FINAL REPORT FROM THE NATIONAL CONSORTIUM OF CLINICAL EDUCATORS MEETING OF REGIONAL CONSORTIA
2016 EDUCATION LEADERSHIP CONFERENCE, PHOENIX, ARIZONA

Background:

Clinical education regional consortia have existed in some form for many years in physical therapy (PT). Little is known regarding the members of these consortia and even less is known about the structure and function of these various organizations from a national viewpoint. As changes occur moving towards best practice in clinical education, gathering a greater understanding of regional consortia is essential to enhance connections and partnerships. In July 2016, the National Consortium of Clinical Educators (NCCE) constructed a survey to send to all doctor of physical therapy programs in the United States. An email explaining the purpose of our efforts and containing the electronic survey was sent directly to each program's Director of Clinical Education (DCE) or Academic Coordinator of Clinical Education (ACCE). Each participant completing the survey provided program information, regional consortium affiliation, and consortium contact information (if applicable). In addition, programs were asked if they were registered with the NCCE. The gathered information fostered initial outreach to each regional consortium for the 2016 Education Leadership Conference (ELC) programmatic planning.

From this survey process, the 20 known regional PT clinical education consortia were invited to participate in an NCCE-led session at ELC. The purpose of the session was to acquire a greater understanding of the regional consortia related to structures, processes, and outcomes. Each discussion group had both a facilitator to elicit conversation through formulated questions and a recorder to record answers. Each group was fluid in discussion and strategically designed to allow for greater sharing of information between the various consortia. At the end of the session, initial data was presented to the participants.

Regional consortia were confirmed during attendance at ELC and then compared to the consortia listed on the American Physical Therapy Association's (APTA) website. For any consortium listed on the APTA website but not present at ELC, online searches along with reaching out to colleagues in the various regions were completed. Following this process, two additional consortia (Iowa and Georgia) were identified and later contacted by NCCE members for interviews to capture complete data for reporting purposes.

At the request of the American Council of Academic Physical Therapy (ACAPT), the NCCE leadership at their first formal meeting at the ELC in 2015 reviewed ACAPT's regional divisions and developed an NCCE liaison for each region to partner with the ACAPT liaison for that region. The NCCE recommended changes to the regional communication structure in an attempt to keep existing regional consortia aligned in the newly developing ACAPT/NCCE regions. As there was no current listing of regional consortia at that time, this was done based on what the NCCE leadership knew through personal involvement and professional networks as well as what was available online. After the 2016 ELC session with regional consortia, the NCCE reviewed the state representation of regional consortia and repeated the review of ACAPT/NCCE regional communication structures to ensure accuracy. Through this review, it was noted that a total of 6 states (AK, AL, HI, LA, MS, WY) are not represented in any of the known regional consortia; three states, AK, HI, and WY, do not have a PT program. In comparing states represented in regional consortia with ACAPT/NCCE regions, only two regional consortia were split between ACAPT/NCCE regions. The ACAPT/NCCE regions were realigned to maintain regional connections and partnerships already present (Table 1). This report provides information for all 22 identified regional clinical education consortia outlined in Table 1.

Table 1. Listing of known regional consortia showing the states they represent and the alignment with ACAPT/NCCE regions

REGIONAL CONSORTIUM	STATES REPRESENTED	ACAPT/NCCE REGION
Carolina Clinical Education Consortium	NC, SC	South Atlantic
Central Coordinators of Clinical Education	MO, KS, OK, AR	West North Central
Central Indiana Clinical Education Consortium	IN	Great Lakes
Chicago Area Clinical Educators Forum	IL	Great Lakes
Florida Consortium of Clinical Educators	FL	South Atlantic
Georgia Coalition of Physical Therapy Educators	GA	South Atlantic
Intercollegiate Academic Clinical Coordinators Council	CA	Pacific
Iowa Clinical Education Consortia	IO	West North Central
Michigan PT Clinical Education Consortium	MI	Great Lakes
Mid-Atlantic Consortium of Physical Therapy Education	MD, DC, VA	Middle Atlantic
New England Consortium of Clinical Educators	CT, MA, RI, ME, NH, VT	North East Coast
New York New Jersey Clinical Education Consortium	NY, NJ	New York New Jersey
Northern California Clinical Education Consortium	CA	Pacific
Northern Plains Clinical Education Consortium	ND, SD, MN, NE	West North Central
Northwest Intermountain Clinical Education Consortium	AZ, CO, ID, MT, NM, NV, OR, UT, WA	West Mountain
Ohio Kentucky Consortium of PT Programs for Clinical Education	OH, KY	Great Lakes
Philadelphia Area Clinical Education Consortium	PA, DE	Middle Atlantic
Pocono Susquehanna Clinical Education Consortia	PA	Middle Atlantic
Tennessee Clinical Education Consortium	TN	South Atlantic
Texas Consortium for Physical Therapy Clinical Education	TX	West South Central
Three Rivers Academic Consortium	PA, WV	Middle Atlantic
WPTA Clinical Education Special Interest Group	WI	Great Lakes

Results of discussions with regional consortia (ELC 2016 and follow-up phone conversations with Consortia not at ELC)

Structures of Regional Consortia:

Regional clinical education consortia have been in existence for many years and they appear to have a relatively stable membership. The average lifespan for the current group of 22 active consortia is 27 years (range 3.5-38 years) and none of the consortia described their membership turnover as often (10 reported occasional turnover, 11 rarely and 1 never). The number of member institutions per consortium ranged from 2-40 with the average being 17. The structure of stakeholders represented in membership varied across consortia. More than half (15/22) have a membership inclusive of both PT and PTA educators while 6 consortia represent PT educators only. A fairly equal split was reported between consortia with a membership of both academic and clinical partners (11/22) and a membership solely representative of academic programs (10/22) leaving only one consortium with an exclusively clinical educator membership. Several of the consortia reporting exclusive membership, in regards to either PT-PTA education or academic-clinical education, stated they had a mechanism to seek input from other stakeholders either formally or informally. For example, one consortium with an academic membership reported collaborating annually with the clinical educator's forum in their region while another reported having a professional advisory committee of clinicians that provides input to their consortium.

In terms of organizational structure, the majority of consortia (19/22) have formal bylaws (17 fully developed, 2 in process of developing) leaving only three consortia reporting that they do not utilize bylaws to direct their operations.

Similarly, 19 consortia reported having elected officers for leadership of their organization. Two of the three consortia that do not elect officers are the same consortia that do not have bylaws while the third consortia without officers is just in process of developing bylaws. Only nine consortia described having standing committees while 11 reported using ad hoc committees. Most frequently reported types of committees were (1) research or scholarship, (2) education, conferences or mentoring and (3) finances or operations. Committee types reported less frequently included awards, bylaws, nominations, website, liaisons and advisory boards. There was an equal division among consortia who have a non-profit status (10/22) and those that do not (10/22) with 1 consortium in process of obtaining their non-profit status. The majority of consortia (15/22) require that member institutions pay dues.

Processes of Regional Consortia:
The organizational processes fell into several subcategories. The first being a platform for communication. The most frequently used mode of communication was email followed by use of a website. Much less frequently used modes included using a listserv, blackboard, telephone, Facebook, web-blast, or video. More than half of the consortia reported maintaining records by using hard copy/electronic documents. Housing documents in Google Docs and websites were reported to be rarely used with only two consortia doing this in each of these cases. There was only one consortium using Yahoo. With respect to routine data collection, the most frequently collected data were clinical slot data with almost half of the consortia reporting. Other data collected included attendance, health requirements, salary surveys, budget, teaching load, and tracking dues. It is interesting to note that almost half of the consortia reported not collecting any data. While all consortia reported having regular meetings, there was no consistent response to the frequency of scheduled meetings. It ranged from twice a year to once a month. Lastly, the majority of consortia (15/22) reported using informal processes for mentoring new members while four had formal processes identified and three had no mentoring processes.

When discussing the functional processes of regional consortia, the most frequent collaborative work reported was serving as a peer network followed by clinical faculty development, dissemination of clinical education resources and clinical faculty recognition. Functions reported by less than half of the regional consortia included collaborative research projects, mentoring clinical faculty, regional policy-setting and student placements. While 8 consortia reported being active in regional policy-setting, only two consortia described their advocacy efforts. One group reported lobbying to their state board to ensure CEUs were approved for CI courses while the other described development of regional policies for communications about student placements (ie: following March mailing deadlines and establishing timeframes for announcing open slots). It is interesting to note that the least reported functional process that consortia collaborate on is student placements. See Table 2 for details.

Table 2. Functions reported by regional consortia.

	Peer Network	Clinical Faculty Development	Disseminate CE Resources	Clinical Faculty Recognition	Collaborative Research Projects	Mentor Clinical Faculty	Regional Policy-Setting	Student Placements
Yes	20	17	17	13	10	9	8	5
No	1	2	2	7	7	10	13	12
Developing	0	1	2	1	4	2	0	4
Considering	1	2	1	1	1	1	1	1
% DOING	90.9%	77.3%	77.3%	59.1%	45.5%	40.9%	36.4%	22.7%

Outcomes of Regional Consortia:
Routine outcomes were also examined as a part of this meeting. Just less than half of the consortia reported that their most frequently reported outcomes were the education of stakeholders which was closely followed by offering scholarships for clinical faculty to attend national conferences. Other types of routine outcomes included local presentations, developing mission/vision statements, standardizing forms, emerging models such as PT/PTA interprofessional and collaborative models, student placements, and scholarly work. Special projects produced by

consortia varied greatly. Examples of these projects were providing an online CI course, having a March mailing template, having funding for a regional core network (RCN), and maintaining a training module/handbook for CIs.

Lastly, the Post-Summit outcomes discussion generated more negative than positive comments with minimal duplicity. The responses centered on the consortia wanting support for and engagement of the clinical educators. There was a strong sense of "waiting" and discouragement due to lack of communication, confusion, and an overall feeling that there was an "ask" for volunteers but no true call to action. There were also comments about the lack of programming for clinicians at ELC. That said, there were notable positive comments about the Summit. After the Summit, there were a handful of consortia who recreated the Summit with local clinicians and academic programs. Some consortia brought in national leaders to talk to consortium programs and several consortia members are currently serving on national taskforces. So even though the negative comments outweighed the positive, it was noted that there have been positive steps taken.

Summary and Recommendations:
It is interesting to note that although regional consortia have been in existence for many years, little was known about their structures, functions and processes outside their respective regions. Prior to this event, there was not an accurate current listing of all regional consortia on the APTA website and the NCCE's survey of academic programs was only able to yield a listing of contacts for 20 of the 22 currently active consortia. By bringing representatives of these collaborative and productive consortia together, the NCCE was able to facilitate dialogue at the national level to generate an updated listing of all 22 active regional clinical education consortia for physical therapist programs and provide this collective overview of their structures, processes and outcomes.

Despite the variability in size and make-up of regional consortia, there are enough similarities in organizational structures and overlap in functional processes to warrant continued efforts for strengthening relationships across regional consortia. While the majority of consortia have formal organizational structures, there are still a few consortia in the formal development phase who could benefit from information sharing. The potential for development of additional regional consortia also exists as six states without involvement in a currently active regional consortium were identified. Facilitating interactions and sharing information with clinical educators in these areas may make the development process smoother and timelier for these regions if they chose to develop a regional consortium. Given that clinical education is dependent on the academic-clinical partnership, it was somewhat surprising to discover that only about half of the regional consortia formally included clinical educators in their membership.

Considering the processes of regional consortia, the observed overlap in functions provides opportunities for more detailed sharing of processes to streamline efforts, reduce duplication of efforts and create dialogue about different practices. At the same time, the more unique functions will allow for creative sharing and brainstorming to help regional consortia deal with the challenges they are facing in our contemporary clinical education environment.

In terms of outcomes, it was not surprising that the professional development of stakeholders was most commonly reported as this aligns with accreditation standards. What was surprising was the overwhelming disappointment that was voiced related to post-Summit outcomes. It appeared that meaningful involvement and positive progress at the grassroots, regional level was not being realized despite the significant efforts in recent years of several groups, committees and task forces.

Recommendations:
Now that a regional communication structure is in place that aligns with existing regional consortia, the NCCE will work on the following recommendations to support and enhance clinical education efforts at the regional and national levels:

1. Develop and maintain a current listing of regional clinical education consortia with contact information for their leadership on the NCCE website to facilitate communication across regions.

2. Develop a system for regular communications with NCCE membership and regional consortia through the NCCE regional liaisons to keep membership informed of national events, facilitate sharing of regional and national issues and initiatives, and provide opportunities for networking and creative strategizing.
3. Commit to sponsor opportunities for regional consortia to network at least annually at the Education Leadership Conference. Providing such opportunities will hopefully lead to collaborations across regions to create a better sense of unification, shared purposes and mobilized efforts.
4. Encourage and facilitate opportunities for expanding inclusion of clinical educators in regional and national clinical education efforts. Given that the premise of membership in NCCE is based on the academic-clinical partnership and its leadership is made up of both academic and clinical educators, the NCCE is well-positioned to assist with advocating for continually increasing clinical educator involvement in initiatives at regional and national levels.

Respectfully submitted,

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