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

Article Title: Common themes identified amongst the 7 articles

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**Overview**

The structure, process and outcomes of clinical education all need reexamined. All three areas need standardization to ensure stability as the profession advances practice and its educational preparation programs.

- Structure provides standardization. (such as number, type or CE rotations, number of weeks, Integrated Clinical Education (ICE) vs yearlong model)
- Process provides some areas where personalization within regions, or at the individual program or clinical site level, can be obtained. (the how something is done, IE: communications and oversight, placement process, consortia, networks)
- Outcomes need defined that can be measured objectively, and be meaningful to all stakeholder (IE: CAPTE, satisfaction, program and clinical site level)
- A new model to deliver clinical education is needed to meet market demands

**Partnerships**

Goal is to move away from random access to CIs and random experiences at the site towards more standardization within and across academic programs and within clinical education sites.

Goal is to increase:

1. collaborative relationship among academic programs (within a network, consortia, etc),
2. collaborative relationship between individual academic programs and select clinical education sites (core sites)
3. foster professional development of DCE, CCCE, CI

Selection of with whom to partner should be a shared responsibility between academic program and clinical education sites. How do mission/philosophies of practice align?

**Roles and responsibilities**

Evolving roles and responsibilities for DCE, ACCE, CCCE, CI.

CCCEs and CI should be considered extension of academic faculty with faculty rank/privileges offered commensurate with abilities of academic institutions.

Academic programs need to consider a formal, standardized mechanism to assess student readiness to enter clinical practice.

Clinical education sites (CES) should begin to develop a clinical education curriculum to help provide structure and guide processes.

DCEs: time and resources needed for development of structure and processes at the CES. DCEs need to take a lead role in this transition period.

CCCEs (or proposed ACCE): focus on clinical curriculum development at point of practice, mentoring of clinical instructors, oversee development of structure/process/outcomes at point of practice.

CI: clinical teaching should be a primary job responsibility at the site level. Could be offered opportunities within academic program to teach in the classroom as well.

Clinical education specialist should be an option for advanced specialty.

**Quality**

Multidimensional

The 2 proposed processes to deliver clinical education (integrated or year-long internship), both require planning, curriculum development, and oversight by academic programs and the clinical site.

Coordination of didactic and clinical education components needs to be intentional and inclusive of faculty from both the academic and clinical side.

It is perceived that once structure and processes become more standard across all aspects of clinical education, then outcomes can be better directly measured.

**Assessment**

A need exists to reexamine:

1. What constitutes entry level clinical practice
2. Assessment tools to provide student feedback in clinical practice

A need exists to create a formal assessment plan at the clinical site level.

**Administration of CE**

A supply/demand issues is creating an urgency to create a new model for PT clinical education. Limited availability of clinical education sites and clinical instructors is a current problem.

Should placement be completed by the academic program or a match system?

Clinical capacity needs to be built (determination of how many rotations are available during a given time frame) and then a system to assign students to available sites is needed.

As much attention is needed to the administration of CE as is given to the learning/academic side of CE.

**Research**

Research in clinical education practices is lacking. A need for a clinical education research agenda exits.

A systematic process is needed to collect aggregated data about a variety of CE processes and outcomes.

Research to support statements that a one year clinical internship model makes a new grad more marketable to demand a higher salary is needed.

When does a student become revenue producing for a clinical practice?

**Challenges**

Clinician workloads, fiscal constraints, expanded documentation requirements, productivity expectations all impact ability to clinical teach and provide ample time and resources for student learning

Different viewpoints on the outcomes of an entry level program are noted. An unspoken gap between health care practice expectations and academic expectations appears to exist. Are current new grads really unprepared for clinical practice, or are expectations between the health care practice sites unrealistic? Or are expectations from academic programs unrealistic?