CSM 2021 NCCE Open Forum
Discussion of next steps with Placement Process Task Force Report recommendations

The purpose of this open forum was to facilitate discussion on the Placement Process Task Force recommendations that the NCCE will be taking lead on:

- Leverage relationships between/among clinical and academic programs as well as regional and/or national structures to improve communications, coordination and access to quality clinical education experiences.
- Explore how a standardized model for terminal clinical education experiences may impact the placement process.
- Investigate the use of a common technological platform to manage data related to clinical education experience placements.

The open forum had 232 registrants with 210 in attendance. Registrants were from 42 states with 78% identifying as academic stakeholders (169 DCEs/ADCEs, 5 academic administrators and 7 academic faculty members), 19% as clinical stakeholders (30 SCCEs, 8 CIs and 6 clinic site administrators) and 3% as "other".

Polling was used to gather opinions from the full group and small group breakout sessions provided opportunity for follow up discussion. The following provides poll results (frequency of responses reported) and themes from breakout group discussions:

Poll #1 – current placement process

	Working for clinic sites	Working for academic programs	Working for students
Yes	38	22	38
No	17	31	9
Sometimes	80	82	88

	Yields best results for clinic sites	Yield best results for academic programs	Yield best results for students
Yes	28	29	26
No	40	56	50
Sometimes	75	58	67

	Is efficient
Yes	18
No	88
Sometimes	40

Poll #2 – perceptions about capacity issues

Perceived capacity issue is due to:	
Distribution issue (inefficiencies in placement process)	75
Shortage in supply (not enough slots offered)	67

Perceived capacity issue is significant enough to warrant investigation of alternative placement process models	
Yes	100
No	42

	Alternative placement process models exist that would solve capacity issue	Alternative placement process models exist that could improve efficiency
Yes	66	90
No	77	53

Breakout session #1 (perceived capacity issues, how can alternative placement process models help improve efficiency and/or capacity)

- *Academic perceptions:*
    - Overall theme: March Mailer does not give sufficient slots to meet capacity and it is inefficient
    - Don't get enough slots, requires follow-up:
        - Not getting balance in type of placements offered
            - Abundance of OP ortho/musculoskeletal - not enough acute, IPR, peds, SNF, neuro, specialty
        - Not getting balance in level of placements offered
            - More slot offers for terminal experiences - issues getting ICE and early (1st) clinical experiences
    - March mailing works:
        - In general participants (academic and clinical) preferred a central mailing date
    - Other comments:
        - There are clinic sites that programs do not wish to use due to "quality" issues
        - First come, first served are difficult to predict
        - Proliferation of PT and PTA programs
        - Data for capacity doesn't actually exist
        - There is not an issue with capacity - there is an issue with transparency. Programs are holding on to their slots; sites that could take students aren't asked.
        - Timing of March mailing is challenging for later terminal experiences. DCEs must 'touch base' to make sure what was agreed upon 18 months prior is still available for following fall/winter. Variability in staff, changes, COVID create barriers.
- *Clinician perceptions:*
    - Clinicians feel as though they get more requests than can fill
    - Requests are too far in advance, each program has a different need, timeline, level of learner, etc.
    - Keep March 1 mailing so they don't get requests throughout the year.
    - Clinics don't know they can say "no" to new programs
    - Focus should be placed on reducing CI burnout
    - Taking students from other programs does provide diversity of future employees.
    - Can't fill all offerings and CI's get frustrated that they were talked into taking student then don't get one
    - Not smooth, different formats being used by schools, lack of consistency
    - 10-25% offered slots go unfilled first round; most remaining typically get filled by "rescue" needs
- *Regional issue:*
    - California is not a SARA state. DCE's not able to place their students in other states but other states can send their students to California, creating even greater capacity issues. Southern California is very densely populated with PT & PTA programs.
- *Ways to improve capacity/efficiency - placement process:*
    - Value of networking and partnerships – "smaller" groups better than "bigger" (local/regional partnerships discussed more than national)
        - Regional consortia
            - Network/share within consortia to utilize unused placements, get additional slots
        - Local partnerships
            - Easier to secure placements locally
            - Capacity - very dependent on relationships and geography so centralized system may not work. Regionally might work.

        - Alumni – assist with taking students
        - National network – only discussed by one group
            - National "Clearinghouse"- might help to get students to available slots, but what about sites that require interviews? What about getting the strong students to the complex environments, the weaker students to the right CI?
    - Data/research/resources needed
        - Investigate why sites will not take 1st year students.
        - Pay attention to the sites that take your 1st year students and contact them often. Build a relationship based on 1st year students.
        - Need toolkit/resources/articles on positive impacts of recruitment, quality, satisfaction, productivity
    - Educate students on the fact that 80% of PTs are employed in outpatient settings, that "specialty areas" are hard to come by. Change the culture of student expectations.
    - Collaboration between programs, through consortia, etc. is not enough. We have all done that and continue to collaborate. We need a multifaceted approach to look at all of the issues affecting the placement of students. This will also need to use all available resources including technology.
- *Ways to improve capacity/efficiency – CE model/curriculum/benefits*
    - Collaborative model
        - Not very popular but trying to promote; need more training
        - Clinicians believe that will only work with clinics that can champion the 2:1 model.
        - Reservation is that these models only work for some students and some students require 1:1.
        - Some expressed frustration 'why are we still talking this - we've been doing it for 30 years!". Others expressing pros and cons dependent on site, CI, students, setting
    - Change program/expectations
        - Have all clinical experiences at end of didactic coursework - could increase need for ICE
        - May need to change program expectations regarding type of experience
    - Benefits to clinic sites
        - Programs offer discounted rates for continuing education, do on-site in-services
        - Providing CIs with CEUs for taking students has helped with student placement
    - Designated clinical mentor - CI has student with them throughout the year = partial employee of the academic program and are paid as an associated faculty role (CI/instructor role).
    - Ensure student has skill sets they need to enter the clinical setting

Poll #3 – leveraging relationships to develop framework for placement process

Best framework for a placement process network would be built at which level	
Local	29
Regional	71
National	32

Poll #4 – standardizing terminal clinical education experiences

	Is standardization of clin ed curriculum required for consideration of alternative placement processes?	Should investigation of alternative placement process models focus only on terminal placements?
Yes	45	34
No	83	94

Poll #5 – data management platforms primarily being used to manage placements

	Academicians	Clinicians
Acadaware	10	0
CSIF	2	0
E-Value	3	0
Excel spreadsheets	9	18
EXXAT	66	5
homegrown database	3	1
Multiple	8	3
Other	3	3
PT Education Manager	2	1
Typhon	1	0

Breakout session #2 (leveraging relationships/how to build regional or national network, what should be standardized, data management/is a common technology platform feasible)

- *Leveraging relationships – how to build a clinical education network at regional/national level*
    - Support of regional model at consortium level
        - Local/regional relationships most effective and strongest
        - Relationships already established, easier to "share" at this level
        - Regional works best but would support national too
        - Smaller groups of relationships "better" than bigger – you know what you are getting
        - Prefer "local" network – not geographic but within program's clinical partnerships/network so school knows site and vice versa
        - Considerations
            - Need to respect mission, vision, values of various academic institutions in region
            - Need clinical communities input on what these "networks" would look like, how they would work best for them – need more buy-in and involvement of clinical partners
    - Challenges to building network even on regional level
        - Due to clinical contracts
        - Geographic/regional difference impact way consortia operate
        - Clinicians not as involved in regional consortia – need their voice to develop regional network
        - May be difficult in regions with more density (east coast vs west)
        - Local network supports local community but doesn't meet needs of students not from that area
    - Mixed support
        - National model better because competition exists regionally
        - Regional model seems like better place to start
        - If go with national model – how do we layer different regional networks into the system?
    - Reviewed pros and cons of each level
        - National system – availability of more diverse treatment delivery in different geographic region but limitations include lesser known partners/quality and costs of travel
        - Regional system – more opportunity in a saturated areas; consortium can support placements but would be concerned that this would restrict travel outside of region for students with interest outside of area
    - Concerns noted with building a network on any level
        - Loss of choice of programs/sites to partner with whomever they want to
        - Having to match a student before met/matriculated
        - Not knowing who CI is prior to placing student
        - Programs may hold spot that could be filled by others

    - Need to define “clin ed network”
    - Regional issue in CA since they did not join SARA and their students cannot go out of state
    - Importance of networking with clinical partners – consider only a few program for each site

- *Standardizing terminal experiences*
  - Questioning standardization – not sure it will work
    - What needs standardizing – need to define (e.g. weeks, final outcome/product, etc.)
    - Opposed to standardizing too much
    - No evidence for what best model is so hard to standardize
    - Value in diversity of programs for different types of student learners – how can we coordinate as a nation/region on respecting differences (e.g. value to not being on same calendar/schedule)
    - Variation important to stagger student throughout year to maximize capacity
    - ICE variable – would be very hard to standardize
  - Standardizing terminal experiences may be good place to start
    - Students at more consistent level across programs to start terminal experience(s)
    - Terminal may be place to start but that is even difficult (e.g. some programs have 1 others have multiple terminal CE experiences)
    - Standardizing time frame – may create capacity issue for academic programs but for larger clinic sites, more efficient to orient students all at one time
  - Need to standardize common terminology/definition of “CE I” – “CE II” – etc.
    - Need standardization of what 1st clinic student looks like so clinicians know what to expect when student gets to clinic
    - Should standardize first experiences
    - May be able to standardize full-time ICE – would help clinicians know what to expect
    - Challenge is with variation in SPT1 and SPT2 across programs
  - Could consider standardizing on a regional level (consortia work together)

- *Data management*
  - Having one common platform would be difficult/not realistic
    - DCEs aren’t always able to use platform they want to – restricted by cost, approval, etc.
    - Cannot mandate use of one system
    - Some institutions use one tool across multiple disciplines so no choice in platform
    - Issue with converting to new system – loose historic, past data
    - Both clinic sites and programs have needs – difficult to meet needs of both stakeholders with one system. Need to support clinic sites more.
  - Benefits of one common platform
    - Provide opportunity to gather and use big data; would facilitate regional/national collaboration; would assist clinic sites to have one tool for profession; would increase access (all stakeholders)
    - Would allow sharing resources of sites not used and could help with discovering how we can get other clinicians to serve as CIs
    - National database of things available outside your state could provide possibility of exchanging slots with another school
  - Concerns with having data management system
    - Cost, assessing more fees may be an issue, how will this effect HBCUs and URMs
      - Recurring costs could be a hindrance, can’t keep passing cost on to students
    - CIs need orientation/training so know what is available in system (e.g. student background info)
    - Firewalls at clinic sites could block access
  - Can we determine what data is being collected via different systems, excel spreadsheets, etc.?

Poll #6 – placement process support functions

	Support most needed to successfully administer a placement process	Area of support that needs prioritized for improvement
Common terminology	10	12
Sound clin ed research base	25	27
Team approach	41	27
Training & development	39	49

Poll #7 – priorities for moving Placement Process Task Force recommendations forward

	first priority
Enhancing current	39
Investigating alternatives	35
Developing support	37

Thanks to all stakeholders that participated in the Open Forum and contributed to this discussion!

Respectfully submitted,

Janice Howman, PT, DPT, MEd
NCCE Chair

Jamie Bayliss, PT, MPT, DHSc
NCCE Secretary