American Council of Academic Physical Therapy

National Consortium of Clinical Educators (NCCE)

Task Force: Payment for Clinical Experience Report

OVERVIEW

In recent years, some clinical organizations have implemented or voiced the intent to assess a fee for clinical education experiences. The topic of student debt has also been a source of discussion within the profession. There is concern that charging for clinical education experiences may drive up the cost of education and become an unsustainable barrier to preparing physical therapists and physical therapist assistants for clinical practice. Current health care and higher education challenges have converged and forced educators to examine the economics of providing clinical education experiences, and to develop sustainable policies for educating future professionals. During the Educational Leadership Conference (ELC) in 2016, there was support from the clinical education community to explore the issue of payment for clinical education experiences. The American Council of Academic Physical Therapy (ACAPT) Board charged the National Consortium of Clinical Educators (NCCE) to examine the issue and make recommendations to ACAPT.

TASK FORCE CHARGE AND SUMMARY OF WORK

The American Council of Academic Physical Therapy (ACAPT) tasked the NCCE with investigating the current landscape surrounding payment for clinical experience (CE). The NCCE Task Force (TF) on Payment for Clinical Experience was created in 2017 with designated co-chairs, and selection of TF members and an expert panel. The call for TF members went out in September 2017. The TF began work in Fall of 2017 for the purpose and objectives outlined below while working under two guiding principles:

1. Endeavor to work toward a positive impact for all parties involved.
2. Involve multiple stakeholders to provide a broad perspective on the issues, not the proprietary interests of one practice area.

Purpose: The Task Force on Payment for Clinical Experience was formed to explore the issue of payment for clinical education experiences and formulate recommendations to ACAPT.

Objectives: The Task Force on Payment for Clinical Experience seeks to solicit input from a broad spectrum of clinical education stakeholders and diverse clinical settings, with the following objectives:

1. Describe existing economic models of clinical education
2. Identify advantages and challenges of each model
3. Examine cost structures that are in place in other professions
4. Explore ethical and legal implications of payment for clinical experiences
5. Identify academic and student expectations if there is payment for clinical experience
6. Incorporate physical therapy ethical standards of practice and core values

Process:

- Task Force Organization: The TF Co-chairs completed a strategic process of TF member selection to include diversity of stakeholders as required by the charter.
    - Academic Administrator
    - Academic Program Director
    - Academic Program DCE
    - Clinical Facility Administrator

- Clinical Facility Site Coordinator of Clinical Education (SCCE)
- NCCE Executive Board Member
- Ex Officio Members
- External Consultants as deemed necessary

Applicants were considered based on a variety of factors including but not limited to: professional role, geographic location, type of practice setting, type of educational institution, and special skill sets. Applicants not selected for the TF were asked to serve on an expert panel.

- Review of the Literature: The TF established monthly meetings and initiated a literature review. The TF Co-chairs completed a comprehensive search of the literature related to clinical education models of various health professional disciplines. A structure was created for critical appraisal of the literature by the TF members. Key concepts and models related to clinical education within each discipline were identified and informed future development of the TF survey research.

- Brainstorming: TF Co-chairs established a meeting structure for early brainstorming activities to identify and discuss known and unknown factors related to payment for clinical experiences. Concepts were outlined and served as a foundation for the survey research.

- Survey Research: The TF members were organized into groups according to their area of expertise and interest. Members were then tasked to create survey questions relevant to the charge and objectives of the TF. Questions were designed to capture essential information from clinical entities (several administrative levels and clinical instructors) and Doctor of Physical Therapy (DPT) academic stakeholders. Once the survey questions and navigation were created in Survey Monkey, the expert panel participated in review. The review process was two-fold. The first round of review was focused on clarity, grammar, concepts, navigation, and structure. Members of the expert panel were provided guidance and a format by which to provide feedback. Feedback was then discussed by TF members and appropriate alterations completed. The second round of the expert panel review was focused on rating each question as "essential", "useful", or "not necessary". Survey questions were retained or eliminated by the TF based on the expert panel level of consensus. To gather necessary information from current DPT students, two TF members established student advisory groups by which information was gathered for survey creation and then reviewed for content validity.

- Distribution to Stakeholders: The distribution of the survey took place through ACAPT and NCCE email conduits and employed a snowball sampling technique. The student survey was distributed through ACAPT academic program members.

- Data Analysis: Initial summary data was presented at the NCCE Business Meeting at ELC 2018. Initial data analysis and qualitative exploration of open responses aligned to four themes.
  - Academic Impact
  - Clinical Impact
  - Ethical and Legal Considerations
  - Student Impact

  The TF members were divided into four separate working teams to further explore data relative to these themes. The TF Co-chairs organized the data and assisted where needed in the data

analysis process. Each team presented relevant data during monthly meetings and all TF members provided further input. Overlap of key data between the teams and bracketing of concepts allowed for a peer review process to remove researcher bias. General summaries based on the research findings are presented in this final report.

REPORT FORMAT

There are several components to this report:

- Task Force Structure and Members
- Summary of Survey Research
- Recommendations for Consideration
- Recommendations for Further Research

Task Force Structure and Members

Clinical Members

- Sara Alhajeri, PT, MPT, GCS
- Jon Anderson, PT
- Todd Bzdewka, PT, MPT, GCS
- Jessica Dunn, PT, DPT, GCS, MS
- Derek Fenwick, PT, MBA, GCS
- Tara Legar, PT, MPT

Co-chairs

- Kathleen Manella, PT, PhD
- Tawna Wilkinson, PT, DPT, PhD

Academic Members

- Gary Chleboun, PT, PhD
- Peggy Gleeson, PT, PhD
- Janet Konecne, PT, DPT, OCS, CSCS
- Shelly Lewis, PT, DPT, GCS
- Katie Myers, PT, DPT

NCCE Board Member and Advisers

- Chalee Engelhard, PT, EdD, MBA
- Carmen Elliott, MS, CAE (APTA VP PPM)
- Simon Hargus, PT, DPT, MBA, OCS (PPS)
- Donna Applebaum, PT, DPT, MS

Expert Panel

- Karen Abraham, PT, PhD
- Christine Alvero, PT, DPT, MBA
- Ann Dietrich, PT, MS
- Jamie Dyson, PT, DPT
- Lynn Fitzgerald, PT, DPT, MEd
- Carrie Foeller, PT, DScPT
- Krissy Grubler, PT, DPT
- Angie Henning, PT, MSPT, Cert MDT
- Patricia Hodson, PT, DPT
- Michele Mulhall, PT, PhD
- Teresa Munecas, PT, DPT
- Laurie Neely, PT, DPT, NCS
- Nina Surber, PT, DPT, GCS
- Ellen Wetherbee, PT, DPT MEd

Stakeholders Surveyed

- Academic Programs:
  - Academic Level 1 (A1): Program Director, Program Chair, Dean
  - Academic Level 2 (A2): Directors of Clinical Education

  ** respondents indicating both an academic and clinical role were included in the summary data for academic role.*
- Clinical Entities:
  - Clinical Level 1 (C1): Executive/Manager (CEO, President, VP, Department Head, Rehab Manager, Practice Owner, etc.)
  - Clinical Level 2 (C2): Clinical Education Coordinator (CCCE/SCCE), Clinical Director
  - Clinical Level 3 (C3): Clinical Instructor (CI) and/or Licensed Clinician
- Students: Enrolled DPT students (any year in program)

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SUMMARY

Payment for physical therapy clinical education has not been well researched. A wide variety of payment models in various health professions exist with payment being common practice in some professions (medicine, nursing, pharmacy, physician assistants) but not all. This survey research explored the current landscape of payment for CE in physical therapy including the frequency of payment for clinical experiences (CE), benefits and barriers to providing CE, and ethical and legal considerations surrounding payment through the lens of clinical, academic, and student stakeholders.

A total of 1883 clinical and academic stakeholders responded to the survey and were included in data analysis. Clinical respondents totaled 1589 with CIs (C3) being the largest respondent group, followed by clinical administrators (C1) and lastly SCCEs or clinic directors (C2). Academic respondents totaled 170, and individuals serving both clinical and academic roles totaled 124 respondents. All nine NCCE regions, all clinical practice settings, and a variety of institution types were represented in the collected data (specifics below). Respondents with missing data were included in the appropriate analyses.

- Practice settings: academic institution, academic medical institution, acute care hospital, community hospital, level one trauma center, skilled nursing facility / long-term care, inpatient rehab facility, outpatient private practice or group practice, hospital-based outpatient facility or clinic, industry, health and wellness facility, patient's home / home care, school system (preschool/primary/secondary), research center, and other
- Institution types: private, public, non-profit, for-profit, urban, rural, underserved

A total of 2815 current DPT students (823 first-year students, 1021 second-year students, 962 third-year students) responded to a separate survey comprised of 12 items. Participating students represented both public (n = 1036) and private (n = 1774) institutions.

All NCCE regions were represented with Great Lakes region having the highest respondent rate:

- Great Lakes: IN, IL, MI, OH, WI, KY = 854 respondents
- West North Central: IA, KS, MN, MO, NE, ND, SD, AR, OK = 405 respondents
- West Mountain States: CO, ID, MT, NM, UT, AZ, OR, WA, NV = 350 respondents
- West South Central: LA, TX = 279 respondents
- Middle Atlantic DE, MD, PA, WV, DC, VA = 245 respondents
- South Atlantic: FL, GA, NC, SC, AL, PR, MS, TN= 240 respondents
- New York/New Jersey: NY, NJ = 178 respondents
- North East Coast: CT, ME, MA, NH, RI, VT = 135 respondents
- Pacific: CA = 123 respondents

Current Payment Landscape

The following information provides a brief overview of stakeholders' perspectives on the current landscape of payment for clinical experience in physical therapy. Very few DPT academic programs are paying and very few clinical sites are receiving payment for clinical experiences. Very few clinical entities have investigated the concept of payment for CE. High level clinical administrators are most frequently the individuals considering payment for CE. Stakeholders were asked to rate their level of agreement with four summary statements related to stakeholders receiving or providing payment for clinical experiences. Not all 1883 survey respondents identified a role or a rating and were removed, leaving a total of 1605 ratings. Frequency of ratings based on identified role are illustrated below. As expected, the number of clinical respondents (n=1350) were far greater
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than academic respondents (n=254) since academicians comprise approximately 1% of licensed physical therapists in the United States. Mean Likert scale ratings for level of agreement were defined as strongly disagree (1 < 1.5), disagree (1.5 - < 2.5, neutral (2.5 - < 3.5), agree (3.5 - < 4.5), and strongly agree (4.5 – 5.0). For reporting purposes, rating categories were collapsed into agree (strongly agree and agree), neutral (neither agree or disagree), and disagree (strongly disagree and disagree).

STATEMENT 1: Rank your level of agreement with "Clinical sites should receive payment for student clinical education experiences".

CLINICAL AND ACADEMIC ROLES

For all clinical roles, there was an even distribution of 33% between the ratings of agreed, neutral, and disagreed (Table 1). The C1 mean rating of 3.12 (neutral) statistically differed from C2 (2.88, neutral) and C3 (2.87, neutral) ratings indicating that clinic administrators' level of agreement with this statement was higher than SCCEs and CIs.

In contrast, for all academic roles, 77% of respondents disagreed with this statement (Table 1).

Table 1. Level of Agreement: Clinical sites should receive payment for student clinical education experiences

	Agree (n)	Neutral (n)	Disagree (n)	Total (n)
All Clinical Roles	*456*	*449*	*445*	*1350*
Clinical Level 1	157	124	119	400
Clinical Level 2	102	133	126	361
Clinical Level 3	197	192	200	589
Academic Roles	29	28	197	254
Total	*485*	*477*	*642*	*1604*

IMPACT OF PROFIT STATUS, PRIVATE/PUBLIC INSTITUTION, and REGION

Statistically, there was a difference in mean ratings between for-profit (2.9, neutral) and non-profit entities (2.57, neutral). There was no difference in mean ratings between public (2.66, neutral) and private (2.81, neutral) entities. There was no difference in the overall of mean rating of 2.82 (neutral) across the nine NCCE regions.

CONCLUSION

Mean ratings for Statement 1 ranged from 2.35 (disagree) to 3.12 (neutral) and suggests that across all stakeholders there was little support for clinical sites receiving payment for clinical experiences. However, it is of note that 33% of clinical stakeholders agreed with this statement.

STATEMENT 2: Rank your level of agreement with "Clinical instructors should receive direct payment for supervising student clinical education experiences".

CLINICAL AND ACADEMIC ROLES

For all clinical roles, there was a similar distribution of approximately 30% for agreed and neutral ratings, while 40% disagreed with this statement (Table 2). The C3 mean rating of 2.96 (neutral) statistically

differed from C1 (2.64, neutral) and C2 (2.69, neutral) ratings indicating that clinic instructors' level of agreement with this statement was higher than clinical administrators and SCCEs.

In contrast, for all academic roles, 75% of respondents disagreed with this statement (Table 2).

Table 2. Level of Agreement: Clinical instructors should receive direct payment for supervising student clinical education experiences.

	Agree (n)	Neutral (n)	Disagree (n)	Total (n)
All Clinical Roles	*428*	*376*	*546*	*1350*
Clinical Level 1	109	94	197	400
Clinical Level 2	91	110	160	361
Clinical Level 3	228	172	189	589
Academic Roles	23	39	192	254
Total	*451*	*415*	*738*	*1604*

IMPACT OF PROFIT STATUS, PRIVATE/PUBLIC INSTITUTION, and REGION

Statistically, there was a difference in mean ratings between for-profit (2.96, neutral) and non-profit entities (2.41, disagree). In addition, public entities' mean rating of 2.83 (neutral) was higher than private entities (2.54, neutral). There was no difference in mean ratings across the nine NCCE regions; total mean rating across all regions was 2.71 (neutral).

CONCLUSION

Mean ratings for Statement 2 ranged from 1.9 (disagree) to 2.96 (neutral) and suggests that across all stakeholders there was little support for CIs receiving direct payment for supervising student clinical education experiences. However, it is of note that 30% of clinical respondents agreed with this statement.

STATEMENT 3: Rank your level of agreement with "Academic programs should be responsible for payment for clinical experience".

CLINICAL AND ACADEMIC ROLES

For all clinical roles, approximately 50% of respondents agreed, 27% were neutral, and 23% disagreed with this statement (Table 3). The C1 mean rating of 3.41 (neutral) statistically differed from C3 (3.22, neutral) rating indicating that clinic administrators' level of agreement with this statement was higher than CIs.

In contrast, for all academic roles, 70% of respondents disagreed with this statement (Table 3).

Table 3. Level of Agreement: Academic programs should be responsible for payment for clinical experience.

	Agree (n)	Neutral (n)	Disagree (n)	Total (n)
All Clinical Roles	*664*	*375*	*311*	*1350*
Clinical Level 1	215	97	88	400
Clinical Level 2	157	119	85	361
Clinical Level 3	292	159	138	589
Academic Roles	41	36	177	254
Total	*705*	*411*	*488*	*1604*

IMPACT OF PROFIT STATUS, PRIVATE/PUBLIC INSTITUTION, and REGION

Statistically, there was a difference in mean ratings between for-profit (3.24, neutral) and non-profit entities (2.88, neutral). There was no difference in mean rating between public (3.12, neutral) and private (2.99) entities. There was no difference in mean rating across the nine NCCE regions; total mean rating across all regions was 3.14 (neutral).

CONCLUSION

Mean ratings for Statement 3 ranged from 2.08 (disagree) to 3.41 (neutral) and suggests that across all stakeholders there was little support that DPT academic programs should be responsible for payment for clinical experience. However, it is of note that 50% of clinical respondents agreed with this statement.

STATEMENT 4: Rank your level of agreement with "Students should be responsible for payment for clinical experience".

CLINICAL AND ACADEMIC ROLES

For all clinical roles, approximately 8% of respondents agreed, 15% were neutral, and 77% disagreed with this statement (Table 4). The C3 mean rating of 1.67 (disagree) statistically differed from C1 (1.85, disagree) and C2 (1.92, disagree) ratings indicating that CIs' level of agreement with this statement was lower than clinical administrators and SCCEs.

In contrast, for all academic roles, 66% of respondents disagreed with this statement.

Table 4. Level of Agreement: Students should be responsible for payment for clinical experience.

	Agree (n)	Neutral (n)	Disagree (n)	Total (n)
All Clinical Roles	*85*	*196*	*1069*	*1350*
Clinical Level 1	28	65	307	400
Clinical Level 2	27	65	271	361
Clinical Level 3	30	68	491	589
Academic Roles	44	43	167	254
Total	*129*	*239*	*1236*	*1604*

IMPACT OF PROFIT STATUS, PRIVATE/PUBLIC INSTITUTION, and REGION
There was no difference in mean ratings among types of entities for this statement; for-profit (1.77, disagree), non-profit (1.79, disagree), public entities (1.82, disagree) and private (1.73, disagree). There was no difference in mean rating across the nine NCCE regions; total mean rating across all regions was 1.82 (disagree).

CONCLUSION
Mean ratings for Statement 4 ranged from 1.76 (disagree) to 2.35 (disagree) and suggests that across all stakeholders there was unanimity that students should not be responsible for payment for clinical experience.

STUDENTS
Students (n=2815) participated in a separate survey comprised of 12 items.
The majority of DPT student respondents believe serving as a CI is a professional duty (strongly agree or agree = 2165, neither agree or disagree = 161, strongly disagree or disagree = 196). When DPT student participants were asked to indicate their level of agreement relative to payment to clinical sites or CI the following responses were indicated:

Clinical sites should not charge for a student full-time clinical experience:
- Strongly agree or agree = 2649
- Neither agree or disagree = 104
- Strongly disagree or disagree = 55

Physical therapists should not accept payment for serving as a clinical instructor:
- Strongly agree or agree = 1801
- Neither agree or disagree = 622
- Strongly disagree or disagree = 384

Students were also asked to consider “if an additional cost was required by your DPT academic program for all clinical experiences (estimated between $3000-$6000) to what extent would this influence, or have influenced, your decision about your selection of a profession other than PT?” Student respondents indicated (n=2160):
- Extremely influential: 562
- Very influential = 400
- Slightly influential = 506
- Not at all influential = 692

The majority of academic institutions indicated additional program fees or higher tuition if payment for clinical experiences becomes standard practice, which would contribute to further student debt and likely reduce the number of applicants to academic programs.

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Limitations: While a large number of individuals participated in this survey research, the results may not fully represent the entire profession due to selection bias and snowball sampling. Although every attempt was made by the TF and expert panel to add clarity to survey questions, misinterpretation may have occurred resulting in inaccurate answers provided by respondents. The TF has identified topics warranting further consideration, greater discussion, and additional investigation.

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TOPICS AND THEMES

Legal and Ethical Consideration

The profession must consider all legal and ethical implications regarding payment for clinical experience related, but not limited to, setting type, clinical site or clinician motivation, teaching quality, and other factors.

Support Statement: Legal and ethical considerations were prominent in survey responses. When asked if they had any legal or ethical concerns about payment for clinical education, nearly 500 respondents shared concerns that payment for clinical education would have negative ethical or legal ramifications. The negative responses included concerns of conflict of interest, cost, "double dipping", professional obligation, quality of experience, "wrong" motivations, and accountability. In addition, student respondents also indicated concerns about rising education cost, quality of the CI and experience, and motivations for an individual to serve as a CI.

Some clinical respondents reported it is illegal for them to accept payment based on various reasons (mission, non-profit, etc.). While some respondents could not accept payment, others indicated they did not know if they could accept payment. Payment is currently not common place and there may be other more equitable ways to neutralize costs for sites. Many respondents highlighted a concept of "fairness" related to some sites being able to receive payment versus others not legally able to do so.

A majority of rehab managers and SCCEs reported they are not seeking payment because of obligation to the profession. They also indicated that seeking payment would likely decrease the number of students assigned to their site. If payment were provided, these respondents expressed a concern about a potential conflict of interest. The majority of CIs stated that payment directly to them or to their facility would not influence their decision to serve as a CI. Although some clinical respondents reported that payment directly to them would negatively influence their desire to take students, thirty-eight percent of the clinical respondents indicated payment to the organization/facility would "make it easier for us" to either "accept students" or "accept more students than we do now". Those who stated it would negatively affect them said they were concerned with the ethics of the situation. When asked to provide last thoughts in an open-ended format, one of the three largest themes was "not charging for clinical education".

The profession's Code of Ethics is also important to examine with regards to payment for clinical experiences. The following principles should be considered:

- *3D: Physical Therapists shall not engage in conflicts of interest that interfere with professional judgment.*
  If they were paid for clinical experiences, some CIs may take a student for the money rather than a desire to teach and may not provide a great learning experience.
- *4: Physical Therapists shall demonstrate integrity in their relationships with ….students…*
  Historically, physical therapists have served as CIs in a voluntary capacity and mentoring relationship with students. Current CIs have benefited from this model and are now in a position to offer the same benefit to support future DPT clinicians and minimize student debt.
- 4B – *Physical therapists shall not exploit persons over whom they have supervisory, evaluative or other authority (e.g., patients/clients, students….)*
  Not taking students unless they are paid, might be perceived as exploiting students especially if the "better" sites charge for clinical experiences. .

The APTA HOD Position statement on Ethical and Legal Considerations for Clinical Education also states:

"*Physical therapists, physical therapist assistants, and academic programs shall provide clinical education that reflects, supports, and promotes professional development, complies with legal and ethical standards for patient/client management, and is consistent with the policies and positions of the American Physical Therapy*

Association. Physical therapist and physical therapist assistant students are obligated to communicate information to their academic program regarding clinical education."

There is no mention of payment in this position statement and, therefore, it implies that physical therapists and physical therapist assistants are expected to provide quality clinical education as part of their professional duty.

- (http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/HOD/Referral/Ethical.pdf)

An overwhelming majority of responding DPT academic programs do not currently pay for clinical experiences and the majority of clinical respondents indicate they do not receive, are not seeking, or are not investigating payment for CE. The majority of academic respondents overwhelmingly responded "disagree or strongly disagree" with regards to payment to clinical sites or CIs. Underutilized alternatives to payment for CE should be explored further. If payment became standard practice, academic respondents indicated this cost would likely be transferred to the student, increasing student debt.

Based on the overall findings and the legal and ethical considerations, there does not appear to be sufficient supporting evidence for the profession to move in the direction of payment for CE at this time. However, respondents acknowledged many factors interconnected with the concept of payment for CE. Some of these factors included reimbursement, productivity, barriers, incentives, and standards.

The following recommendations are presented for consideration:

Reimbursement, Supervision, and Productivity

1. The APTA should investigate reimbursement for student-provided physical therapy services under the supervision of a licensed physical therapist as a top priority, including Medicare and all payors.

Support Statement:

Reimbursement concerns, supervision regulations, and productivity expectations were primary factors limiting clinical placements as identified by respondents.

- Open-ended statements by all stakeholder respondents contributed to one of the three largest themes identified "reimbursement issues need to be addressed."
- Student supervision restrictions due to payer sources was one of the highest selected "real or perceived barriers related to staffing" by clinical stakeholder respondents.
- Productivity demands were identified by clinical respondents as one of the top real or perceived barriers to providing student clinical education experiences. This barrier was followed by paperwork expectations and administrative burden.

Skilled services should be reimbursed regardless of whether the CI provides the service, or the student provides the service under the supervising CI's license. If employers/supervisors can recoup the cost of the care delivered by supervised students, productivity expectations would be more easily met during a student clinical experience.

Advocacy to prevent increasingly restrictive student supervision rules, while gaining appropriate reimbursement for physical therapy services, will allow CIs to continue to mentor students for intrinsic motivations, which is consistent with the APTA Code of Ethics.

Alternative Benefits and Incentives

2. All stakeholders should identify alternatives to payment for clinical experiences that benefit all stakeholders and provide non-monetary incentives.

2a. Recommend that standardized CEUs be awarded for CI student supervision hours on a national level by the APTA and/or State Licensing Boards and promoted by the Federated State Board of Physical Therapy.

2b. DPT academic programs should explore providing alternative benefits such as clinical site administrative support, discounted tuition for academic degrees, and opportunities for the Director of Clinical Education (DCE) to create learning experiences in the clinic as alternatives to payment.

Support Statement:

The majority of academic respondents (89%) do not feel that payment should be standard practice. The reasons provided include ethical/legal considerations and student debt. Academic and clinical respondents indicated high concern for current student debt, increasing cost to students if were payment required, and low starting salary relative to debt load. Of the academic respondents reporting on the source of payment for clinical experiences, all but 2% indicated the student would be the source of payment through increased tuition or fees.

Clinical instructors indicated their primary motivations for serving as a CI were not financial incentives, and that direct payment would cause ethical concerns or conflicts of interest. Benefits such as APTA membership, sponsorship to attend conferences, continuing education, etc., were mentioned as motivators to serve as a CI. Standardizing CEUs for clinical instruction and providing this benefit to all CIs acknowledges the clinician's professional development activities required to competently educate students in the clinical environment. Specifically, CIs must prepare educational opportunities for students, examine and interpret the literature for current evidence in practice, and discuss theory/rationale for examination and intervention. They must also develop skills in communication, mentoring, and feedback. All of these CI development activities increase value to clinical sites and the profession, enhance patient outcomes, and foster excellence in patient care. Awarding CEUs to CIs demonstrates their value to the profession and encourages them to earn licensure required CEUs by mentoring students. Currently, the CEU credit for clinical instruction varies from state to state, and some states do not award any CEUs for this professional development activity.

Alternatives to direct payment should be explored with all facilities and key clinical administrative stakeholders. Some benefits commonly offered by DPT academic programs to CIs and sites include discounted tuition for continuing education courses, issuing CEU certificates to CIs, library access, and continuing education opportunities. Survey results indicated that other alternatives to payment were underutilized by DPT academic programs. Less frequently offered incentives included clinical site administrative support, discounted tuition for academic degrees, and faculty-led clinical site learning or research experiences. Expanding these offerings would provide added value to the CI and the clinical site.

National Standards for Payment and Student Impact

3. ACAPT and/or APTA should craft a position statement on payment for clinical experiences and investigate development of national standards.

Support Statement:

Currently, a very limited number of DPT academic programs are paying for clinical experiences to a very limited number of sites. For those few programs and sites, wide variation exists in the amount of payment, how payment is made and to whom. Payment ranged from $50 to $30,000 per year with one entity paying

$100,000 per year for adjunct faculty. A majority of respondents agreed that if payment is required, there should be national standards.

Many respondents (academic, clinical, and student stakeholders) indicated ethical and legal considerations (previously discussed) and concerns for student fees and tuition increasing overall student debt. ACAPT and APTA must consider the financial impact on students as they consider a position statement and future investigations. As indicated by respondents, onboarding costs are almost entirely paid for (in full or in part) by students. Greater guidance is needed to aid academic and clinical organizations in establishing policies and procedures regarding payment and costs for clinical experiences. Often students are responsible for direct costs which can be itemized, such as an ID badge, background check/drug screen, purchase of necessary equipment such as a lab coat or gait belt.

Payment for clinical experiences, if widely accepted, may place greater demands on DPT academic programs and clinical sites. Student respondents overwhelmingly would expect access to current and more detailed information about clinical sites and CIs when selecting clinical placements. This expectation would impact the workload for clinical sites and DPT academic programs associated with the student placement matching process.

Education Regarding Student Tuition

4. ACAPT should explore and create a mechanism to provide clinical entities with information about how student tuition dollars are allocated during the DPT academic program.

Support Statement:
Many clinical respondents provided comments about DPT academic programs receiving tuition dollars when students are at clinical sites and CIs are educating the students. Increasing awareness about DPT tuition allocation, loan distribution, etc. may provide greater understanding and transparency across all stakeholders.

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RECOMMENDATIONS FOR FUTURE RESEARCH

Further study is recommended to explore variation in supervision regulations, utilization of payment for clinical experiences by clinical sites currently receiving payment, variation in clinical education, and models of integrated clinical education experiences.

Supervision Rules/Regulations and National Standards: ACAPT/APTA should investigate variability in practice acts related to supervision and formulate standardized guidelines that represent an educational framework for teaching and learning in the clinical environment. In addition, leadership should work to clarify and/or standardize supervision regulations for each setting and provide a national resource for questions and support regarding student supervision guidelines.

Responses to expectations and level of supervision given during a clinical education experience varied. While many survey respondents were adamant that they are required to provide line-of-sight supervision at all times and cannot do other tasks, others reported the ability to multi-task and use some discretion. Beyond payer source, inconsistency with level of supervision is evident.
On the APTA website, the resources on student supervision are not conclusive and require much work and interpretation on the part of the site or CI to check state practice acts and insurer contracts. Updated
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resources are essential to provide clarity, guide clinical sites and instructors, and minimize the inconsistencies. (http://www.apta.org/PTinMotion/2018/5/ComplianceMatters/)

Utilization of Payment for Clinical Experiences: While payment for clinical education is not a wide-spread practice, we should further explore how sites that currently require payment allocate the revenue generated.

The survey responses indicated that only a small number of clinical sites are requiring payment for clinical experiences. However, there was evidence that clinical site administrators are considering payment. At this time, it is not known how payment supports clinical education at the clinical site and there is limited understanding of why payment is necessary. If we are able to define the motivations underlying the request for payment by a clinical site to support clinical education, stakeholders may be able to identify solutions or alternatives that do not include a monetary impact on the student. If payment becomes expected practice, DPT academic programs will need to explore mechanisms well in advance to plan for the increased costs.

Integrated Clinical Experience (ICE): A limited number of respondents indicated receiving payment for ICE. CAPTE standard 6E states "Clinical education includes both integrated and full-time terminal experiences", and further defines ICE as "Clinical education experiences that occur before the completion of the didactic component of the curriculum and prior to the start of any terminal clinical experiences". DPT academic programs must implement ICE in the curriculum. There are many unknowns as to the structure and variability in ICE encounters.

Survey results indicated that ICE and First full-time CE were more financially burdensome to sites than Intermediate or Terminal full-time CE. When asked "**when do you begin to break even in costs during clinical experiences",** respondents selected "do not break even" at a rate of 44.8% for ICE, 47.9% for First full-time CE, 24.8% for Intermediate full-time CE, and 13.7% for Terminal full-time CE. Further investigation is necessary to better understand ICE variability and explore the direct benefits and costs to clinical sites for providing ICE.

Variation in Clinical Education: ACAPT, APTA, and ELP should continue to investigate best practice in clinical education to minimize unnecessary variation. Current work of the task force on clinical education placement process will further inform the profession.

Survey respondents indicated variation in student preparation and readiness, and clinical experience length and start dates as top real or perceived barriers to providing student clinical education experiences. Continued research with regards to variation in clinical education is essential.