FEATURE

How Schools and Sites Manage Clinical Education In an Era of Change

Each PT school seems to have a unique clinical education program. Meanwhile, sites have their own needs and requirements. How do these variations affect the profession? How can these programs remain viable as health care evolves?

By Donald E. Tepper | June 2018

It's a truism that no 2 snowflakes are identical. The same can be said about integrated clinical education programs (ICE), with variables that include clinical sites, scheduling, length of programs, content, the student-clinic matching process, and much more.

Some view the wide variation of programs as positive—a reflection of the school, students, clinical sites, and patient needs. Others view that same lack of uniformity as negative—resulting in variables that may be inconsistent with the future vision of physical therapy.

That debate was evident late last year—and remained unresolved—as APTA's Board of Directors considered recommendations related to best practices in clinical education. (See "Strategy Group Seeking Input on Clinical Education Recommendations" on page 21.)

Let's start with a question: What does clinical education look like today?

There's general agreement that finding the right clinical education student slots at the right time has become more difficult. Laurie Kontney, PT, DPT, MS, is a clinical professor and director of clinical education (DCE) at Marquette University. She explains: "Health care has changed, and there's a lot of
pressure on clinicians to maximize productivity. Insurance has put restrictions on the number of visits or what it will pay for. As a result, you have patients allowed only 3 or 4 visits, leading to hesitancy to take on a student who might not be as proficient as is an experienced PT. Also, the number of PT [physical therapist] and PTA [physical therapist assistant] programs has grown. And many programs have increased the number of weeks for a clinical education rotation."

Donna Applebaum, PT, DPT, agrees that reimbursement, the changing health care system, and the growing number of education programs put pressure on clinical education. She identifies other issues, too, including the evolution of the workforce, greater expectations from consumers, and growing evidence regarding teaching and learning techniques.

Addressing the last issue, Applebaum says, "Adult learning theory and research about teaching and learning has shown that learning in context is the most meaningful. This has led to strengthening of practices around integrated clinical education. This also has led to a shift in the way we coordinate the curriculum—toward more tightly woven academic-clinical experiences. There is a shift toward clinical education as an integrated part of the curriculum rather than separate from didactic preparation."

Applebaum is DCE in the physical therapy department at MGH Institute of Health Professions in Boston. She also is chair of the American Council of Academic Physical Therapy (ACAPT) National Consortium of Clinical Educators.

A Sampling of Schedules and Strategies

Each school seems to have its own schedule and structure for clinical education.

Kontney, for instance, describes Marquette's program as "on the lower end of total weeks of clinical education." (As described later in this article, students who enter Marquette as freshmen can begin taking physical therapist courses as seniors, reducing the usual 3-year DPT program to 2 years after receipt of an undergraduate degree, for a total of 6 years.)

Students complete a full year at the school, plus the first semester of the second year. Then comes a 4-week clinical education session. In the summer between the students' fifth and sixth year is a 10-week internship. After being at school the first semester of their sixth year, the students participate in either 1 18-week program or 2 9-week programs. Kontney explains that "it varies based on the site."

The University of North Dakota (UND), meanwhile, has a 1-week clinical session during the first year of the program, then 9 weeks at both the start of the second year and the end of the final year. That's a change from the 1990s, explains Cindy Hom-Meland, PT PhD, the DCE at UND in Grand Forks. Back then, clinical education consisted of 1 week full-time at the end of each semester, then terminal experience at the end of the program. "What comes around goes around," she says. "We're back to
what we did 25 years ago—getting students in the clinic early, getting them exposed, and then having them return to the classroom."

Gannon University, in Erie, Pennsylvania, schedules clinicals at the end of each year, reports Julie Hartmann, PT, DSC, an assistant professor and the program’s DCE. There’s a 10-week clinical after the first and second years, then 8-week and 12-week clinicals in the third year.

Those are just 3 of many examples. As for subject matter content, many schools try to schedule a clinical in a subject immediately after that topic is covered in the classroom—orthopedics, for instance. That's particularly the case in initial clinicals.

Clinical sites, of course, have their own preferences regarding length and scheduling. Scott Euype, PT, DPT, MHS, is a clinician at Cleveland Clinic. That institution consists of 11 hospitals and more than 40 satellite locations. Each hospital has a center coordinator of clinical education; Euype oversees that process. Within the physical therapy arena alone, Cleveland Clinic has 47 different contracts—representing 21% of the nation's PT schools. Overall, Cleveland Clinic places more than 200 physical therapist students a year.

"The clinical education experience can be from 6 to 24 weeks, and variability ranges from first to fifth student rotation," Euype says. While sites provide flexibility in scheduling, Euype has his preferences. "I try to have longer clinical experiences. Six to 8 weeks seems to be too little. Twelve weeks seems to be a better learning experience, and students are more comfortable," he says.

As for the push to standardize the scheduling and length of internships, Flom-Meland is cautious. "Here's what I see as the hard part: If students were all out at the same time, placements might be even more difficult," she says, adding, "If we had year-long internships, I know we'd lose placements. We have local sites that take 4 students over the course of a year. But with a year-long internship, they'd only take 1."

Kontney describes the same problem—a year-long internship reduces the number of available slots from 4 to 1—but says she's seen the same problem in reverse. "Marquette has a neuro rehab residency for which we partner with the Veterans Administration—1 resident for a year. The VA wanted to expand the programs to 3 residents. That dried up our internships, so a site that might have taken 3 students in neurology only takes 1."

**Searching For Sites**

Finding clinical sites for students is a major challenge for most schools.
Applebaum doesn't mince words: "We have a completely disorganized and inefficient system for student placement, [resulting in] missed opportunities. The historical placement process was built on a combination of local resources, alumni and social contacts, and student wants and needs—and on a foundation of goodwill. We all acknowledge that this is a problem, but we press on and have not reached consensus that the system needs to change."

Kontney describes Marquette's process as "controlled chaos."

Marquette's students must complete 1 of their longer internships in outpatient orthopedics, or, conversely, complete a 4- and a 9-week orthopedics program. "They can't just do 4 weeks," she explains. In addition, all students need inpatient acute and inpatient rehab or subacute experiences. In their final academic semester, all students take an advanced elective in a "specialty" area such as cardiopulmonary physical therapy, pediatrics, neurology, or women's health. Marquette then finds each student an internship in his or her specialty area.

But that's not the end of it. The school requires that each student be exposed to multiple practice settings. "That's where it gets challenging," Kontney concedes. Three internships require students to participate in a draft. First, students are assigned to a group. "For 1 internship, a group will pick an upper third, middle third, and lower third. We randomize the students within the group, and we rotate the groups. That way, everybody has 3 chances to be at the top of the group and 3 chances to be at the bottom."

Isn't there a simpler way?

Maybe, but Kontney is cautious. "Other schools—and we've played around with the idea—use software that allows students to create wish lists, and the computer matches them. We're debating going to that. It would remove the drama, but it also would remove some of the accountability. I've been doing this for 25 years, and I'm all about accountability."

UND uses a different process. Flom-Meland explains, "We've always tried to match our students as best we can. We're already setting up sites with our first-year students. In setting up second-year clinicals, we ask, 'Where are you from? What are you interested in?' We work with them finding placements. By third-year clinicals, we know the students well, so we can better match them."

Gannon University also takes a hands-on, personalized approach. Hartmann says, "We don't use a lottery or any computerized system. We get a form back from the sites, determine what slots are available, and make the decision with student input."

And there's another factor: housing. She explains, "Where students will live can be a major concern. We work with them on housing and finances, as well as on whether they will match well with the site. For
example, does the student like more hand-holding or prefer being thrown to the wolves? During the first year, we guide them. In their second through fourth rotations, they have more insight. They talk with other students, and we discuss it with them. We try to take all those factors into account."

At California State University-Fresno, the matching process also is personalized, but location can be a double-edged sword. Leslie Zarlinkameh, PT, DPT, the program's DCE, says, "The final decision rests with me, and sometimes I have to rescue students from themselves. Sometimes they're just choosing sites based on location, for instance, so they can go home for the summer. I do take into consideration their wants and career goals, but the final decision is up to me, in consultation with the rest of the faculty. I try to place students where they will be most successful. And I consider other factors: If they have children or health issues, I try not to send them out of state. But students understand that they may be sent out of the area at their own expense for clinical internships."

From the clinic's perspective, Euype explains, "We want good students. But what's a good student clinically? Some of the programs are good at selecting the student for the site; they know the sites well. That's the vision we have. Other schools randomly select—drawing numbers so students just pick a site on the list. With that randomness, I might be getting a student who's not interested in coming to my site."

Geography also plays a role in which students are accepted by clinics. Euype says, "We have several schools in our geographic region. We take a lot of their students. They stay in the area and we hire a lot of them." What about schools outside the area? Euype says they might take 1 a year, since "we're not going to be hiring them." And, he adds, "If I accept a student from Chicago, I may take away a place for a local student from Cleveland."

Live Every Day, a 4-location Connecticut-based physical therapy practice with a focus on orthotics and prosthetics, has found its own solution to that issue. The practice's founder, Matt Calandrillo, PT, is an alumnus and adjunct faculty member at Springfield College in Massachusetts. He says, "We've focused our efforts on a robust relationship with Springfield College and guide all students through a focused integrated clinical experience." The practice recently became 1 of the first orthopedic residency programs in Connecticut.

Calandrillo advises other clinics that "ICE isn't just for the 'big guys.' Connect and create a true partnership with an institution or several institutions close to you. Unless each knows the other well, the relationship will be difficult. Invite them to visit you and meet your staff. That partnership is an advantage for the patients and the PTs involved in the program."

Schools certainly look for sites with a practice focus that aligns with the school's course content—for instance, an orthopedics site after the student has devoted a semester to orthopedics—but there's more.
Although finding enough sites—with the appropriate required skills—can be difficult, schools still do their own site screening to make sure their students benefit from them. Hartmann explains, "We want sites to provide an educational opportunity for students—not just a site that wants an extra body to do work. I look for ones that provide experience in different areas, and with clinicians with different areas of expertise. We don't always 'go big.' Our students learn so much from smaller community-based hospitals. Yes, it's nice to send them to large institutions, but it's also good to be able to send students to smaller areas. We also want sites with good communication skills. We encourage our sites to communicate with us as much as possible to prevent problems from occurring."

Calendrillo agrees. "There's a notion that only large hospital or medical systems can lead in clinical education. I couldn't disagree more," he says. "The majority of residencies are captured in large hospital systems, yet most outpatient care continues to be provided by local private practices. It only makes sense for smaller and local clinics to showcase and become more involved in the educational process," he says.

**Who Should Pay?**

There's a cost to clinical education—and most of those interviewed for this article acknowledge that it isn't being fully covered, at least in dollar terms. Kontney says, "There's a lot of hubbub about students paying tuition during internships. But there's a cost on our end for students to be out there. So why don't universities pay the clinical education sites? Because there's just no money in the budget to do that. If we had to pay, we'd have to reduce our class size.

"We've had the same budget since I started at Marquette," Kontney continues. "So, we've gotten creative. I'll go out to the sites and do free in-services. Or, I'll do a presentation that benefits their staff." One program leader adds, "Unfortunately, people who sit in higher places at the clinical sites don't always realize that their own staff didn't just become professional. They needed internships, too. And when you're a clinical instructor [CI] teaching in the clinic, you learn, too. Initially, the CI spends a lot of time with the student, but there is a benefit for the institution, too."

Then there's the benefit of sites hiring staff from among the students. "A lot of times," Kontney says, "those sites hire the students. That saves on their costs for advertising and interviewing."

The bottom line, though, is: "If we have to start paying, it'll be a nail in the coffin of clinical education. A lot of programs will have to close," Kontney cautions.

Flom-Meland says clinical sites haven't asked her program for payment, but "it's out there." She adds, "It's frightening to me, though, because some of the dollar amounts are staggering. We're a state-funded school, and we wouldn't be able to afford that. The students wouldn't be able to, either."
Her program, and a growing number of others, seeks to offer something of nonmonetary value in return. For example, "We provide library access to clinical coordinators and clinical instructors for a minimum of 18 months," she notes.

Applebaum says that in the MGH curriculum, "We've developed as many opportunities as possible for clinical instructors to be paid lab instructors. That enriches our program and harnesses their enthusiasm."

Hartmann also says that site requests for compensation isn't yet a major issue. "I've only encountered a few sites asking for reimbursement. However, I can see that possibly happening down the road. But I would hope that sites don't accept students just based on compensation." Hartmann also wonders, "Where does that money come from? Does the student pay? Does the school pay? If so, do we increase tuition?" To provide some additional value to the clinics in return, she says, "If there are clinical instructor courses offered, we offer discounts."

Zarrinkhameh says requests for compensation greatly depend on the availability of PTs in the area—and that it's not always the clinical sites asking for payment. Fresno is in California's Central Valley, with Sacramento about 175 miles to the north and Los Angeles about 215 miles to the south. She says, "I haven't heard much around here about sites being compensated. But I have heard about it happening in Southern California. However, there's such a shortage of PTs in the Central Valley, and an aging population. Some sites are coming to us. They want to use ICE as a recruiting tool. Some sites even offer stipends."

From the clinic's perspective, Calandrillo comments, "It's our professional responsibility to educate the growing professional base behind us. In my practice, we've been able to enhance or facilitate additional roles for our providers. Not everyone can be a 'director of this' or 'manager of that.' But involvement in an ICE program is important in itself. We value our CI employees—more than half our employees are CI-credentialed."

Euype says, "Some hospitals and private practices are asking, 'If schools are charging students on their clinicals, why shouldn't we charge the schools?' Ethically, I have a problem charging students to come here. That adds to loan debt. But, at the same time, the schools are saying, 'Let's increase enrollment.' Students should be aware that clinical sites aren't growing fast enough to accommodate the increased enrollment.

"I've been asking some of the schools to increase the length of clinicals," Euype continues. "A longer clinical also helps improve a student's productivity. We just deal with the school's length requirement. But we're leaning toward schools that offer the longer clinical experience. If schools want to place more students, we'll tend to ask for longer experiences," he says.
Euype suggests that sites seek opportunities to work with schools. "How can we collaborate with schools outside of charging?" he asks. "Through teaching? Research?" Referencing a recent issue of the *Journal of Physical Therapy Education (JOPTEd)*, he suggests, "Educational institutions and sites might coordinate to offset costs by sharing resources. The institution has faculty, research potential, and students—some of whom can help us with research projects. They also could help with continuing education so that we can develop our staff. Maybe they can teach part of the course, with the understanding that we'll take some of their students. I've heard some institutions talk about paying for staff who take students to conferences." Another *JOPTEd* suggestion: Offer the clinical instructor a clinical adjunct position at the school. "It helps the CI feel valued," Euype says. "Many CIs would like that."

Calendrillo, whose clinic already participates in such a program, says it also can result in better coordination between the site and the school. "A number of clinicians on my staff serve as adjunct faculty at Springfield College," he notes. "That helps us know the curriculum. Coordination of classroom and clinical education becomes seamless."

Although APTA is closely studying and monitoring clinical education, external forces also will help shape its future. Hartmann, for example, predicts that residencies will continue to grow. "Residencies may eliminate slots. I don't see an answer to that. We see problems even with 16-week rotations. It'll take a while to resolve that conflict between traditional clinical education and residency-based programs," she says.

**Looking Ahead**

Euype expects technology to play a growing role in clinical education. He says, "A few educational institutions have wanted to do something with their iPads. Or they've asked to Skype in. One program wanted to videotape a patient visit. Although we couldn't do that because of HIPAA [the Health Insurance Portability and Accountability Act], the idea does have potential. Telehealth is another promising area. And students with their smartphones—those can be powerful tools. It's amazing what's out there. Are we aware of all that? Probably not, especially not the Baby Boomers. But I'm open to it. Sometimes, the students are teaching us."

Another part of the answer to sustainable clinical education may lie in a collaborative model in which there may be more than 1 student for 1 or more CIs. Perhaps the most common structure is 2:1—2 students and 1 CI. Zarrinkhameh says, "From what others have reported, it's a viable model, but it must be planned very well. And it requires a good student pairing selection, with a good clinical instructor and clear expectations."

Elizabeth Toscan, a DPT student at Creighton University, recently participated in such a 2:1 clinical experience. In the first week of her second clinical rotation at a skilled nursing facility, her CI informed
her that she would have the opportunity to mentor another student. Toscan was a third-year student on her second 6-week clinical. The other student would be joining her during her last 2 weeks. The second student was completing her second year and beginning her first clinical rotation.

One interesting twist: The second student was from a different program and had a different educational background.

Toscan says the experience went well: "As the mentoring student, I noticed a significant improvement in my ability to reflect on patient care in action. Watching another student work with patients gave me the opportunity to step back and observe. As a result, I was able to recognize and suggest modifications for certain aspects of a treatment session, such as suggesting improvements in gait mechanics or safety awareness. Those were modifications I likely would not have perceived if I'd been working directly with the patient." She adds, "Having a peer to collaborate with allowed me to rely less on my CI and helped improve my critical thinking skills."

Toscan's CI, Jennifer Bruursema, PT, DPT, from Hillcrest Health & Rehab, comments, "This 2:1 student-CI model resulted in increased peer collaboration, increased confidence in treatment planning, and a fostering of a sense of independence from me during difficult treatment sessions."

Nor is it necessary in a 2:1 program that both students be DPT candidates. Zarrinkhameh of California State University-Fresno is working with the Institute of Technology (IOT) in nearby Clovis, California, on developing a 2:1 program with PTA students.

Jimmy Pacini, PTA, is DCE of the newly launched PTA program at IOT. (See "Clinical Education: Not Just for PTs" on page 24). Pacini says, "We are working on a model of placing a PT and PTA students together. Usually the 2:1 model refers to 2 DPT students. But since we have the Fresno DPT program so close, we'd like to work on placing a PT and PTA student at the same time. One challenge is finding the right facilities and the right CIs. The other challenge is scheduling—when our clinicals occur and when the program can be set up. But both schools are definitely on board."

Perhaps part of the solution lies in restructuring the DPT program. Some schools are addressing the pre-DPT course of study. At least 1 school has restructured the final portion.

Marquette, for example, introduces physical therapy courses during a student's undergraduate education. Students enter as freshmen and work toward an undergraduate degree. Although most select exercise science, choices have run the gamut from Spanish and nursing to business and psychology. Because the program reaches down into the freshman class, "students do the majority of their course work in their major in the first 3 years," Kontney says.
A student's senior undergrad year is the first year of the professional phase: "They're taking undergraduate classes while starting the PT classes." In fact, some of the school's physical therapy classes are electives for the undergraduate program. The result: The entire program—an undergraduate degree plus a DPT—requires only 6 years. (Students who transfer to Marquette with an undergraduate degree undergo the more typical 3-year program.)

MGH Institute of Health Professions addresses the situation at the end of a student's program. It includes a 1-year paid clinical internship. The first portion of the internship is the student's final clinical experience. The student then graduates and takes the licensure exam.

The novel element of the MGH program, Applebaum notes, is that students continue after licensure as interns at the clinical site. "When they graduate, they are fully trained in the clinical organization, and the clinical organization is able to reap the benefits of having someone already part of the staff," she says. "We all know the steep learning curve during the first year. This builds in a safety net. It's a continuum, rather than graduation being an end point."

Is the employer required to retain the student postgraduation? No, says Applebaum. "They don't have an obligation to keep the intern beyond graduation if the intern isn't meeting expectations. We put elements in place in hopes that they'll have a good fit. The interview process is a big part of that. But we've been doing this since 1997 and it's very rare that, after graduation, the intern isn't seen as a good fit."

Both the pre- and postlicensure portions of the internship are paid. The intern's salary is adjusted to reflect the additional efforts employers are putting into the intern. "The financial piece—getting the salary right to account for the mentorship—has to be right. Otherwise, the program wouldn't be sustainable," Applebaum says.

**Enviable Opportunities**

"When I went to school, our opportunities were limited," Hartmann says. "You did your rotations in hospitals. It's exciting that students have an opportunity to experience so many great things. I teach a geriatrics course, and I tell them they'll like the geriatrics environment. They go out, and when they return they say, 'I never knew.' I'm a little envious of that. We must be doing something right, because all the schools are graduating some pretty phenomenal students. The students are doing well and patients are getting better."

*Donald Tepper is editor of PT in Motion.*

**References**

Strategy Group Seeking Input on Clinical Education Recommendations

The Education Leadership Partnership (ELP), a group comprising representatives from APTA, the Academy of Physical Therapy Education (APTE—formerly the Education Section of APTA), and the American Council of Academic Physical Therapy (ACAPT), was formed in 2016 with a goal of eliminating unwarranted variation in practice by focusing on best practices in physical therapy education. This year, the ELP formed a subgroup that will continue a dialogue with stakeholders that began with the recent work of 2 APTA education-related task forces and an ACAPT Clinical Education Summit held in 2014.

The new Clinical Education Strategy Group is sponsoring a meeting this fall that will bring together representatives from across the spectrum of physical therapy education. That meeting will help the strategy group develop a clinical education research agenda to inform future steps, which likely will include projects and studies with further opportunities for input.

The strategy group was created after the APTA Board of Directors (Board) recommended in November 2017 that the ELP explore clinical education recommendations that a Board-appointed task force had developed. The Board does not have authority to formally charge the ELP to take specific actions. Instead, the Board has demonstrated its trust in the ELP and its approach, which involved receiving input from thousands of APTA members and nonmembers in the study leading up to the 2017 Board decision.

Clinical Education: Not Just for PTs

Jimmy Pacini, PTA, is the director of clinical education for the Physical Therapist Assistant (PTA) Program at the Institute of Technology (IOT) in Clovis, California. IOT enrolled its first 36 students in November 2017. The program is structured as 5 15-week semesters with no breaks. It has 2 8-week clinical rotations—one in the fourth semester and the other in the fifth. One rotation is inpatient, the other outpatient.

According to the Commission on Accreditation in Physical Therapy Education (CAPTE), that's pretty typical. Of the 360 accredited PTA programs in 2017 (another 40 were under
development), the average program consisted of 77 weeks, of which 15 were full-time clinical education.¹

Pacini says that, overall, student PTA placement is similar to that of student physical therapists (PTs). "The biggest selling point I have is that a PTA clinician can serve as a PTA clinical instructor," he says. "There's always a PT supervising the PTAs, but it does take the burden off the facility." The majority of IOT's sites are outpatient, especially orthopedics and sports. "They tend to be the most supportive and the easiest to secure. Hospitals and skilled nursing facilities are a particular challenge due to the specific processes of establishing contracts with their facilities."

The program, though, is running into a problem not faced by institutions placing PT students. "One of the biggest struggles we've had is the lack of knowledge by clinicians about what PTAs do and how to use them," Pacini says. "A lot of clinicians still don't know what a PTA does. That's because we've had very few PTAs in the workforce around here. Many sites are familiar with taking a PT student, but they don't understand the benefits of using PTAs in the clinic. They're not comfortable with the idea. The challenge, first and foremost, is educating them about what PTAs do—and then convincing them to take a student."

Pacini meets with all student applicants and advises them that they may have to travel to their clinical sites.

He explains the significance: "PTAs often are making a career change. And, in any case, a PTA student typically is a different type of student. Many have families, responsibilities, and a busy schedule and life outside of class. That's why I meet with every student. I want to make it as convenient as possible. If they have a spouse working full-time, or kids at home, I understand that it'll be more difficult to move to the Bay area, for example, for 8 weeks. A third of the students with whom I've met have been in that situation. They're a little bit older, have had other careers, and are going back to school to get an education. Those definitely are going to be factors in determining how they're going to be placed."

References

PT in Motion, APTA's official member magazine, is the successor to PT—Magazine of Physical Therapy, which published 1993-2009. All links within articles reflect the URLs at the time of publication and may have expired.

Comments

I need a clinical education with a mentor. I am in Florida and I am a recent graduate of an online tDPT program. Please help me.

Posted by Therese Masters -> DGUCBF on 5/31/2018 8:51:24 PM

UW-Madison does a wonderful job with our clinical rotations. We as students are able to make contracts with new facilities, apply to facilities application based, as well as rank our wish lists in a lottery. We are required to have an acute, ortho, and neuro rotation. https://www.med.wisc.edu/education/physical-therapy-program/clinical-experiences/

Posted by Deandra Elicock -> DGP_DM on 6/4/2018 11:53:02 AM

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