Best Practices for Physical Therapist Clinical Education (BPPTCE)
2017 Report to the House of Delegates
Stakeholder Feedback on Recommendations

EXECUTIVE SUMMARY

In 2014, the House of Delegates approved 2 motions specific to investigating the future of physical therapist education: RC 12-14: Promoting Excellence in Physical Therapist Professional Education, and RC 13-14: Best Practice for Physical Therapist Clinical Education. In response to:

- RC 12-14, The APTA Board of Directors (Board) established the Excellence in Physical Therapist Education Task Force (EETF) that presented 8 recommendations to the Board in November, 2015. Subsequently, the Board approved the recommendations, which included establishment of the Education Leadership Partnership (ELP) as the vehicle to address those recommendations.
- RC 13-14 the Board created the Best Practice for Physical Therapist Clinical Education Task Force (BPCETF). The work of the BPCETF began in January 2016 and concluded in January 2017.

The BPCETF's charge was to consider strategies and provide a recommendation(s) to the Board, identifying best practice for physical therapist clinical education, from professional level through postprofessional clinical training, and proposing potential courses of action for a doctoring profession to move toward practice that best meets the evolving needs of society.

The BPCETF identified 3 principle challenges as it engaged in its work:

(1) A comparison of current clinical education models suggested that inadequate clinical education and postgraduate professional development experiences contribute to unwarranted variation in physical therapist practice;
(2) The overall capacity for clinical education placements is limited, leading to competition among physical therapist academic programs; and,
(3) Economic factors affecting academic institutions, students, and facilities providing clinical education experiences significantly impact clinical education.

Six assumptions guided the work of the BPCETF:

(1) There are complex factors involved in clinical education and no simple solutions to address the issues of unwarranted variability, capacity, and quality in current models;
(2) Recommendations being made are interrelated;
(3) Implementation of these recommendations will require engagement of multiple stakeholders;
(4) Other professions are facing similar challenges in clinical education;
(5) There is no evidence supporting a single superior physical therapist clinical education model; and,

(6) Economic factors must be a primary consideration in future physical therapist clinical education, and recommendations should not result in increased student debt.

After engaging in a year-long review process, including 2 face-to-face meetings and over 20 conference calls, the BPCETF submitted 5 content recommendations and 1 dissemination recommendation to the Board:

1. **That formal preparation for practice includes physical therapist professional education, followed by a clinical internship and mandatory postprofessional residency, and is accomplished through a process of staged licensure and specialty certification;**
2. **That a structured physical therapist clinical education curriculum that includes, but is not limited to, the following elements be developed and implemented:**
    - Determination of a minimum and maximum amount of full-time clinical education that can be integrated into the didactic phase (prelicensure) of physical therapist professional education. Once determined, this standard shall be universally adopted;
    - Define the role and structure for clinical education experiences within the didactic phase of physical therapist professional education programs;
    - Define essential clinical education settings, experiences, and exposure to patient and client populations that shall be required for all physical therapist students in the didactic phase of physical therapist professional education programs Define minimal student competencies required for engaging in integrated full-time clinical education experiences during professional education and postgraduate clinical internship phases, including knowledge, skills, and behaviors;
    - Define the roles of simulation and learning technologies as part of clinical education in the phase of professional education;
    - Define essential competencies for transition into entry-level (restricted license) practice, including knowledge, skills, and behaviors;
    - Enhance existing residency and certification processes to complement the total of the professional education and postgraduate clinical internship phases;
    - Develop and implement standardized tools for measurement of expected student competencies at all phases of physical therapist education to ensure that student and graduate competencies are consistent with expected student outcomes; and
    - Identify opportunities for standardization of clinical rotation schedules, onboarding requirements, or other factors that may influence program and site capacities and efficiencies.

3. **That a framework for formal partnerships between academic programs and clinical sites that includes infrastructure and capacity building, and defines responsibility and accountability for each (eg, economic models, standardization, sustainable models), be developed. Infrastructure and capacity must be developed across all stages of clinical education, to include:**
   - Models of clinical supervision (eg, trainee to instructor ratios, academic faculty as preceptors);
   - Mandatory clinical instructor training, certification, and recertification;
   - Effective communication among all stakeholders across all phases of clinical training; Student readiness to enter each stage of clinical education; and
   - A comprehensive evaluation plan for clinical education.

4. **That clinical education be incorporated into the recommendations approved by the Board and forwarded to the Education Leadership Partnership regarding education data management systems, include and not be limited to the following:**
   - A unique "professional (secure, or protected) lifetime" identifier is assigned to individuals at the time application or acceptance;
   - A national clinical education matching program is used for assigning students to clinical education sites;
   - Outcomes of care provided by physical therapist students/interns/residents are included in patient/clinical outcome registries;
   - Data entry and data management systems are interoperable with other data systems relevant to physical therapist education (eg, CAPTE, FSBPT, ABPTRFE, CPI, CSIF); and
   - Data is accessible to researchers, academic programs, regulatory bodies, program evaluators, clinical training sites, and interested parties.

5. **That the physical therapy profession's prioritized education research agenda include a line of inquiry specific to clinical education;** and,

6. **That the BPCETF report submitted for the January 2017 Board meeting be made available to the Education Leadership Partnership and other stakeholders within the physical therapist education community.**

The BPCETF report was submitted for consideration to the January 2017 Board meeting, at which **the Board adopted a revised version of recommendation 6: That APTA design a plan for dissemination of the BPCETF report for receiving widespread stakeholder input prior to consideration by the Board for adoption at its November 2017 meeting. The rationale for this recommendation was based on an appreciation for the need to allow all stakeholders to engage in a review of the BPCETF's recommendations, and to let the collective community bring its thoughts and suggestions forward.** The Board recommended that the ELP be charged with leading this stakeholder review.

ROLE OF THE EDUCATION LEADERSHIP PARTNERSHIP

The ELP, a collaborative effort among the American Council of Academic Physical Therapy (ACAPT), the American Physical Therapy Association, and the Education Section of the APTA formed in 2016. The ELP's initial focus was on the recommendations of the 2015 Excellence in Education Task Force Report, but its purpose statement has since evolved to ***reducing unwarranted variation in practice by focusing on best practices in education".*** Unwarranted variation in health care service delivery refers to practice pattern variation that cannot be explained by illness, medical need, or the dictates of evidence-based practice.

The APTA Board of Director's asked the ELP to collect stakeholder feedback on the recommendations of the Clinical Education Task Force, with a report due in October 2017. Following the release of the Task Force's report in the 2017 Reports to the House of Delegates in April, the ELP reviewed the report and determined that it needed to facilitate broad outreach to receive stakeholder feedback.

Given the 6-month window of opportunity to gather feedback the ELP chose to create an ad hoc committee to assist with facilitation of the review process. Thirteen individuals were asked to serve on the committee and assist in outreach to all stakeholder groups, not only those with which they were professionally associated.

Please join for one or more of the **town halls scheduled between June and October, and respond to a survey scheduled for release in August. We look forward to your feedback.**

Town Hall Calendar

Date:	**Time:**	**Location:**
June 22	1:00 pm – 2:30 pm (ET)	Boston, MA/NEXT Convention Center, Room 152
June 23	8:00 am – 9:30 am (ET)	Boston, MA/NEXT Convention Center, Room 152
July 20	8:00 pm – 9:30 pm (ET)	Virtual/Online Registration Link (advanced registration required): https://fs3.formsite.com/apta/CETownHall/index.html
August 17	8:00 pm – 9:30 pm (ET)	Virtual/Online Registration Link (advanced registration required): https://fs3.formsite.com/apta/CETownHall/index.html
October 12	6:00 pm – 9:00 pm (ET)	Columbus, OH/ELC ACAPT Open Forum, Room TBA

Link to the Report to the 2017 House of Delegates: https://goo.gl/28W5Zm

Link to video overview (.mpeg file must be downloaded to watch the full 20 min. presentation): https://www.dropbox.com/sh/rc2hmxtemaldr3p/AABj6kDO1vz13J8hH-RiWDn_a?dl=0