

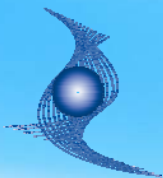
THE UNIVERSITY OF BRITISH COLUMBIA  
**Department of Physical Therapy**

Report on the proceedings of the  
**CLINICAL EDUCATION  
SYMPOSIUM**

October 30 - 31, 2008

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## Executive Summary

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In response to a changing physical therapy educational and practice environment, the University of British Columbia (UBC) Department of Physical Therapy (PT) held a two-day symposium to examine the current state and future direction of clinical education in the MPT Program at UBC. The expanded enrolment of the UBC MPT Program, the move to an integrated curriculum, the potential for a second program at UNBC, and the well-known health human resource shortages in the province were some of the drivers that led to a strategic review of the Clinical Education section of the MPT curriculum.<sup>1</sup> Clinical preceptors, managers, clinicians and other education stakeholders were invited to this workshop to assist in the development of an effective, high quality clinical education program for UBC PT students. Throughout the workshop, participants demonstrated the willingness and energy to take on this challenge. There was great enthusiasm and a spirit of cooperation between stakeholders and the UBC Department of Physical Therapy to work towards achieving the goal of providing excellent clinical education experiences for future physical therapy professionals. Creative brainstorming throughout the symposium resulted in the generation of effective and realistic solutions. The objectives of fostering dialogue across key stakeholders and developing a strategy and action plan for clinical education that reflected the vision and values of physical therapy education stakeholders were successfully achieved. This report presents a summary of the proceedings from this two-day symposium. Designed as a working document that will evolve with participant input and feedback, it serves to synthesize the findings, collate identified themes, provide a brief overview of the literature as relevant to the findings and generate key recommendations which have been translated into action steps.

## Introduction

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Students wishing to gain entry to physical therapy practice in Canada must complete an accredited university training program prior to writing the Physiotherapy Competency Exam, which is a requirement for licensure in most provinces. Clinical education—a combination of education and clinical experience received in the clinical setting—remains integral to the professional education and is obtained under supervision of licensed physical therapists working in the field. The Canadian Physiotherapy Association (CPA) *Clinical Education Position Statement* reads:

*Clinical education is a critical component of physiotherapy education programs and is essential to the future provision of quality physiotherapy health care to Canadians. Physiotherapists perform a vital role in clinical education by sharing their professional and clinical expertise and knowledge with students. As clinical instructors, they facilitate learning and critical thinking, as well as teach and evaluate the student's clinical performance and behaviours. All members of the Canadian Physiotherapy Associations (CPA) share the responsibility of contributing to the clinical education of physiotherapy students.<sup>2</sup> CPA supports and promotes collaboration on the exploration and development of flexible models for clinical education of physiotherapy students between all stakeholders.<sup>3</sup>*

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<sup>1</sup> For the purposes of this document, the terms practice education and clinical education are synonymous, though practice education is the preferred term in British Columbia.

<sup>2</sup> Canadian Physiotherapy Association. *Code of Ethics, Responsibilities to the Profession*, Item 3.6: "Physiotherapists shall be willing and diligent preceptors in the education of physiotherapy students." June 1989.

<sup>3</sup> Canadian Physiotherapy Association. *Position Statement - Clinical Education of Physiotherapy Students*. Toronto, ON: CPA;2005.

In much the same way that health care practice evolves with changes in the larger system, the education of health care practitioners must also change to reflect the environment that graduates are entering. This is as true for clinical education as it is for academic curriculum. In June 2001, the National Physiotherapy Advisory Group, comprised of the Canadian Alliance of Physiotherapy Regulators (the Alliance), the Canadian Physiotherapy Association (CPA), the Accreditation Council for Canadian Physiotherapy Academic Programs (ACCPAP), and the Canadian Universities Physical Therapy Academic Council (CUPAC), released a statement that the preferred entry level requirements for physiotherapists should change from a bachelor's degree to a professional master's degree.<sup>4</sup> The 13 physical therapy training programs across Canada were expected to phase in this requirement by 2010. The revision of educational requirements was prompted by changes in the Canadian health care system such as the regulation of physiotherapists as autonomous practitioners, the de-institutionalization of rehabilitation services (leading to a rising number of practitioners working independently) as well as the increasing complexity of health care needs of clients. Furthermore, it was recognized that the acquisition of skills and knowledge should consider the escalating amount of information and research available and applicable to the health field. All physical therapy programs in Canada are expected to use the *Entry to Practice Physiotherapy Curriculum: Content Guidelines for Canadian University Programs (May 2009)* and the *Essential Competency Profile for Physiotherapists in Canada* as a guideline for curriculum development.<sup>5</sup> Developed by the ACCPAP, the Alliance, CPA and CUPTAC, this document references the essential competencies that physical therapists must demonstrate upon entry to the profession and maintain throughout their careers.<sup>6</sup>

## Background

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In response to the decision to move towards a professional master's program, UBC conducted a major review of the PT curriculum in 2002, which resulted in significant changes in the way the academic program was structured and delivered. The traditional "block" system of musculoskeletal, cardio-respiratory and neurosciences was replaced by an "integrated" model in which the curricular content progresses from "simple to complex" as students gain knowledge and experience using a case-based learning approach. This new model incorporates concepts of adult education and is supported by evidence-based practice.<sup>7</sup> The goals of the new curriculum are to link theory, research and practice with a focus on self-directed learning. The goal of the program is to graduate physical therapists who are.<sup>8,9</sup>

- Autonomous practitioners, capable of dealing with a rapidly changing health care world
- Client-/family-centred in their practice
- Effective communicators and educators with clients, families and other caregivers, team members, colleagues, government, and the public
- Constructive and collaborative interdisciplinary team members
- Knowledgeable of legal and ethical issues affecting physical therapy practice
- Accountable for their professional decisions and actions
- Reflective practitioners

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<sup>4</sup> National Physiotherapy Advisory Group. *Frequently asked questions about physiotherapy entry-level education*. Toronto, ON: Canadian Alliance of Physiotherapy Regulators; 2002.

<sup>5</sup> Redenbach D, Bainbridge L. *Canadian physiotherapy education: The University of British Columbia example*. Physical Therapy Reviews 2007; 12:92-104.

<sup>6</sup> Accreditation Council of Canadian Physiotherapy Academic Programs. *Essential Competency Profile for Physiotherapists in Canada*. Toronto, ON: 2004.

<sup>7</sup> Redenbach D, Bainbridge L. *Canadian physiotherapy education: the University of British Columbia example*. Physical Therapy Reviews 2007; 12:92-104.

<sup>8</sup> UBC Department of Physical Therapy: [http://www.physicaltherapy.med.ubc.ca/programs/mpt\\_professional\\_entry\\_level\\_program.html](http://www.physicaltherapy.med.ubc.ca/programs/mpt_professional_entry_level_program.html) (retrieved Feb 14, 2009)

<sup>9</sup> S. Murphy (Personal communication January 2009)

- Committed to injury prevention and health promotion
- Advocates for clients
- Exemplary professional role models, actively promoting the profession and practice role models for students
- Committed to lifelong learning and active participants in continuing professional education
- Critical consumers of research and consistently engaged in evidence-based practice and involved in clinical research as possible
- Actively engaged in their profession

While these goals are reflected throughout the academic content of the revised MPT Program, the clinical education component of the program was largely ignored during the curricular revision. Clinical education continued to follow the traditional apprenticeship model, whereby students learn the theoretical foundation of clinical skills in the academic setting and then practice these skills in the clinical environment under direct supervision from a licensed physical therapist. This model continued essentially unchanged, despite the different methods of academic learning, changes in expectations of new graduate students and the program timetable being compressed from three years to twenty-six months (following an undergraduate degree and pre-requisite courses). Despite the overall reduction in the length of program, UBC MPT students must still complete 1,100 hours of supervised clinical experience. This is in line with many other Canadian physical therapy schools, where hours range from 1,200 hours at Queen's University to 1,100 hours at the Universities of Alberta and Saskatchewan. The Canadian Alliance of Physiotherapy Regulators requires candidates to complete 1,050 hours of clinical supervision as a prerequisite to the national Physiotherapy Competency Exam.

Currently UBC graduates 40 physical therapy students per year from the professional master's program (MPT). The program will increase enrolment to 72 students in 2009 and to 80 by 2010. Discussions are underway with the University of Northern British Columbia to also operate a MPT Program which would accept 20 students initially. Expansion of the UBC program and increase in the number of physical therapy graduates will be welcomed by many given the number of vacancies and shortage of physiotherapists throughout British Columbia, especially in rural, remote and northern communities. The Canadian Institute for Health Information notes a 7% increase in the supply of physiotherapists in BC between 2001 and 2006, which is considerably lower than the Canadian average of 11% growth.<sup>10</sup> The overall shortfall of physical therapists in BC, coupled with an aging workforce, and little if any financial remuneration for student supervision, makes the provision of quality practical education experiences for an expanded enrolment a significant challenge. The recent appointment of a full time Academic Coordinator for Clinical Education (ACCE) to the UBC MPT Program acknowledges the increased complexity and responsibilities of this position. In order to better understand the realities of the system and collaborate with the stakeholders of clinical education, Sue Murphy, current UBC ACCE, held a Symposium on October 30<sup>th</sup> and 31<sup>st</sup>, 2008, to explore the future of Clinical Education for the MPT Program.

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<sup>10</sup> Canadian Institute for Health Information. *Workforce Trends of Physiotherapists in Canada*, 2007. Ottawa, ON: CIHI;2008.

The objectives of this workshop were to:

1. Identify the strengths, challenges and opportunities of clinical education within the current reality
2. Create a vision for the future of clinical education in the MPT Program
3. Develop an action plan to proceed with this vision

The following discussion report was generated from a transcript of all flip charts created during the two-day symposium. These charts recorded the conversations, the ideas generated during brainstorming sessions, and summaries of exercises designed to illicit innovative thinking and provoke exploration of issues.

Who was there and why were they there?

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A variety of key stakeholders were invited to attend the symposium. These included clinicians, managers, and education coordinators representing the five Health Authorities, private practitioners, practice education coordinators from other disciplines and programs as well as representatives from the professional association and regulatory college (see Appendix 4 for a full list of participants). This list is consistent with the Canadian Physiotherapy Association's (CPA) statement that the "primary responsibility for clinical education within the profession is taken by clinical physiotherapists and the clinical facilities, and support for clinical education is a responsibility shared by physiotherapy academic programs, professional associations, physiotherapy regulatory bodies and academic and physiotherapy accrediting agencies."<sup>11</sup>

Although participants had been individually invited to the workshop due to their role and involvement in clinical education, they were asked to identify their reason for accepting the invitation. Responses can be grouped into four categories:

1. To enhance existing relationship between the clinical and professional community and UBC
2. To build new partnerships
3. To engage stakeholders and the profession in the clinical education planning process
4. To share in the future of the profession.

Issues that were raised as significant by the participants included:

1. Aligning academic knowledge with practice education
2. Coordinating the demand for placements with the supply of preceptors and practice education sites
3. Providing support for preceptors
4. Supporting rural/interprofessional (IP) and First Nations placements
5. Raising the profile of practice education and its importance in health human resource (HHR) planning
6. Exploring innovative placement opportunities

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<sup>11</sup> Canadian Physiotherapy Association. *Position Statement- Clinical Education of Physiotherapy Students*. Toronto, ON: CPA;2005.



The symposium took the form of facilitated small group discussions, using questions, scenarios, vignettes and exercises designed to illicit open thinking and engage discussion. Participants were randomly divided and groups frequently interchanged so as to maximize exchange of ideas, returning to large groups to reach consensus.

## Discussion

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Participants were asked to identify what they perceived as strengths and challenges of the current UBC Physical Therapy Clinical Education Model. Common themes that were identified and emerged from the discussions have been collated and are expanded on here.

***Increasing the capacity of Clinical Education in BC:*** The need for additional clinical placements and preceptors was identified as the critical issue in the current CE system, both by the ACCE and by the stakeholders. The ACCE cited difficulty in finding an adequate number of sites for PE opportunities in general as well as in specific practice areas. Participants in the workshop noted that while many clinicians enjoy being involved with education and precepting students, the increased workload experienced by preceptors preclude many from taking students and increase the likelihood of burnout amongst those who do act as preceptors. The participants identified critical factors that should be addressed in a comprehensive, integrated plan which would improve the quality and sustainability of the clinical education program at UBC.

***Partnerships between UBC and Clinical Practice:*** The importance of collaboration between the academic institution and the practice environment was emphasized throughout. This collaboration requires regular, effective communication between the two constituents. The exchange of information regarding academic requirements and clinical education expectations was identified as critical to preceptors. Strong, supportive partnerships between UBC and the practice environment would allow for innovative solutions to the challenge of finding an increased number of placements in a climate of health care cutbacks and shortage of physical therapists. Stakeholders expressed support and interest in exploring alternate placement models such as multiple students to preceptor(s) if provided with support and partnership from the academic institution. The need to increase placement capacity was viewed by many as an opportunity for collaborative research, innovative education models and leadership. The positive outcomes of this symposium were seen as a prime example of successful collaboration.

***Quality of the Academic Program:*** Maintaining high quality faculty, instructors, curriculum and clinical education was identified as being of high priority as the MPT Program increases enrolment. The emphasis on evidence, research and problem solving throughout the curriculum was recognized as a strength, however this needs to be matched with quality practical experience for students. Stakeholders felt the UBC MPT Program admission criteria resulted in more mature students with higher skill level. Students were well prepared for placement and for the profession. The enthusiasm and expertise of the professional community as well as the faculty were seen as integral to maintaining this quality.

***Value-added Clinical Placements:*** The knowledge exchange and reciprocal learning that occurs with precepting students was cited as one of the main drivers for clinicians to accept students on placement. Students in the clinical setting also provide new energy and enthusiasm to clinicians. While several stakeholders felt that students increased the stress and workload on clinicians, it was also acknowledged that in some instances, student placements provided assistance with the caseload. Alternate clinical education models have the potential to provide innovative programs such as the student run *Student Physiotherapy Outpatient Clinic* at the Royal Columbian Hospital, or additional services in private practice (see private practice initiatives below). Participants felt that all students should be encouraged to complete a minimum of one rural placement as it provided valuable learning experiences for students and exposure to all levels of the continuum of care. Interest was expressed in providing more

interprofessional education in the clinical setting through formal programs or informal opportunities. Clinical placements were seen as beneficial for recruitment and retention and should be integrated with health human resource planning at the Health Authority level.

**Support for Students and Preceptors:** Support for students in the form of funds for travel and contact with the UBC Department of PT during clinical placements was identified as being crucial to the success of clinical education. It was suggested that strengthening this support might increase the willingness of students to travel outside of the Lower Mainland. Providing support for preceptors was also noted as being essential to maintaining preceptor involvement. This was defined as training for preceptors, regular communication with UBC and involvement in clinical education planning. A few clinicians expressed concern that the new entry-level requirement of MPT brought a sense of inferiority or inadequacy for some practitioners who do not have graduate degrees. The expectations and attitudes of students to their clinical education were seen as a compounding factor for this concern. Recognition at all levels of preceptors experience and skills, as well as their participation in clinical education, was cited as being critical to ongoing involvement with clinical education. It was suggested that this recognition, possibly through remuneration or continuing education credit, needed to come from employers as well as from the academic institution. Acknowledgement from employers of the importance of clinical education could result in dedicated resources to clinical education (physical space, scheduling and job descriptions). Increased workload and decreased time availability was frequently cited as an obstacle to accepting students however increased support and recognition may assist in overcoming these barriers.

**Logistics:** The logistics of clinical placements were recognized as presenting a number of challenges. Concern was expressed regarding the timing of placements relative to other programs (Rehabilitation Assistant or other health professional programs) as well as the length of placement (for some too long, others too short). As noted previously, the capacity for clinical placements was identified as a critical issue. Finding placements for the current number of students was already difficult and that this would only escalate with the increase in enrolment. Obtaining placements in specific areas, such as paediatrics, private and rural practice was especially difficult. It was suggested that if requests for placements were in the form of general practice area rather than population, this might improve the match. Providing a diversity of placements (rural/urban, practice areas, practice settings) was recognized as being important to learning and the preparation of students for the profession. There was unanimous consensus that the administration of placements has been greatly improved through the appointment of a full time Academic Coordinator for Clinical Education (ACCE). Improving communication through the use of a common email address, regular reminder emails, a consistent yearly calendar and accessible information regarding issues such as liability coverage for students, would assist preceptors.

**Evaluation of Clinical Education:** Many participants commented on the challenges associated with using the student evaluation tool, the Clinical Performance Indicator (CPI). It was noted that the CPI was too lengthy, and cumbersome as an evaluation measure. Some clinicians suggested that the development of placement goals with students at the beginning of placement improved the process. Others expressed the desire to adapt the evaluation form to the particular clinical setting (e.g., private practice). Feedback from the students regarding their placement experience provides beneficial information to all stakeholders in the planning and design of clinical education.

**Private Practice:** Many students request private practice experience however there is a significant shortage of these clinical placements. A separate brainstorming session regarding clinical education in the private sector was conducted. The reluctance of private practitioners to accept students was attributed to many of the same factors as experienced by public practitioners. While funding models remain an obstacle, it was suggested that income loss could be minimized by improving the efficiency of the practitioner's time and maximize the student learning through hosting two students to one preceptor (2:1). Doubling the appointment time of patients such that the student spends the second half of the appointment with the patient would serve to minimize disruption, meet client expectation and provide additional services to the patient. Reimbursement in the form of credit towards continuing education

courses, discounts on software or texts through the UBC bookstore or recognition of professional contribution from the professional association or regulatory college was considered by some clinicians as valuable compensation. Innovative programs beneficial to all parties such as working with physicians to identify low income patients who would benefit from supervised treatment from students and providing much needed services otherwise financially prohibitive to the client were shared amongst clinicians. To assist in preparing for a student placement, practitioners requested a better understanding of the student's assessment and treatment skills prior to the placement. It was evident that enhanced understanding of different learning styles and current education methods would assist clinicians in knowledge translation in the clinic.

## Recommendations

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One of the successes of the symposium was the generation of numerous practical recommendations for the future of clinical education for the UBC MPT Program. While all recommendations have been detailed in a separate document entitled *Action Plan and Recommendations for UBC MPT Clinical Education* (see Appendix 6), the most prominent are outlined here.

**Administration of UBC MPT Clinical Education:** There was unanimous support for the maintenance of a *full time* Academic Coordinator for Clinical Education (ACCE) for the UBC MPT Program. Furthermore, the creation of regional Clinical Education Assistants for Vancouver Island as well as the North and Interior was considered essential to maintaining communication and connection between clinical sites, preceptors and the academic institutions, particularly in light of the potential development of the UNBC PT program. Providing preceptor and student support was identified as the main priority for the ACCE. Examples of support include preceptor training, communication with clinical sites regarding placement logistics, student knowledge and skill level and recognition of preceptors. It was agreed that the formation of a Provincial Clinical Education Advisory Committee, made up of public and private clinicians and managers, would assist in maintaining dialogue and collaboration amongst stakeholders.

**Innovative Solutions to Practice Education:** All participants at the symposium expressed interest in exploring alternate practice education models. It was noted that this presented an opportunity for collaborative research and leadership in the area of practice education provincially and nationally. Expanding pilot projects such as the multiple students to preceptor(s) initiative currently operating in the Lower Mainland, and increasing the number of interprofessional placements are two examples that would capitalize on this enthusiasm. Levering technology to provide support and training was suggested as a means to improve efficiency and connectivity as well as overcome such barriers as geography and inability of preceptors to attend training due to lack of backfill.

## Review of the literature

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A review of the literature regarding physical therapy practice education frameworks and models was conducted to provide context for symposium findings and in which to consider the themes generated. Using the OvidSP search engine, a search of the PubMed (1950 to present) and EmBase (1980 to present) databases was conducted. Search terms used included: clinical education, health education, medical education, physiotherapy and physical therapy. References cited in key articles were reviewed and relevant articles sought out. While this resulted in 129 articles, only 27 met the inclusion criteria of pertaining to physical therapy education, practice education but not preceptor training. Pertinent articles related to the findings of this symposium are reviewed here.

**Alternative Practice Education Models:** Physical therapy has traditionally followed the apprenticeship model of clinical education, whereby a student learns alongside a mentor or skilled professional, most commonly in a ratio of one student to one preceptor (1:1). While this remains the common PE model,

there is minimal research to show its validity.<sup>12</sup> The critical physical therapy personnel shortage coupled with expanding enrolment of physical therapy programs has sparked increased interest worldwide in other practice education models.

Lekkas et al. conducted a systematic review of the literature from 1980 to 2005 regarding models of physical therapy clinical education.<sup>13</sup> Six different practice education models being used in practice were reviewed: one-educator-to-one-student (1:1), one-educator-to-multiple-students (1:2), multiple-educators-to-one-student (2:1), multiple-educators-to-multiple-students (2:2), non-discipline-educator and student-as-educator. When evaluated for outcome measures such as productivity, student assessment and for advantages and disadvantages, no model was found to be superior over another. Recommendations for implementation of each model were also compared to analyse for benefits. The majority of studies were descriptive and not experimental so comparative analysis could not be done adequately by the researchers. Each model was reviewed and strengths and weakness of each presented. It is evident that no gold standard for practice education exists and each model should be regarded for its individual merit and the context in which it is to be applied.<sup>14</sup> Lekkas et al. make a strong case for increasing the quality of research by practice education frameworks improving their measures of productivity, educational benefits, and impact on placement capacity. One study not included in this systematic review, done by DeClute and Ladyshevsky, specifically measured clinical competency of final year PT students who completed a collaborative 2:2 placement and those who completed a traditional 1:1 placement.<sup>15</sup> Evaluation was done using the Evaluation of Clinical Competency tool used by the University of Toronto. Results showed a significant increase in the level of measured clinical competency of students who participated in collaborative placements in the areas of clinical judgement, program planning, implementation of treatment and professional behaviour. It is suggested that peer and social integrated learning has a positive effect on some areas clinical competency.

Stiller et al. conducted a qualitative study of the perceptions of physical therapy educators towards two different practice education models: shared responsibility (where the responsibility for student supervision is shared amongst therapists) versus a designated clinical educator.<sup>16</sup> While shared responsibility for education remains the most common method of providing clinical experience for students, most therapists participating in this study preferred the designated clinical educator model as it was perceived that it allowed more time for practice education, would reduce levels of stress and increase the consistency of supervision and assessment standards for students. Bennett conducted a survey of physiotherapists in Britain which concluded that a team approach to providing practice education would encourage more therapists to participate in clinical supervision as it was seen as being less of a burden.<sup>17</sup>

**Increasing capacity for Practice Education and preceptor support:** Clinicians frequently cite the time required to supervise students and subsequent decreased productivity as a negative repercussion of student placements. Many participants of this symposium voiced similar perceptions. However numerous studies have concluded that productivity increases rather than decreases when a student is present in the clinical setting.<sup>18,19</sup> The research indicates that the number of new patients seen by a

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<sup>12</sup> DeClute J, Ladyshevsky R. *Enhancing clinical competence using a collaborative clinical education model*. Physical Therapy 1993; 73(10):42-57.

<sup>13</sup> Lekkas, P, Larsen T, Kumar S, Grimmer K, Nyland L, Chipchase L, Jull G, Buttrum P, Carr L, Finch J. *No model of clinical education for physiotherapy students is superior to another: a systematic review*. Australian Journal of Physiotherapy 2007; 53: 19-28.

<sup>14</sup> Moore A, Morris J, Church V, Maartin M. *Evaluation of physiotherapy clinical education models: comparing 1:1, 2:1, and 3:1 placements*. Physiotherapy 2003; 89 (8):489-501.

<sup>15</sup> DeClute J, Ladyshevsky R. *Enhancing clinical competence using a collaborative clinical education model*. Physical Therapy 1993; 73(10):42-57.

<sup>16</sup> Stiller K, Lynch E, Phillips AC, Lambert P. *Clinical education of physiotherapy students in Australia: Perceptions of current models*. Australian Journal of Physiotherapy 2004; 50:243-247.

<sup>17</sup> Bennett R. *Clinical education: perceived abilities/qualities of clinical educators and team supervisors of students*. Physiotherapy 2003; 89(7): 432-442.

<sup>18</sup> Holland KA. *Does taking students increase your wait lists?* Physiotherapy 1997; 83(4):166-172.

<sup>19</sup> Schoen Dillon L, Tomaka JW, Chriss CE, Gutierrez CP, Hairston JM. *The effect of student clinical experience on clinician productivity*. Journal of Allied Health 2003; 32(4):261-265.

therapist/student team is greater than a therapist alone and the length of treatment session per patient increases during student placements.<sup>20</sup> Recognition of challenges faced by preceptors and obtaining solutions that are tailored to the individual workplace appears to be fundamental to successful practice education. As noted in the review of clinical education models by Lekkas et al., measurement of all aspects of practice education on the clinical environment would assist in evaluating the perceived and real impacts.

The challenge of providing graduating physical therapists with the essential competencies necessary for the changing health care system within a compressed timetable was frequently discussed during the two-day symposium and is also echoed in the literature.<sup>21</sup> In an editorial in the Australian Journal of Physiotherapy, Crosbie et al. acknowledge the issues that face physical therapy education programs in designing curriculum in an era of exponential growth in the field of knowledge relevant to physical therapy.<sup>22</sup> They present various perspectives regarding entry-level competency, specialization and continuing education. The move by Canadian physical therapy programs to a graduate level program has meant that required knowledge in some of the fundamental sciences such as physiology and sociology is now acquired at the undergraduate level and illustrates the point that physical therapy academic programs cannot be expected to cover all areas of learning. While the discussion regarding specialization within the profession has questioned what constitutes essential competencies, there is little doubt that equipping students with the skills to review and synthesize the ever-increasing literature and put evidence into practice remains pivotal to entry-level knowledge. Providing physical therapy education is extremely fiscally and labour resource intensive. An editorial by McKeeken outlining the costs of providing physical therapy education with regards to the demand upon clinicians to participate in clinical education within an increasingly strapped workforce was a sentiment expressed by many at the symposium.<sup>23</sup> McKeeken stresses the importance of raising these issues at the system level and developing sustainable solutions. Advocating for change at the political level was raised in the literature as well as amongst stakeholders at the symposium. A recent review of practice education programs in British Columbia by the Practice Education Committee of the BC Academic Health Council (BCAHC) acknowledged the significant contribution that students involved in practice education make to the health sector in the form of full time equivalents (FTEs). In 2007, the UBC MPT student practice education clinical hours amounted to the equivalent of 22 FTEs.<sup>24</sup>

**Levering Technology:** The use of technology in practice education is an emerging field and participants at the symposium mentioned the importance of leveraging technology were possible. Jones and Sheppard proposed an evidence-based model of physical therapy education using experiential learning methods and simulated patients.<sup>25</sup> While the use of simulated patients may not be too distant, the use of technology in providing connectivity between clinical sites and the university offers practical, efficient solutions to preceptor training, student support and increased knowledge transfer. In its *Strategic Report on Practice Education*, the BCAHC makes reference to the increased use of technological tools such as *HSPnet*<sup>26</sup> (a computer-assisted student placement program) and *E-Tips*<sup>27</sup>, an online preceptor development tool in assisting practice education initiatives succeed.<sup>28</sup>

The findings of this symposium corroborate with the literature on many fronts; in particular regarding the development of innovative practice education models that are responsive to the clinical environment and health care system in which they are situated. The focus on quality practice education, expanding

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<sup>20</sup> Schoen Dillon L, Tomaka JW, Chriss CE, Gutierrez CP, Hairston JM. *The effect of student clinical experience on clinician productivity.* Journal of Allied Health 2003; 32(4):261-265.

<sup>21</sup> Crosbie J, Gass E, Jull G, Morris M, Rivett D, Ruston S, Sheppard L, Sullivan J, Vujnovich A, Webb G, Wright T. *Sustainable undergraduate education and professional competency.* Australian Journal of Physiotherapy 2002; 48:5-7.

<sup>22</sup> *ibid*

<sup>23</sup> McMeeken J. *Physiotherapy education - what are the costs?* Australian Journal of Physiotherapy 2008;54:85-86.

<sup>24</sup> BC Academic Health Council. *Advancing Practice Education in British Columbia.* Vancouver, BC: BCAHC;2008.

<sup>25</sup> Jones A, Sheppard L. *Physiotherapy education: A proposed evidence-based model.* Advances in Physiotherapy 2007; 10:9-13.

<sup>26</sup> [www.hspnetcanada.net](http://www.hspnetcanada.net)

<sup>27</sup> [www.practiceeducation.ca](http://www.practiceeducation.ca)

<sup>28</sup> BC Academic Health Council. *Advancing Practice Education in British Columbia.* Vancouver, BC: BCAHC; 2008.

capacity through innovative models and raising the profile of practice education at all levels mirror the findings of the BC Academic Health Council's *Practice Education Strategic Plan* of March 2008.<sup>29</sup> Furthermore, as has been mentioned numerous times during this report, the revised Clinical Education Model for the UBC MPT Program offers numerous exciting opportunities for further research and academic inquiry.

## Conclusions

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The symposium on the future of clinical education for the UBC MPT Program was a significant first step in the development of a revised model of clinical education for the program. Stakeholders of the UBC MPT Program demonstrated their dedication to the profession and education of future professionals through their enthusiasm and willingness to create a sustainable, high quality clinical education model. Key priorities identified through this process to increase placement capacity include collaboration and communication amongst stakeholders, support for students and preceptors, exploring innovative means of providing clinical education and provide opportunity for research and professional leadership. Analysis of the findings from this symposium and from the literature identified a number of recommendations and action steps that will enable clinical education to move forward and meet the challenges and demands of the current health care system. Providing excellence in clinical education for health care professionals is a shared responsibility of students, preceptors, managers, education coordinators, institutions and governments. This will take significant support from and effort on behalf of employers, clinical managers, preceptors and UBC to ensure that the momentum for change created by this symposium does not dwindle. Implementation of key recommendations should be initiated as soon as feasible. In conclusion, the symposium on the future of clinical education for the UBC MPT Program was a terrific success, generating fruitful discussion, innovative planning and concrete action steps by which clinical education stakeholders can assist in moving the MPT Program forward into the next decade.

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<sup>29</sup> BC Academic Health Council. *Advancing Practice Education in British Columbia*. Vancouver, BC: BCAHC; 2008.

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## Strengths and Challenges of the current UBC PT Clinical Education Program

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### ***STRENGTHS of the current Clinical Education Program:***

- Partnerships between academia and clinical practice: communication and collaboration
- Quality of the academic program (faculty/instructors and curriculum) emphasizing evidence, problem-solving
- Students: program admission standards and skills of students graduating (research experience, preparation for profession)
- Preparation of students for placement and support during placement (funds for student travel)
- Variety and quality of placements (rural/urban, practice areas)
- Knowledge exchange/reciprocal learning of students in clinical education environment
- Enthusiasm, support, expertise of the professional community
- Benefit of clinical placements for recruitment

### ***CHALLENGES of the current Clinical Education Program:***

- Clinical placement logistics
  - Timing of placements relative to other programs
  - Length of placement
  - Request for practice area versus population
  - UBC administration of placements
- Capacity for clinical placements
  - Finding enough placements
  - Finding a variety of practice areas e.g., paediatrics, rural
  - Finding funding preceptors
- Student clinical education evaluation tool (CPI)
- Travel for clinical placement: funding and willingness of students to travel, e.g., rural
- Private practice
  - Remuneration of private practitioners/practices
  - Shortage of private clinical placements
  - Client expectations
- Preceptor workload/burnout
- Preceptor support
- Physical capacity for student placements
- Student expectations: challenges/opportunity



## Clinical Education Values

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### **UBC MPT Clinical Education Mission Statement (draft):**

*The clinical education component of the MPT Program at UBC promotes and fosters innovation and excellence in clinical education.*

### **UBC MPT Clinical Education Vision Statement (draft):**

*An integrated provincial network of clinical practice education encompassing a diverse range of placement settings and models with capacity for PT students from UBC, UNBC and other accredited academic institutions to develop and consolidate clinical problem solving skills and clinical reasoning.*

### **Clinical Education Values as determined and defined by participants at the Clinical Education Symposium October 30-31, 2008:**

#### **LIFELONG LEARNING**

*Defined as learning within the profession throughout all stages of one's career*

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- How it shows up in clinical education program
  - Continually evolving and integrating knowledge, skills and application
  - Journal club participation
  - Opportunities to share knowledge
  - Taught value of lifelong learning and how to bring it to others
- Ways to implement
  - Peer and self-evaluation
  - Learning plans
  - Presentations
  - Increased preceptor performance and participation
  - Mentorship/clinical instruction
  - Engagement in professional bodies/college

#### **QUEST FOR KNOWLEDGE**

*Defined as pursuit of EBP in a lifelong learning continuum      Learner → Preceptor → Learner*

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- How it shows up in clinical education program
  - Access to multiple streams of learning
  - More info about academic curriculum in given practice area for preceptors prior to clinical experience
  - Use of technology – podcasts, etc.
  - Active and engaged members in profession – CPA, PABC – local activities
  - Support knowledge exchange *Learner → Preceptor*
- Ways to Implement
  - Ongoing mentoring throughout career
  - Make preceptor training broadly available throughout province
  - Maintaining professional memberships and contributing to the profession
  - Collaborative case presentations – student and preceptors
  - Engage available technology to deliver/access information

## **SUSTAINABILITY**

*Defined as A model that continually evolves and innovates overtime to meet needs of system (Financial, QA, efficiency, patient outcomes)*

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- How it shows up in clinical education program
  - Innovative clinical model (e.g., 2:1)
  - Preceptor recruitment plan – education, recruitment, support
  - Supporting preceptors
  - Strong network (communication) – HA, Academic Institutions, Association
- Ways to Implement
  - Obtain senior level support
  - Identify accountable leadership
  - Try clinical models and share them
  - Evaluate models and programs

## **ENSURE CHOICES for PT, student, and preceptor**

*Sufficient variety of learning situations and styles within the framework of the MPT Program*

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- How it shows up in clinical education program
  - Students identify their preferred learning styles
  - Facilities provide a variety of learning opportunities and environments
  - Matching preceptor with student styles
- Ways to Implement:
  - Facilities include preceptor styles in offers for placement

## **DIVERSITY**

*Defined as appreciation of the breadth of educational experiences offered at the University and in clinical placement*

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- Learning styles
- Location
- Community culture
- Breadth of experience
- How it shows up in clinical education program
  - Students and preceptors taught learning styles
  - Continuum of care – diversity of placement experience
  - Cultural diversity/values included in program
  - Urban/rural/remote clinical practicum available
  - Students participate in intra-professional placements – students and preceptors seek out these experiences
  - Not educating “cookie cutter” PTs – all have different strengths/interests
- Ways to Implement
  - Preceptors need to understand curriculum
  - Have rural-based ACCE with a knowledge base of community networks
  - Education/tips on how to run intra-professional placements at a facility
  - Provide students financially to participate in rural placements

## Symposium Presentations

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**Alison Greig** (*MPT Program Coordinator, Department of Physical Therapy, UBC*) provided a synopsis of the MPT curriculum. Recognizing the changing face of the health care system and emerging roles for physiotherapists, the program aims to equip students with the knowledge and skills needed to work in a diversity of roles (primary health care, health promotion, etc.), with increasing complex clients (chronic disease management, etc.) and in a variety of settings (autonomous practitioners, etc.). The program endeavours to graduate students who are collaborative, client-centred, compassionate and committed life-long learners.

**Scott Brolin** (*PT Professional Practice Lead, Fraser Health Authority*) presented an overview of the pilot Student Run Outpatient Clinic being offered at the Royal Columbian Hospital. In response to the need for higher density student placements and a general decrease in the availability of publically funded outpatient services for specialized populations such as the frail elderly, stroke or acquired brain injury, this clinic serves to provide much needed service to the community while offering students experience working in an autonomous, collaborative environment. He listed the benefits for the students as satisfaction with the placement, expanded opportunity, education research on education models and the benefits for the health authority as recruitment, providing ambulatory care, being involved in education research and improving health service delivery.

**Simone Gruenig** (*Practice Support PT for the Medical-Surgical Team at Vancouver General Hospital*) presented the Multiform Placement Project at VGH which offers a 10:3 (student: preceptor) clinical education placement.

**Brenda Loveridge** (*Interim Head, Department of Physical Therapy, UBC*) gave an update on the Distributed Learning Model for Physical Therapy Education at The University of Northern British Columbia.

**Marion Briggs** (*Site/Operations Leader, Brock Fahrni Extended Care and Honoria Conway Assisted Living, Providence Health Care*) gave an overview of the *Interprofessional Education and Care of Elders Project*.

**Elizabeth Dean** (*Faculty member, Department of Physical Therapy, UBC*) gave a talk on evidence-informed and evidence-based practice, and the role of physical therapy in addressing some of the major causes of mortality.

**Kathy Copeman-Stewart** (*Program Manager, Interprofessional Rural Program of BC*) presented a video about the IRPbc, an example of an innovative interprofessional practice education model that has been running since 2003 in a number of communities across the province. Physical therapy students have been integral team members.

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Draft Statement of Mission, Vision and Values

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## Statement of Mission, Vision and Values

*For Clinical Education in the Master of Physical Therapy Program at the University of British Columbia****Mission Statement***

The clinical education component of the Master of Physical Therapy (MPT) Program at the University of British Columbia promotes and fosters innovation and excellence in clinical education.

***Vision***

The PT Clinical Education Program at UBC provides an integrated provincial network of excellent clinical practice education experiences encompassing a diverse range of placement settings and innovative learning models.

***Values***

Clinical education in the MPT Program is based on the following values:

1. Lifelong learning
2. Evidence-based practice
3. Embracement of diversity
4. Customer service (for students, preceptors and clients)
5. Collaboration (between UBC students, faculty, the clinical community and government)

Action Plan and recommendations for UBC MPT Clinical Education

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DRAFT SUMMARY OF ISSUES AND PRELIMINARY RECOMMENDATIONS  
**Clinical Education Symposium, October 30-31, 2008**

<b>GOVERNANCE STRUCTURE FOR CLINICAL EDUCATION: <i>Strengthen Relationships</i></b>		
	<b>Opportunity</b>	<b>Action Plan</b>
<i>UBC</i>	<ul style="list-style-type: none"> <li>• Formation of Provincial &amp; Regional Advisory Committees</li> <li>• Restructuring of roles between ACCE and Assistant</li> <li>• Review need for Assistant ACCE positions in VIHA, IHA</li> </ul>	
<i>Potential UNBC program linkage</i>	<ul style="list-style-type: none"> <li>• Preliminary planning for a model to include UNBC program Assistant ACCE position</li> </ul>	
<i>Health Authority/ Employer</i>	<ul style="list-style-type: none"> <li>• Professional Practice Education offices to partner with UBC</li> <li>• Northern Health to work with sites to develop additional CE sites</li> </ul>	
<i>Government</i>	<ul style="list-style-type: none"> <li>• Recognize the contribution of Practice Education to HHR planning</li> </ul>	<ul style="list-style-type: none"> <li>• Communication with Sue Illmayer (MOH Therapy Services Portfolio)</li> <li>• Recognition of CE in contributing to health care system partnership in HHR planning</li> </ul>
<b>PRECEPTORSHIP: <i>Support, Recognition, Engagement</i></b>		
	<b>Opportunity</b>	<b>Action Plan</b>
<i>UBC</i>	<ul style="list-style-type: none"> <li>• Provide education for preceptors</li> <li>• Increased number of workshops</li> <li>• Review/revise content of workshops (e.g., increased content on what MPT curriculum looks like, learning models (case-based learning))</li> <li>• Consider half-day educational event(s) specifically targeting those who do not take students/those who have questions</li> <li>• Provide support during placement</li> <li>• Simplify evaluation process</li> <li>• Provide preceptor recognition</li> </ul>	<ul style="list-style-type: none"> <li>• Linkage with BCAHC Preceptor Development Initiatives</li> <li>• Identify other web resources available:               <ul style="list-style-type: none"> <li>○ UWO Preceptor Education Program (PEP) <a href="http://www.preceptor.ca/index.html">http://www.preceptor.ca/index.html</a></li> <li>○ University of Virginia preceptor Development Program <a href="http://www.med-ed.virginia.edu/courses/fm/precept/">http://www.med-ed.virginia.edu/courses/fm/precept/</a></li> </ul> </li> <li>• Partnership with CHD for IP training/HA IP preceptor training</li> <li>• Make use of video-conferencing and web for education</li> <li>• Email/phone call at mid-term during placement</li> <li>• Provide instruction on use of CPI at Preceptor Workshop</li> <li>• Task group to investigate preceptor recognition (Anne Rankin to chair) to include incentives such as UBC bookstore discounts, Continuing Education discounts</li> </ul>

<b>PRECEPTORSHIP: Support, Recognition, Engagement (continued)</b>		
<i>Health Authority/ Employer</i>	<ul style="list-style-type: none"> <li>• ? Funding for preceptors (n.b., union considerations in public sector)</li> <li>• Support for preceptors (backfill, education, technology)</li> <li>• Clarify expectation of staff to be involved in clinical education</li> <li>• Recognize the contribution of preceptors in providing leadership (CE position/role)</li> <li>• Retired staff to act as mentors or preceptors</li> </ul>	<ul style="list-style-type: none"> <li>• Develop CE models that support preceptors, encourage workload sharing and IP collaboration</li> <li>• Increase in-house preceptor training (NHA) e.g., IP</li> </ul>
<i>Placement Site/ Facility</i>	<ul style="list-style-type: none"> <li>• Review implications of students on workload and devise strategies to prevent educator overload/burnout</li> </ul>	<ul style="list-style-type: none"> <li>• Work with UBC on innovative CE models of supervision</li> </ul>
<i>Preceptors</i>	<ul style="list-style-type: none"> <li>• Recognition of Reciprocal Learning opportunity</li> <li>• Retired PTs to consider preceptorships</li> </ul>	<ul style="list-style-type: none"> <li>• Provide UBC with feedback regarding preceptor support required</li> <li>• Provide support for new preceptors in the form of mentoring</li> </ul>
<i>CPTBC</i>	<ul style="list-style-type: none"> <li>• Consideration of preceptor hours as contribution to continuing education</li> </ul>	
<i>PABC</i>	<ul style="list-style-type: none"> <li>• Recognition of PTs involved in CE</li> </ul>	<ul style="list-style-type: none"> <li>• Continue to support Mentorship program</li> </ul>
<b>STUDENTS: Support, Engagement in Opportunity</b>		
	<b>Opportunity</b>	<b>Action Plan</b>
<i>UBC</i>	<ul style="list-style-type: none"> <li>• Continue to provide travel stipend to students for out of town placements</li> </ul>	<ul style="list-style-type: none"> <li>• Secure funding from provincial initiatives</li> </ul>
<i>Students</i>	<ul style="list-style-type: none"> <li>• Recognition of learning opportunity offered by variety of placements/full scope of practice</li> <li>• Share knowledge from Systematic Review, research and EBP with preceptors</li> </ul>	<ul style="list-style-type: none"> <li>• Provide preceptors with learning objectives prior to placement</li> <li>• Learning Objectives on placement to include sharing of research and EBP</li> </ul>
<b>CLINICAL EDUCATION PLACEMENTS: Maintaining and Enhancing Quality and Variety</b>		
	<b>Opportunity</b>	<b>Action Plan</b>
<i>UBC</i>	<ul style="list-style-type: none"> <li>• Request population-based placements (acute, geriatric, rehab etc.) rather than by system (cardioresp/MSK, etc.)</li> <li>• Increase use/knowledge of HSPnet to provide some level of support for clinical sites</li> <li>• ? Newsletter (via email) to keep clinicians &amp; preceptors current with UBC CE program</li> <li>• HSPnet; provide infrastructure to support its use for PT</li> </ul>	<ul style="list-style-type: none"> <li>• Calls for offers annually in January</li> <li>• Generic email address for Placement Assistant</li> <li>• Introduce population-based placements</li> </ul>
<i>Health Authority</i>	<ul style="list-style-type: none"> <li>• Creative means of providing physical space for students (meeting rooms for interprofessional teams, etc.)</li> <li>• HSPnet; provide infrastructure to support its use for PT</li> </ul>	<ul style="list-style-type: none"> <li>• Create a culture of CE in practice</li> <li>• Resolve issues regarding reimbursing student for mileage in home care</li> <li>• Recognition of the potential for CE to supply HHR</li> </ul>
<i>Placement Site</i>	<ul style="list-style-type: none"> <li>• Make geriatric placement exciting! Expand the potential</li> </ul>	

<b>PLACEMENTS: Increase CE Capacity through Innovative/Non-Traditional Placement Models</b>		
	<b>Opportunity</b>	<b>Action Plan</b>
<i>UBC</i>	<ul style="list-style-type: none"> <li>• Explore innovative CE models in conjunction with placement sites</li> <li>• Continue to investigate/promote interprofessional placements</li> <li>• Engage new preceptors/sites/private practices</li> </ul>	<ul style="list-style-type: none"> <li>• Work with new sites to identify barriers to CE</li> <li>• Provide support to sites willing to pilot models</li> <li>• Continue to lobby Government MOH (Sue Illmayer) and MAdvEd for funding for CE placements (HHR)</li> <li>• Work with private practice to align student skills with placement expectation</li> </ul>
<i>Health Authority</i>	<ul style="list-style-type: none"> <li>• Explore and support innovative CE models in conjunction with UBC</li> <li>• Identify gaps/inefficiencies in service as opportunity to provide CE (Fraser Health Student IP OP Clinic, CDM group visit/health promotion)</li> </ul>	<ul style="list-style-type: none"> <li>• Share successful projects with other sites/ Health Authority</li> <li>• Lobby Government MOH (Sue Illmayer) and MAdvEd for funding for CE placements (HHR)</li> </ul>
<i>Placement Site</i>	<ul style="list-style-type: none"> <li>• Innovative CE models (alternate supervision, interprofessional team, expanding learning opportunities beyond the walls, student:clinician, etc.)</li> <li>• Research opportunity: implementation and evaluation of Innovative CE initiatives</li> </ul>	<ul style="list-style-type: none"> <li>• Work with UBC to pilot projects</li> </ul>
<i>Private Practice</i>	<ul style="list-style-type: none"> <li>• Consider value-added service to clients of student</li> <li>• Work with physicians re: student placement and opportunities to see low income or patients requiring more time</li> <li>• Health promotion and Community Education services</li> </ul>	<ul style="list-style-type: none"> <li>• Existing private practices to share positive rewards of CE/students with other practices</li> </ul>
<b>RURAL PLACEMENT: Increase Capacity and Expand Learning Opportunities</b>		
	<b>Opportunity</b>	<b>Action Plan</b>
<i>UBC</i>	<ul style="list-style-type: none"> <li>• Continue to work with IRPbc to place students at each site</li> <li>• ? introduce curricular content related to rural practice</li> <li>• Recognize and develop the reciprocation of urban/rural clinical opportunities for students UNBC/UBC</li> <li>• Continue to provide travel stipend to students for out of town placements</li> </ul>	<ul style="list-style-type: none"> <li>• Promote IRPbc and benefits (IP, scope of practice) of rural placements to students</li> <li>• Use of video-conferencing to provide preceptor education, support</li> </ul>
<i>Health Authority</i>	<ul style="list-style-type: none"> <li>• Work with new and existing sites to overcome barriers</li> </ul>	<ul style="list-style-type: none"> <li>• Provide UBC with a plan for increasing potential sites</li> </ul>
<i>Government</i>	<ul style="list-style-type: none"> <li>• Follow up on BCAHC recommendations for a rural academic health plan, including for Allied Health</li> </ul>	
<i>Rural Site</i>	<ul style="list-style-type: none"> <li>• Work with other disciplines to support students in rural communities - housing, transportation, etc.</li> <li>• Promote opportunities in community as a means to assist with recruitment and retention</li> <li>• Support students throughout placement</li> </ul>	