ACAPT Shared Vision for Clinical Education Initiative
JOPTE Special Edition Article Summary

Article Title: Building Physical Therapy Education Networks

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Proposed Clinical Education Position/Model

Create a framework of Physical Therapy Education Networks (PTENs) comprised of an individual academic program and a small number of clinical sites which encompass the full scope of PT practice. These sites would be recruited by the academic program based on geographical proximity and/or common philosophical and educational mission. Clinical sites could be part of a small number of PTENs. The clinical faculty would have joint appointments in the clinic and the academic program(s) and be involved in curriculum planning and decisions. There would need to be comprehensive clinical affiliation agreements to outline the specific terms of the partnership, including the rights and responsibilities of the academic program, clinical site, and clinical faculty, placement targets, curriculum expectations and shared accountability of clinical and academic faculty.

Evidence/Rationale to Support Position/Model

* To be most successful, clinical sites and academic partners need to have a common educational mission and work collaboratively to benefit all parties involved.
* The limited number and availability of clinical sites is a prohibitive factor in continuing clinical education in its current form.
* With the rise in enrollment over the past several years, the demand to the clinical sites is great and the programs are now averaging 458 contracts per program. The administrative burden of maintaining the contracts, CSIFs, updating the database and maintaining communication with all of those sites is very challenging for the academic programs.
* Unrealistic for academic programs to rely on volunteerism to provide clinical education to students with a lack of control over what students do during this portion of the curriculum, which may account for 30-40% of the overall program.
* CIs, especially those who are in a facility that affiliates with many programs, are challenged to learn the curriculum, educational requirements and grading expectations of each of those programs.
* ”We would never offer an academic course without knowing who the instructor will be, or what his or her qualifications are; …teach a class without knowing what students have already learned, or how they are expected to integrate that knowledge with their other courses;…we would not expect faculty to teach without understanding the program’s education philosophy – yet we do all of these things in clinical education.”
* Educators – clinical and academic, should work collaboratively to own the curriculum.
* Working together collaboratively in a PTEN should result in resource sharing, improved student outcomes, improved quality of care, better time efficiency, and better cost-containment.
* A smaller network of sites would provide better opportunity for planned clinical experiences addressing the

Variations/Flexibility of Position/Model

* Clinical organizations can be close in proximity to the academic program or at a distance if the fit is right.
* Clinical sites could belong to more than one PTEN.
* Collaboration should occur through regional consortia and would include members from the academic and clinical programs
* Could be used with integrated clinical experiences, full time clinical experiences and longer internships
* Effective learning experiences could be accomplished with a 2:1, preceptor model or traditional 1:1 model
* Simulation, service learning, community wellness/health promotion and interprofessional practice could be part of this model

Challenges to Implementation noted by authors

* Requires a significant shift in how we think about academic and clinical partnerships
* Identifying and sustaining financial support from academic institutions to clinical sites
* Compensation to CIs without more financial burden to students
* Getting MCOs and other payers on board with new arrangements that mirror that in medicine and pharmacy
* Figuring out how to fairly distribute resources (ie. Clinical placements, staff, financial support, etc.) among programs
* The capacity for clinical education sites/CIs is not addressed

Gaps in Presentation and/or Challenges to Implementation noted during summarization

* Details of the model have not been described so it is difficult to see how this would work (ie. No working model to refer to)
* The PTA clinical educational model was not really discussed
* Resource distribution not clearly outlined or guidelines were not proposed
* May lead to increased competition among programs for desirable sites

Additional Insight/Background to the Position/Model

* It will be critical to build a common faculty across clinical and academic settings to support the DPT curriculum and provide meaningful, practical learning experiences
* The DCE and CCCE roles would change such that the DCE would be senior faculty with faculty development and educational theory background and would be responsible for staff development. The CCCE would change to ACCE and secure student placement, share development responsibilities with the DCE and ensure ongoing communication throughout the clinical experience. Also CI would become clinical faculty.

Questions/Comments in Preparation for webinars/Summit

* How will the PTENs be created? Will there be a set number or max number of clinical sites per program?
* Could a PTEN be formed with more than 1 academic program and then several sites, all with similar philosophies?