment with Longer Terminal Internships

Although a few physical therapy programs have adopted a one-year internship model, most webinar participants had reservations about the benefits of requiring this model. The clinical education community may be open to increasing the length of the terminal clinical education experience if doing so does not diminish their ability to offer integrated clinical education or expose students to diverse clinical education settings. Supporters of the year-long internship said this model better prepares entry-level practitioners, is consistent with practices in other doctoring professions, and could contribute to a clinical site's productivity and financial goals.

Create Structures and Processes for Closer Clinical Education Affiliations

Although there was strong interest in fostering closer relationships between academic programs and clinical sites, the webinar participants had a number of questions about how to implement either of the two proposed structures for partnering, the physical therapy education network (PTEN) and the regional core network (RCN). Both structures emphasize regional collaborations and could work separately or in concert with each other.

PTENs are focused on individual academic programs developing closer, more intimate relationships with fewer clinical sites and health systems. This relationship would be defined through comprehensive agreements that would commit academic and clinical faculty to broader relationships encompassing teaching, professional development and research, such as clinical faculty appointments and compensation for clinical instructors. PTEN partners would determine the clinical education curriculum and make wise and creative use of available clinical sites. While many questions about logistics arose, the idea of stronger relationships seemed to resonate with participants.

The RCN would create a centralized technology and communications infrastructure to support and streamline clinical site recruitment and placements. Centralizing these processes would allow greater efficiency of time and resources, allowing academic and clinical coordinators the opportunity to focus their efforts on clinical site and clinical instructor development. While many logistical questions were raised about the RCN, the possibility of improved efficiencies through this model generated positive discussion.

Before agreeing to create these structures, academic and clinical education programs would want to be assured these networks will foster quality without unduly constraining their ability to match students and clinical sites, even beyond a defined region. They also had important questions about how these structures could be established, managed and financed.