

ACAPT NATIONAL CONSORTIUM OF CLINICAL EDUCATORS
REGIONAL NETWORKING SESSION AT 2022 EDUCATION LEADERSHIP CONFERENCE
REPORT TO MEMBERSHIP

Background:

The purpose of the 2022 ACAPT National Consortium of Clinical Educator's (NCCE) regional networking session was to explore how sharing data up, down and across the local-regional-national clinical education (CE) network can help all stakeholders advance CE excellence in our day-to-day work. The session facilitated networking around data sharing related to three topics/questions:

- Medical center affiliations: What role do they play in clinical education?
- Academic-clinical engagement: How can we do better?
- Clinic site visits: Do the logistics matter?

The session used data from ACAPT's 2022 Institutional Profile Survey (IPS) to provide baseline information to stimulate discussions during breakout sessions.

Invitations were sent to all regional consortia contacts and to PT programs in states without regional consortia (Alabama). 157 clinical educators representing 22 of 23 regional consortia and Alabama pre-registered for the session (123 academicians, 34 clinicians). Actual attendance for the session was estimated at approximately 180, including the 19 NCCE Board members and one ACAPT Centennial Scholar who were present to lead the session and facilitate breakout discussions. Attendees were seated at 17 roundtables with a random mix of academicians and clinicians at each table with an NCCE appointed facilitator/note taker.

Institutional Profile Survey data

Data for sharing during the session was obtained from ACAPT's full report of the 2022 IPS (available to members in the member portal). In addition, ACAPT staff provided cross tabulated data for questions related to the number of weeks/hours of integrated clinical education (ICE) experiences and medical center affiliation.

Regional networking session

Introduction

The networking session began with a brief overview of data-driven decision-making (DDDM), ACAPT's definition of excellence, ACAPT's Center of Excellence and the IPS. Polling to get a sense of the audience's engagement with the IPS revealed that 63% of the session's academic attendees were aware of the survey (53 of 84 responses) while only 38% of the clinician attendees were (8 of 21 responses). Academicians were also asked if they assisted their institution's Program Director in completing the CE portions of the survey; 40% responded in the affirmative (38 of 95 responses).

With this introduction to data sharing, the networking session moved into exploring data about the three focus areas described above.

Medical center affiliations: What role do they play in clinical education?

To begin this portion of the session, attendees were asked to participate in a Kahoot poll to quantify attendees whose CE programs were affiliated with a medical center and those who were not. Thirty-eight respondents reported being affiliated with a medical center while 81 were not (15 did not respond). Both those affiliated and not affiliated with a medical center were asked if they perceived this as an advantage, disadvantage or, neutral (Table 1). It is interesting to note that none of the attendees from medical center affiliated programs felt their status was a disadvantage to their CE program while 41% of attendees from programs without medical center affiliation did.

Table 1. Perceptions of benefit of medical center affiliation status.

	ADVANTAGE	DISADVANTAGE	NEUTRAL	NO ANSWER
Do you feel your medical affiliation is an advantage, disadvantage, or neutral to your CE program?	20 (57%)	0 (0%)	15 (43%)	99
Do you feel not being associated to a medical affiliation is an advantage, disadvantage, or neutral to your CE program?	11 (13%)	35 (41%)	40 (46%)	48

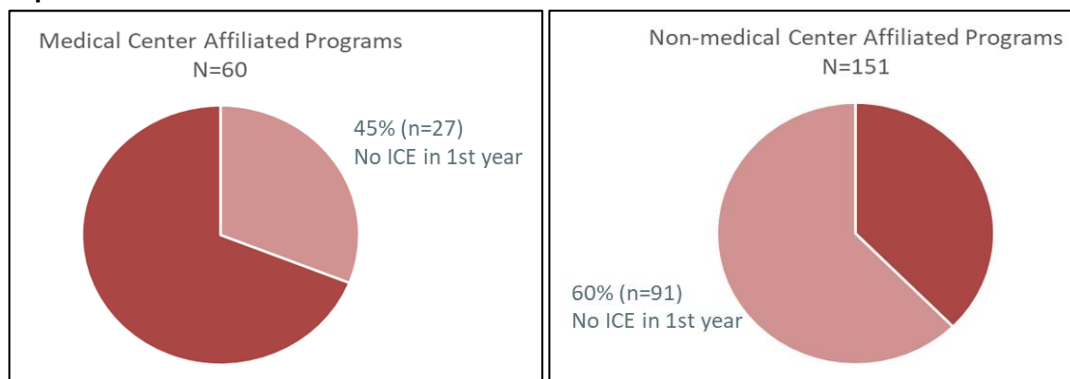
Attendees then participated in small group discussions to expand on their perceptions of affiliation (or absence of affiliation) with a medical center. Scribes recorded the discussion and common themes are reported in Table 2.

Table 2. Summary of attendee perceptions on medical center affiliation versus non-medical center affiliation.

	Medical Center Affiliated	Non-medical Center Affiliated
Advantages	<ul style="list-style-type: none"> ● Ease & availability of student placement ● Opportunity “emergency” placement ● Increased engagement with CI’s, e.g. communication, in-services, adjunct positions, curricular knowledge ● Increased ICE and IPE opportunities ● Support of remediation needs ● Proximity of location 	<ul style="list-style-type: none"> ● Greater diversity experiences, systems, and locations to support wide breadth of PT practice ● Greater flexibility to meet individual student needs ● Opportunity to strengthen external clinical partnerships
Disadvantages	<ul style="list-style-type: none"> ● Student familiarity with workforce and faculty ● Difficult to diversify student pool (placement of students from external programs) ● Management of student expectations, e.g. placement at MC is not guaranteed 	<ul style="list-style-type: none"> ● Decreased familiarity of CI’s with program curriculum ● Difficulty placing in MC with an affiliated PT program ● Higher burden to maintain more contracts ● Potential for decreased academic program and clinical partner engagement
Abbreviations: CI: Clinical instructor; IPE: Interprofessional Education; ICE: Integrated Clinical Experience; MC: Medical Center		

After Breakout 1 discussion, speakers presented common biases that may be associated with medical versus non-medical center affiliation. For example, those affiliated with a medical center may be perceived to have more engagement between CIs and program faculty, more access to post-professional education, and more ICE hours. Conversely, those not affiliated with a medical center may have more active CE agreements and greater diversity of CE experiences (breadth, depth, urban/rural). Speakers presented data from the 2021 IPS that either confirmed or refuted those possible biases. Cross tabulating IPS questions based on medical center affiliation status revealed no significant difference in number of CE agreements, active engagement with clinical partners, employment offers after graduation and student plans to enter residency or fellowship upon graduation. There was a significant difference noted in first year ICE with non-medical center affiliated programs less likely to have early ICE experiences that do not count towards the CAPTE minimum than their medical center affiliated peers (Fig. 1). After the first year, there was no significant difference in part- or full-time ICE experiences between these two types of programs.

Figure 1. Percentage of medical center affiliated and non-affiliated PT programs not providing first year ICE experiences.



To close up this portion of the session, attendees participated in a second breakout discussion which asked attendees to consider their data needs to support DDDM at two levels: 1) for their individual CE programs; 2) for external benchmarking. Two common themes emerged from the discussions: 1) desire for more feedback from students and clinical partners; 2) data comparing quality of student CE experience between types of clinic sites. Examples of desired information to support DDM included:

- Student perceptions of CE and placement process
- External perceptions of CE
- Perceptions of CI experience/effectiveness
- Workforce expectations
- Definitions and metrics for student success

Academic-clinical engagement: How can we do better?

This section began with a brief discussion about how we define academic-clinical partnerships and sharing data about number of affiliations per program (CAPTE aggregate report and ACAPT IPS survey). A Kahoot poll was used to determine how academicians in the session define a “clinical affiliation”. Results revealed that variation exists in how academic clinical educators determine their number of affiliations (aka: their partnerships):

- 45% of respondents (27 of 60) consider the clinic site corporation as the affiliate
- 27% (16 of 60) think of each clinic site satellite as their affiliate
- 15% (9 of 60) define clinical affiliate as the group of CE sites that an SCCE oversees
- 13% (8 of 60) reported “other” but no discussion ensued to determine what these options were

IPS survey data on academic program’s perceptions of how well they engage with their clinical partners was shared. While 74% of the IPS respondents felt they did well/very well incorporating input from CE faculty into their program improvement, 93% of respondents also reported that they only actively engage 1-25% of their clinical partners in their program. Attendees were then asked, through small group discussions, to define active engagement and explore engagement opportunities currently in place as well as those needing to be developed. ‘Engagement’ was emphasized as being a two-way activity, initiated by either the academic program or clinic site.

Many attendees considered “benefits” as active engagement; including continuing education courses, lunch and learns, etc. Excluding those responses, the definition of active engagement centered around relationships that extended beyond student placement/clinical education. Opportunities for engagement, reported by clinical partners, included guest lectureships, assisting in the classroom, lab, or a pro bono clinic as adjunct faculty, and serving on the academic program’s advisory board. The academic-clinical partnership, whereby there is ongoing communication and consistency in placement, was also noted as an example of active engagement.

Attendees reported that some opportunities are in place to engage clinical partners through involvement across all pillars of academic physical therapy (teaching, research and service). Similar to the definition above, engagement included advisory board participation, teaching assistant/adjunct positions, research opportunities/collaboration, and clinician involvement in academic program services (e.g. pro bono clinics, standardized patient experiences, and assisting with admissions interviews).

Some engagement opportunities came out in both the question about what is available and what still needs to be developed (e.g. advisory board participation, assistance with admissions, teaching). This may indicate that existing opportunities are not being utilized to the breadth and depth that they could be. As such, it is essential that academic programs reach out to all clinical partners with intentionality to increase awareness of engagement opportunities that already exist. Another consideration that may influence clinical partner engagement with such activities may be that some academic programs offer these opportunities while others do not. Nonetheless, recommendations were made to consider ongoing intentional networking with partners to generate other mutually beneficial ways to engage (e.g. journal clubs, needs assessment of each partner, increased number of site visits, networking for employment purposes).

The discussion then shifted to the non-monetary and other benefits being provided through the academic-clinical partnership. Presenters shared IPS data on benefits provided to clinical partners by academic programs. Non-monetary benefits frequently include continuing education (75%), free or reduced enrollment in CI credentialing courses (60%), and university privileges for library resources (47%). While less frequently reported, scholarships to attend professional meetings or conferences (19%) are also offered.

Attendees were asked to identify what benefits their program/clinical education site offers and what additional benefits are needed. Similar to the IPS, responses indicated academic programs offer benefits related to teaching and service. These relate to CE faculty development (e.g. continuing education and financial assistance with enrollment in CI credentialing courses) and faculty appointment/ engagement in teaching. Benefits offered but less likely to be used included enrollment in elective courses and scholarships to attend conferences.

Barriers to unused benefits that are offered were also queried. While time constraints were the most common response, limited funding (university and site) and lack of knowledge about benefits were also noted.

This section ended with attendees identifying priorities for what data needs to be collected to help us better define/measure academic-clinical partnerships in PT education. The responses from these small group discussions could be categorized into these three themes:

1. Data to further explore non-monetary and other benefits (e.g. what is desired, what is being used, barriers to utilization, impact of benefits provided)
2. Data about CE sites (e.g. frequency of placements, how many sites only offer terminal placements, what are barriers to taking students/early students, how many students obtain employment at a site, impact/value of CE for site)
3. Data about CE experiences (e.g. defining entry level performance for all settings, ideal number of weeks of CE, defining quality/excellence and determining benchmarks)

Clinic site visits: Do the logistics matter?

The final portion of the networking session began with a brief overview of data from the IPS about CE site visits. All programs completing the IPS reported doing CE site visits (defined as both in-person and virtual) with 49% visiting every student during every CE experience, 25% visiting every student at least once during the program, 25% visiting student at sites selected by the program and 1% only visiting students experiencing issues. When

cross tabulating IPS questions based on site visit frequency, the size of the student cohort and the tuition cost of the program did not appear to influence decisions about when to make site visits, but medical center affiliation did seem to have some impact (Table 3).

Table 3. Site visit frequency based on medical center affiliation status

Clinical education site visit approach	Medical center affiliated	No medical center affiliation
Visit every student, every clinical education experience	22%*	78%**
Visit every student at least once during the program	25%	75%
Visit some clinical education sites selected by program	43%*	57%**
Only visit students experiencing issues	33%	67%

**statistically significant difference between these cells*

***statistically significant difference between these cells*

Small group discussions were facilitated about considerations before, during and after CE site visits. Themes from each of the three breakout discussions are summarized below. One theme that resonated across the before, during and after continuum was that of building the academic-clinical relationship.

During the “before” small group breakout discussion, attendees were asked to consider what key considerations are when planning a CE site visit. Three indications for a site visit were identified from these discussions:

1. Students experiencing challenges - A CE site visit in these situations can help to ensure clear and open communication among all parties and provide support to the student and CI.
2. New CE site or beginning academic-clinical relationship – A CE site visit with new or beginning partnerships can help to establish a culture of trust and awareness of resources.
3. CE sites experiencing student challenges – A CE site visit in this situation can provide support, guidance and development resources as well as assist in enhancing the CE culture of the clinic.

Additional considerations for the “before” phase included offering scheduling options, planning ahead (e.g. anticipate need for site visit based on prior academic or clinical struggles), recognizing budgetary limitations, need for having policies and procedures in place to support site visits, and the geographic location of the CE site.

The “during” site visits breakout focused on the key components of a CE site visit (e.g. purpose, type, structure, timing, people involved). The three most common purposes that emerged were: (1) building the academic-clinical partner relationship, (2) supporting the CI and (3) assessing the CE site. There was also discussion about the importance of clarifying the purpose and expected outcomes of the site visit so it is beneficial to all parties. Discussions about the logistics of the visit itself were more variable. Attendees discussed the benefits and challenges of in-person and virtual visits as well as the challenges of scheduling/timing. Most groups agreed that timing a CE site visit “around” the midterm of a CE experience was typical and that the DCE, student and CI were the stakeholders involved in the meeting. Some groups described the SCCE as occasionally assisting with a tour or participating briefly in a CE site visit. Discussion about the structure was variable with some reporting having everyone meeting together, some having the DCE meet the student and CI individually and yet others doing both. While not a common theme across groups, a few groups mentioned observing students providing patient care during a CE site visit. Discussions about the information shared/gathered from CE site visits primarily centered around a description of student performance, feedback on curriculum/student preparation, assessment of the CE site (e.g. tour, support for students, staff make-up, specialty programs, learning opportunities available, etc.) and education/support for the CI (e.g. sharing resources/tools).

Attendees discussed what key data they used from the site visit during the "after" CE site visit discussions. Data assessing the CE site and the academic program's curriculum were most frequently discussed as being used after the visit. Another common theme noted was that of using the data from the site visit to "provide support". This was described as looking ahead to determine how the academic program and CE site can be better prepared for future students. For academic programs, there was discussion that this could mean better matching students in the future, adjusting the curriculum to better prepare students for clinical practice or providing educational opportunities for CIs to help better prepare them to mentor future students. For CE sites this could mean that CIs are better educators for future students and have more tools for helping students deal with challenges (e.g. mental health considerations, generational differences in learning). Information gleaned from the site visit on how to enhance the academic-clinical relationship and further advancing student performance were also discussed as data that is used post CE site visit.

REPORT SUMMARY AND RECOMMENDATIONS:

ACAPT NCCE thanks our regional consortium members who attended the 2022 ELC Regional Networking Session. Their enthusiasm for sharing information and networking with others is what makes our annual meetings successful and provides direction for future work that benefits clinical educators nationally.

Based on the information from this session, the presenters and ACAPT NCCE plan to:

1. Submit an abstract for ELC 2023 to further disseminate information about current status of CE site visits.
2. Further explore what "active clinical partner engagement" means through a joint ELC 2023 educational session on the topic with the Academy of Education's CE SIG.
3. Submit the following terms to the common terminology glossary joint sub-group for their consideration for development of a standardized definition
 - a. Medical center affiliation – This term is used in the IPS but has not yet been defined
 - b. Academic-clinical partnership – Consideration of this term should include the range of academic-clinical partnerships (e.g. one clinical placement every 2-3 years to ongoing and continual engagement for CE experiences, teaching, research and service)
 - c. CE site visit – May need to consider if this is the best terminology or if another term is more appropriate (e.g. midterm conference)

A longer term recommendation for consideration by ACAPT NCCE and the future ACAPT CE Commission is to develop resources to support CE stakeholders in advancing best practices in CE site visits to ensure maximum benefit and best efficiency with site visits. Developing an FAQ or best practice guidelines or training (e.g. webinar, in-person course, modules) may standardize CE site visits, help new CE faculty (academic and clinical) prepare for visits, and make vetting of new CE sites more efficient and uniform. Determining meaningful resources and content will require more investigation into the purposes, planning, logistics and outcomes of CE site visits and may be best accomplished through an ACAPT Task Force.

Respectfully submitted (titles at time of presentation),
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