

**AMERICAN COUNCIL OF ACADEMIC PHYSICAL THERAPY
CLINICAL EDUCATION SUMMIT**

October 12-13, 2014

Interim Report:

April 1, 2017

Final Report:

October 1, 2020

SUMMARY

The Clinical Education Summit (Summit) was held in October 12-13, 2014 in Kansas City, Missouri. The Summit brought together clinical and academic educators to discuss the concerns of the physical therapy clinical education system and develop options to address identified issues.

The Summit generated a significant amount of energy and enthusiasm around the topic of PT clinical education and resulted in a report containing 11 harmonizing recommendation and 3 innovative recommendations. Following the receipt of the report, the ACAPT Board of Directors prioritized the recommendations and formed 3 strategic initiative panels to address the highest priority topics.

Attendees left the Summit anxious to tackle the ideas generated during the two-day meeting. As a result, work on some recommendations has been picked up by groups outside of ACAPT and some has begun to occur organically within the PT clinical education community.

Work of the panels began in January 2015. The panels worked in concert with one another with the collective effort led by a Post-Summit Coordinator. The coordinator and 3 panel chairs identified areas benefiting from collaboration to ensure that the work products were supportive and well-coordinated.

The first 3 panels submitted their final reports and recommendations to the ACAPT Board in June 2017. Reports contained recommendations that required membership adoption or Board consideration. Motions presented to the membership were adopted at the 2017 annual meeting ELC.

The Board, in collaboration with the coordinator, discussed the remaining recommendations from the Summit report and launched a second round of initiatives. As of this writing, the second round of work is either nearing completion or has been disposed of in other manners. The board and the coordinator have determined that there is sufficient ACAPT infrastructure to eliminate the coordinator position and funnel initiatives to other ACAPT groups. In addition, the Education Leadership Partnership (ELP) has been actively engaged in clinical education and thus some work is most appropriately managed under their watch.

The purpose of this report is to summarize the accomplishments to date and to identify where there are other groups involved in continuation of these initiatives. It is clear that the Clinical Education Summit of 2014 served as a catalyst for conversation and action. The physical therapy education and clinical communities are benefitting from the creative and practical recommendations generated by Summit attendees and ongoing engagement by these communities is evidenced by the work that continues to date.

SUMMIT RECOMMENDATIONS

The following recommendations, rationale, guiding principles, and implementation steps are lifted verbatim from the original Summit report. Following each recommendation is a status report with links to resources and indication of which groups are continuing to address the recommendation.

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.

Update 4-1-17

Development of common language for clinical education has been addressed by the Common Terminology Strategic Initiative Panel.

CONCLUSION 10-1-2020

Common terminology was adopted by ACAPT (October 2017)
Article published in PTJ: September 2018 Volume 98 Number 9 Physical Therapy _ 76
Terminology disseminated broadly with the assistance of a task force of the National Consortium of Clinical Educators (NCCE)

RESOURCES:

ACAPT PT Clinical Education Glossary:

https://acapt.org/docs/default-source/pdfs/common-terminology-glossary-for-physical-therapist-clinical-education.pdf?sfvrsn=25978bd8_2

PTAESIG PT Clinical Education Glossary:

<https://aptaeducation.org/pdfs/Physical%20Therapy%20CE%20Glossary%202019.pdf>

HANDOFF:

Future edits and updates of the ACAPT document will be managed by the NCCE.

PTAESIG created a parallel document (linked above). Coordination with the PTAESIG may need to occur to prevent duplication of effort.

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.)

UPDATE 4-1-17

This recommendation aligns well the findings of the PTE 21 research. That group also determined that stronger partnerships are key to excellence in PT education. The articles outlining the findings of the PTE 21 research have been accepted for publication and are due out in the near future.

There may be a role for a strategic initiative panel to begin this work. A potential charge to a panel could include description of the benefits to partnership development, the process required to establish partnerships, and potentially develop a tool kit to assist academic institutions and clinical facilities in achieving this goal. Membership in such a panel should include academic and clinical program directors, directors of clinical education, and clinicians.

Another option to accomplish this work may be to request the NCCE to convene a group with a similar make-up as described for a panel to tackle this recommendation.

Ensuring that ELP is engaged in this initiative may be beneficial.

CONCLUSION 10-1-2020

The work on Academic-Clinical Partnerships was picked up by the ELP as a component of their work on clinical education. A subgroup explored options to enhance academic and clinical partnerships during the Clinical Education Strategy meeting held in October 28-29, 2018 in Alexandria VA. There were 4 recommendations forwarded from that subgroup back to ELP.

1. Define models of quality and effective academic – clinical partnerships.
2. Develop a mechanism to hold academic programs accountable for creating partnerships as defined above.
3. Develop a national clinical education placement management system to be used by partners to maximize the effectiveness of clinical placements (PT and PTA).
4. Outline and disseminate the evidence-based value of a clinical education partnership (productivity, patient satisfaction, outcomes, CI professional development, etc.)

Subsequently a follow-up meeting, the Academic-Clinical Partnerships Strategic Planning meeting, was held March 6-7, 2020. The 4 subgroups in that meeting were:

- Characteristics and Models of Academic-Clinical Partnerships
- Organizational Partnerships for Physical Therapy Education
- Curriculum: Entry-level
- Curriculum: Post-graduate

The work from each sub-group of that meeting was also sent to ELP for consideration in the overall strategic planning process.

RESOURCES:

APTA House of Delegates document:

Guidelines To Promote Excellence In Clinical Education Partnerships Hod G06-19-62-59

HANDOFF:

ELP has taken on the responsibility for this work and is working with a consultant on the culminating PT education strategy meeting. Determinations as to who is best positioned to shepherd this work in the future will be determined after the final ELP strategy meetings.

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.

CONCLUSION 10-1-2020

Several actions related to this recommendation and the proposed implementation steps have been accomplished or are in process. These include:

- APTA recently reworked the CI Credentialing Level I course. The rollout of the revised version may include an online component.
[verify with Keith Mendenhall keithmendenhall@apta.org]
- APTA recently began psychometric analysis of CPI with a final report expected by Dec 2020. APTA, Liaison International, Clinical Education Special Interest Group (CESIG), Physical Therapist Assistant Education Special Interest Group (PTAESIG) and NCCE are collaborating to develop an Advisory Committee to Liaison International. A committee structure has been developed and each organization is now gathering names of volunteers to serve on inaugural committee targeting the first meeting to occur in fall 2020.
- Some information about alternative clinical education models has been developed and disseminated, primarily by regional consortia. For example, the Philadelphia Area Consortium and Florida Consortium both have courses related to the collaborative model.
- The NCCE/CESIG just collaborated on webinars related to collaborative models and a recording will soon be available on Learning Center. The webinars were training for using the collaborative model toolkit developed by Bilyeu et al. and that resource is available on NCCE/CESIG websites.
- The NCCE convened a Payment Process Task Force. The group was charged to examine the question of payment for placement. They made a determination that payment for clinical education is not recommended and non-monetary benefits provided to clinical instructors and clinical sites by academic institutions should be considered. NCCE has worked with ACAPT to craft motions for consideration at ELC 2020 reflecting these findings.
- NCCE and CESIG collaborated on a Placement Process Task Force with a goal of exploring the issues of the placement process and formulate recommendations. Work is ongoing and recommendations are forthcoming.

RESOURCES:

Collaborative Model Toolkit: <https://acapt.org/news/news-detail/2020/06/22/collaborative-model-of-clinical-education-toolkit-and-resource-handbook>.

HANDOFF:

NCCE and the CESIG will be the best candidates to take this work and continue to develop and disseminate initiatives related to this recommendation with institutional initiatives led by NCCE and individual initiatives led by CESIG.

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.

CONCLUSION 10-1-2020

Note: There has been a change in terminology and the CCCE has become the Site Coordinator of Clinical Education (SCCE).

There has been a concerted effort to bring clinicians to ELC. Strategies have included better programming for clinicians and clinical instructors and providing some supportive funding to help offset costs for clinician attendance. These successful efforts support leadership development of our clinical partners.

Membership in NCCE is predicated on identification of a clinical partner and the academic representative and clinical partner join as a pair. This enhances the voice of the clinical partners at a national level and concurrently supports leadership development.

RESOURCES:

Reference Manual for Site Coordinators of Clinical Education

<https://aptaeducation.org/special-interest-group/clinical-education-faculty-sig/pdfs/2018-SCCE-Manual-FINAL.pdf>

HANDOFF:

NCCE and CESIG partnership with institutional initiatives led by NCCE and individual initiatives led by CESIG.

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 difficulty attending the traditional two-day course.

UPDATE 4-1-17

In February 2017 the ACAPT Board approved appointment of a strategic initiative panel to address this recommendation. The call for volunteers is slated to occur in mid-2017.

CONCLUSION 10-1-2020

In 2017 ACAPT approved a panel process to begin work on this recommendation. A conference call with interested parties was held September 27, 2018 and it became apparent that progress on this recommendation had happened organically within the clinical education community, specifically as a collaborative effort between the New York / New Jersey and the New England Clinical Education consortia. ACAPT determined that building on the work that this group had initiated made more sense than beginning the process anew. The members of the development group were appointed to the panel and the process of determining next steps was initiated.

Because significant investment of time and talent had been made by the development group prior to their appointment as an ACAPT panel, transitioning that process and work product into an official ACAPT panel was not possible and ultimately a decision was made, collaboratively with ACAPT and the original development group, for the group to continue their work in an independent manner and so the panel was disbanded.

RESOURCES:

N/A

HANDOFF:

At this point efforts are continuing at a grassroots level. Should opportunities for collaboration present in the future, those will certainly be considered.

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.

CONCLUSION 10-1-2020

Similar concepts and themes are identified in the Best Practices for Clinical Education Task Force report. As a component of the work, stakeholder feedback was gathered and presented.

The Oxford debate at NEXT 2017 explored the question of development of specialists or generalists with entry-level education. Although entertaining, the Oxford debates are also intended to spark professional discussion and debate.

RESOURCES:

2017 House Reports:

http://communities.apta.org/p/do/sd/sid=3940#collapse_16139

HANDOFF:

ELP Education Strategy meetings for consideration of any related activities or recommendations

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.

UPDATE 4-1-2017

A Strategic Initiative Panel has addressed this recommendation. The panel report will be given to the ACAPT Board in June 2017.

CONCLUSION 10-1-2020

ACAPT prioritized this recommendation among the first for work by the post-summit panels. The summit recommendation speaks to educational programs including ICEs as a component of the clinical education curriculum. ACAPT determined that the best approach to address this recommendation was to standardize terminology, identify best practices for use of ICE, and provide tools and resources to enable such inclusion. The Integrated Clinical Education (ICE) Panel was formed in 2015 and brought forth final work products the ELC in 2017. The ICE Panel developed a definition of 'integrated clinical education,' developed 8 parameters as baseline expectations for ICE, and created guidelines for development of an ICE for use by academic programs. The final panel recommendations were adopted and a link to the resources can be found below.

CAPTE Standard 6E requires integrated clinical experiences as a component of the overall curriculum.

RESOURCES:

ICE definition:

[https://acapt.org/docs/default-source/pdfs/definition-of-integrated-clinical-education-\(ice\).pdf?sfvrsn=3b978bd8_2](https://acapt.org/docs/default-source/pdfs/definition-of-integrated-clinical-education-(ice).pdf?sfvrsn=3b978bd8_2)

Baseline Parameters:

https://acapt.org/docs/default-source/public-docs/parameters-of-baseline-expectations-for-integrated-clinical-education.pdf?sfvrsn=4fda8bd8_2

HANDOFF:

Information will continued to be housed on the ACAPT website. Edits and changes will be managed by ACAPT.

Note: Recommendations VIII, IX, X and XI are interrelated and need to be considered in concert. Because separate teams developed these recommendations, they are reported here as distinct recommendations to preserve the fullness of their proposal; however, the summary of work addresses all of the recommendations.

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?

CONCLUSION 10-1-2020

There has been no work to date specifically addressing the terminal internships. See below for work related to entry level competencies.

RESOURCES:

N/A

HANDOFF:

N/A

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.

UPDATE 4-1-17

A Strategic Initiative Panel has addressed this recommendation. The report will be provided to the ACAPT Board at the June 2017 meeting.

CONCLUSION 10-1-2020

ACAPT approved and funded a panel, the Student Readiness Panel, to start by addressing recommendation IX. The Student Readiness panel has had in-depth discussions about the feasibility and timing of determining levels of student competence at defined points in time. The conclusion drawn by the panel is that when considering the PT education across the profession the only common points in time that are logical to address readiness against a standard and defined set of competencies is when a student enters the first full-time clinical experience and as the student enters clinical practice.

The Student Readiness Panel used a Delphi methodology to develop a set of competencies to assess a student's readiness to enter their first full-time clinical experience. These competencies were presented to and approved by the ACAPT members in October 2017. The work of the panel was subsequently published in PTJ.

RESOURCES:

The KSAs and Levels of Competence for Considering Student Readiness:

https://acapt.org/docs/default-source/public-docs/ksas-and-levels-of-competency-for-considering-student-readiness.pdf?sfvrsn=47da8bd8_2

Link to PTJ article:

Physical Therapist Student Readiness Into the First Full-time Clinical Experience: A Delphi Study
<https://doi.org/10.1093/ptj/pzy134>

HANDOFF:

The documents will reside on the ACAPT website.

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.

CONCLUSION 10-1-2020

ACAPT approved and funded a panel, the Student Readiness Panel, to start by addressing recommendation IX – development of competencies as reported above.

There has been no additional work to determine processes for assessing competence using the requisite set of KSAs developed by the Student Readiness Panel.

RESOURCES:

N/A

HANDOFF:

Continued work on this recommendation will be considered based on other related work.

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.

UPDATE 4-1-17

Recommendations IX, X, and XI are closely related. All of these recommendations speak to the need to assess competency at various points in the educational curriculum. The Student Readiness panel has had in-depth discussions about the feasibility and timing of assessing student competence at defined points in time. The conclusion drawn by the panel is that when considering the PT education across the profession the only common points in time that are logical to address readiness against a standard and defined set of competencies is when a student enters the first full-time clinical experience and as the student enters clinical practice.

The first point in time (enter into first full time experience) has been established by the panel. There are a couple of potential options to address development of common competencies for entry level practice.

- 1) The Student Readiness panel is willing to tackle this task. They propose completing another Delphi study to develop this set of competencies.
- 2) Issue an RFP for a research study to develop the core competencies for entry level practice.

CONCLUSION 10-1-2020

At the conclusion of development of KSAs to move into the first full time clinical experience, ACAPT approved the continuation of that panel to address recommendation XI. The panel begin their work and then became aware of work on a parallel path by ELP to develop entry level expectations in the form of entrustable professional activities (EPAs) modelled after a similar construct used in medicine. The members of the ACAPT panel met with the EPA group and it became clear that there was significant overlap in the work. The final decision was to disband the ACAPT panel and support the continuation of the EPA group.

[Need to talk with Jean Timmerberg re. status]

RESOURCES:

N/A

HANDOFF:

This work is being managed by the ELP

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.

CONCLUSION 10-1-2020

Some of the concepts outlined in this recommendation are reflected in the discussions and recommendations of the Models sub-group during the Academic-Clinical Partnerships strategy meeting held in March 2020.

RESOURCES:

N/A

HANDOFF:

Likely picked up by the ELP culminating strategy process.

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.

CONCLUSION 10-1-2020

The NCCE sponsors an annual regional networking session at ELC to facilitate collaboration across regional consortia. It encourages networking with an emphasis on improving communication/collaborations among all clinical education stakeholders and sharing of resources to minimize duplication of efforts.

Discussions facilitated by NCCE have also identified a need for a national database to better connect stakeholders for communication and a potential need for centralized repository for clinical education resources.

RESOURCES:

N/A

HANDOFF:

The NCCE in potential collaboration with the CESIG

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.

CONCLUSION 10-1-2020

Although no specific actions have been taken related to this recommendation, development of the EPAs would serve as a foundational step.

RESOURCES:

N/A

HANDOFF:

N/A

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.

CONCLUSION 10-1-2020

There has been no specific action taken from the national level.
There has been some grassroots development with pro-bono clinics associated with academic programs across the country.

RESOURCES:

Pro-Bono PT network: <http://theprobononetwork.com/>

HANDOFF:

N/A

Desired Outcomes

The Summit report included the following section that articulated the desired outcomes after the first day of work and discussion. These desired outcomes then became the recommendations put forward. Based on the analysis of progress with each recommendation the following outcomes were assessed as either:

ACHIEVED
ADVANCING
ATTENTION REQUIRED

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. ADVANCING

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. ACHIEVED

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. ADVANCING

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. ADVANCING

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. ADVANCING

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. ADVANCING

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. ATTENTION REQUIRED

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. ADVANCING