NATIONAL CONSORTIUM OF CLINICAL EDUCATORS
REGIONAL NETWORKING SESSION AT 2018 EDUCATION LEADERSHIP CONFERENCE
REPORT TO MEMBERSHIP

Background:
The National Consortium of Clinical Educators (NCCE) began sponsoring regional networking sessions at the Education Leadership Conference (ELC) in 2016, making this year's session the 3rd annual meeting. There were 51 clinical education stakeholders representing 20 regional consortia present at the inaugural session which focused on sharing information about the structure, functions and outcomes of consortia. Information gathered at the session and four recommendations for enhancing clinical education efforts at the regional and national level were disseminated through a Final Report to the NCCE membership (available on the NCCE website) and a publication in the Journal of Allied Health.[1] The regional consortia session at ELC 2017, which was similar in size with 55 participants from 22 regional consortia, promoted fluid networking among participants on the topics of academic-clinic partnerships, capacity and variation. Thought-provoking discussions were generated during the session and participants/consortia were encouraged to collaborate on actionable items but no mechanisms were in place to record discussions and potential action plans developed. Therefore, uncertainty exists in regards to the outcomes of this networking session. Information from the session was made available to the membership by posting the session powerpoint on the NCCE website.

In April 2018, the NCCE Board of Directors began discussing ideas for the ELC 2018 regional networking session and by June, a group of six Board members (three academic and three clinical members) were identified to plan the ELC 2018 session. General objectives for this year's session included increasing number of participants to expand stakeholder involvement, reaching out to geographic regions not currently represented by formalized regional consortia and using more structured processes than in 2017 to enhance data collection. The planning group identified potential topics and networking activities for the session which were vetted by the full Board. From this process, the Board determined that the purpose of this year's session would be to explore the effectiveness of clinical education communications from individual, regional, and national perspectives.

The planning committee sent a preliminary invitation in June to all regional consortia contacts and to PT programs in states without regional consortia (AL, MS, LA) encouraging each region to rally 7-10 representatives for the meeting. By September, the official invitation with link to a registration survey was sent to each region's contact person who forwarded the information to their representatives. In addition to serving as registration for the session, this survey sought to gather information about current processes and participant opinions which was used to begin conversations during the session. Initial pre-registration was for 123 participants from 23 regions/consortia but inclement weather created travel delays so actual attendance was 108 participants from 20 regions/consortia (28 clinical participants, 80 academic participants).

The session itself was divided into three segments all related to the overall topic of clinical education communication (see powerpoint on NCCE website). Part I focused on the structure and function of communication, Part II related to communication for day-to-day operations and Part III related to communication for yearly planning of clinical placements. Session leaders introduced the topics to the entire group then participants networked in small groups through structured roundtable activities. During Part I, participants were purposefully grouped together so they could work with others in their same region/consortia then participants were re-grouped to facilitate networking across regions for Parts II and III. Each roundtable had a facilitator/scribe to elicit conversation through formulated questions and to record answers.

Summary of key concepts from session:

Part 1: Clinical Education Communication – Structure and Function

This portion of the session began with a review of the current distribution of clinical education stakeholders at the individual, regional and national levels. Individual level stakeholders were identified as the people (DCEs, ACCEs, Assistant DCEs, SCCEs, CIs and students) and organizations (PT and PTA academic programs and clinic sites) that directly partner for clinical education experiences. Regional level stakeholders include 22 known regional consortia for PT clinical educators, some of which include PTA educators, and an unknown number of regional consortia for PTA clinical educators. It was recognized that the geographic distribution of the 22 known regional consortia is uneven creating duplication in some regions and gaps in others (Fig. 1). National level stakeholders include the APTA, American Council of Academic Physical Therapy (ACAPT), National Consortium of Clinical Education (NCCE), Academy of PT Education (APTE) and the Clinical Education Special Interest Group (CESIG); all of whom collaborate through the Education Leadership Partnership (ELP).

After this review, participants engaged in three roundtables activities. During the first activity, participants categorized lines of communication between stakeholders as effective (strong), less reliable or non-existent. The other two roundtables focused on brainstorming potential structures for improving communication between stakeholders. An overview of the information gathered during these roundtable activities is outlined below:

- Effective (strong) lines of communication were reported between:
    - National level stakeholders (APTA, ACAPT/NCCE, APTE/CESIG)
    - Regional consortia and academic programs
- Lines of communication that were perceived as non-existent:
    - Between the national level and individual clinic sites
    - Lateral communication between regions
    - Lateral communication between individual clinic sites
- Feedback was more favorable than negative when asked if regions/consortia should have a role in a national communication structure. Common themes among favorable responses related to improved cohesiveness/strengthened partnerships and logistical benefits such as improved efficiency, more uniformity, enhanced transparency and increased sharing. Negative comments centered around concerns about the uniqueness of each region/consortium, competition and trust issues, equal representation and adding another layer/national oversight.
- Two main types of organizational structures were noted on diagrams drawn to depict the ideal communication structure between clinical education stakeholders:
    - Top-down/bottom-up with the majority showing national entities at the helm relaying information downstream to academic and clinical stakeholders
    - Circular organization with one central stakeholder (variability in identification of the central stakeholder)

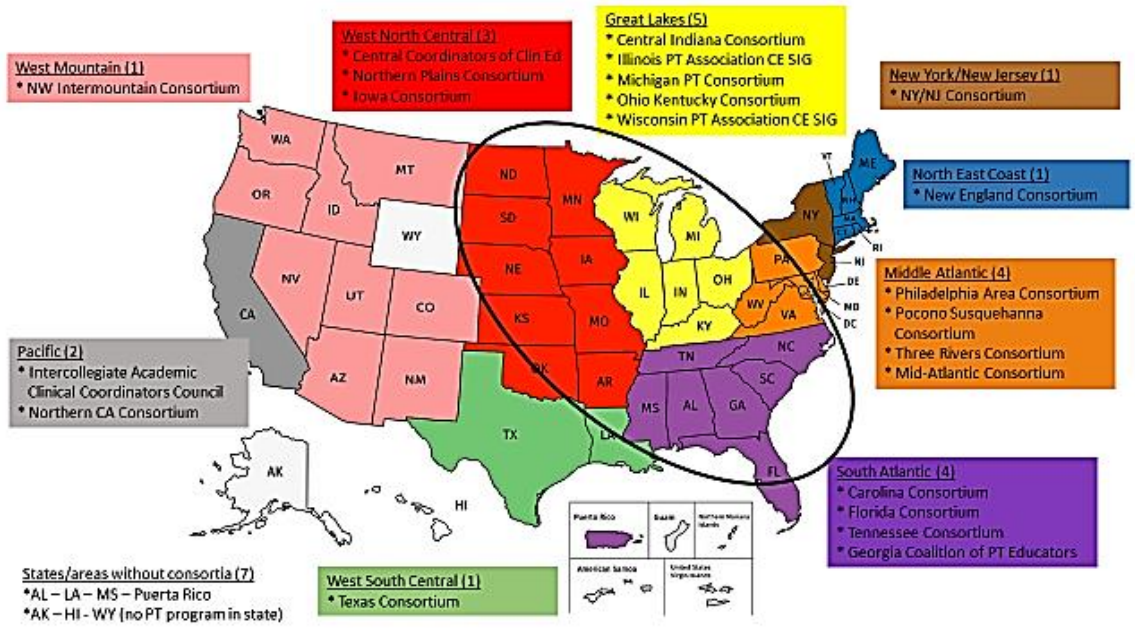

Figure 1. Geographic distribution of PT regional clinical education consortia categorized by NCCE regions. Note: 16 of the 22 regional consortia are located in the central four NCCE regions and seven states/regions are not represented by a known regional consortium.

Part II: Clinical Education Communication – Day-to-Day Operations

This part of the session engaged participants in three roundtable activities to discuss communication before, during and after clinical education experiences. During the first activity, clinical participants were asked to describe essential information needed to begin a clinical education experience and their preferred means of communicating this information. All participants completed a short survey related to communication during clinical experiences during the second roundtable activity. The final roundtable included brainstorming about components of evaluation tools that help to effectively communicate essential performance assessment at the end of a clinical education experience. An overview of the information gathered during these roundtables is outlined below:

- Clinical participants preferred using email as the platform for communication *before* a clinical education experience and preferred to receive the information from the DCE. Essential information requested by clinical participants included student preparedness, special requests/goals, and areas of need to direct the onboarding process and CI assignment.
- Academic and clinical educators preferred in person meetings and phone calls for communications *during* a clinical education experience. The most reported frequency of contact was 2 times during a "typical" experience.
- Themes that emerged about communicating performance assessment *after* a clinical experience indicate that participants envision the ideal assessment tool as one that is simple to use, intuitive, efficient and uniformly used by all stakeholders nationwide.

Part III: Clinical Education Communication – Yearly Planning

The final portion of the networking session began with a historical review of our current clinical placement process using the Voluntary Uniform Mailing dates established by the CESIG in 1998, an announcement about the recently formed clinical education placement process task force (collaborative

effort between ACAPT and CESIG) and data from the pre-session survey on current placement processes. Survey results revealed:

- The majority of session participants follow the established mailing date timeline with most academic programs emailing forms to clinic sites to gather information about available clinical placements.
- The majority of clinical participants reported 75-100% of offered placements are used and the majority of both academic and clinical participants reported little to no cancellation of offered placements.
- More than half of the academic (64%) and clinical (65%) participants reported satisfaction with the current placement process.

To conclude the session, participants engaged in two roundtable activities to share strengths and challenges of current placement processes and to envision a future placement process that would meet the needs of all stakeholders at the local, regional and national level. An overview of the information gathered during these roundtable activities is outlined below:

- Participants described the lack of inpatient, neuro and early clinical experiences, communication response time between stakeholders, and the trend toward first-come, first-served offers as challenges of the current placement process.
- When asked about strategies to overcome challenges in the current clinical placement process, participants resoundingly reported building stronger and more strategic relationships and collaborating within region/consortium (ie: release unused slots back to consortium).
- When asked to describe a future vision of the clinical placement process, the most frequent responses included a national match process with more standardization (ie: start dates, length of experiences, etc.), a national clearinghouse for available clinical placements and better utilization of the collaborative model of clinical education.

Summary and recommendations:
Overall, participants perceived day-to-day and yearly planning communication as effective but there was less agreement about the effectiveness of communication for strategic planning on a national level. While clinical education communication was considered effective, participants acknowledged that there was room for improvement. All regions reported missing lines of communication indicating some clinical education stakeholders are not included in the conversation. Participants enthusiastically engaged in sharing ideas for developing a more formalized national communication structure as well as their vision for improving current performance evaluation tools and the annual clinical education placement process. The grassroots participants in this session expressed interest in having their perspectives on these topics shared upstream to inform national initiatives. As discussed during the networking session, the NCCE shared the pre-session survey results related to the clinical placement process and the information gathered from Part III roundtables with the ACAPT-CESIG collaborative task force on the clinical education placement process in an effort to facilitate this bottom up communication.

The themes that emerged from this session indicate that most grassroots regional organizations want to have a productive and meaningful role in national clinical education communication and coordination. Recommendations for future work to be completed by the NCCE, in collaboration with other stakeholders, are as follows.

- Further engage regional clinical education stakeholders to advance the development of a formalized national clinical education structure which engages all stakeholders, balances the representations of individual and regional stakeholders, and creates lines of communication between national entities and individual clinic sites, across regions and across clinic sites
- More completely analyze the information for greater dissemination and use during consideration and development of a formalized national structure
- Develop initiatives to facilitate individual and global clinical education relationship building to provide all stakeholders with opportunities and resources for strengthening partnerships at the individual level and to enhance network building within and across regions to ensure equal distribution and representation nationally
- Lead a discussion with the NCCE membership and, if indicated, develop a motion to evaluate current clinical performance instruments and make recommendations for identifying or developing a more ideal, uniform and efficient tool

Respectfully submitted,

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Reference:

1. Howman J, Wilkinson T, Engelhard C, Applebaum D. Collaborations in clinical education: Coordinating top-down and bottom-up efforts to advance best practices in physical therapist education. *J Allied Health*. 2018; 47(3):e67-e74.