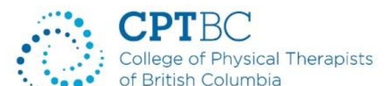
Continuing Professional Development Needs of BC Physical Therapists

Executive Summary

August 2014



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A. Background

Little data exists about the relationship between British Columbia (BC) physical therapists (PTs) and their lifelong learning needs, specifically with respect to how continuing professional development (CPD) relates to the profession of physical therapy. This suggested that a comprehensive needs assessment was needed in order to fully understand matters including, but not limited to:

- Current practices, attitudes and beliefs toward CPD, including areas of practice interest, practice gaps (knowledge and/or skills), preferred means of learning, and who PTs look to for providing education
- Identification of the barriers and enablers to participating in CPD amongst BC PTs, particularly with respect to demographic characteristics.

The University of British Columbia (UBC) Department of Physical Therapy (UBC PT) partnered with the UBC Faculty of Medicine Division of Continuing Professional Development (UBC CPD) and a number of key stakeholders interested in the CPD of PTs to conduct a province-wide needs assessment of the CPD needs of PTs in BC.

Purpose

The intended focus was to better understand the CPD needs of PTs in BC by performing an inventory of CPD needs. The end goal was to develop a strategy to build capacity through faculty development for quality clinical education in BC in order to support recruitment and retention of new graduates and clinical education instructors, and ultimately enhance CPD programming and patient care.

Research Questions

The research questions that drove all phases of the study (literature review, key informant interviews, and the needs assessment survey) were:

1. What is the current CPD landscape for PTs in BC?
    a. What is the inventory of practice expertise in BC?
    b. What are the current practices, attitudes, and beliefs of PTs towards continuing education, CPD, and lifelong learning?
    c. What are PTs' learning needs? Specifically, what are their areas of interest, perceived practice gaps (knowledge and/or skills), and preferred learning format?
2. What factors influence the landscape of CPD for PTs?
    a. What is the inventory of CPD courses in BC?
    b. What are the barriers to PT participation in CPD?
    c. What are the enablers to increasing participation and engaging PTs in CPD?
3. What strategies and educational approaches can improve CPD activities that meet the need of PTs in BC?

B. Methods

A multi-stage process was undertaken to create the province-wide needs assessment. First, literature reviews, environmental scans and key informant interviews were conducted to determine the issues related to PT participation in CPD activities and to inform the development of the survey instrument. Next an Advisory Committee was formed to provide high level direction on the development, implementation, and engagement for the province-wide needs assessment.

In the Fall of 2013, the 58 question online survey was emailed to all registered PTs in BC – a total of 3,560 PTs. Five hundred and fifty-seven (557) surveys were completed yielding a 16% response rate. The survey data was analyzed using descriptive statistics, chi-square tests, effect sizes and content analysis. Please see the **full report and appendices** for more details on the literature review, environmental scan and key informant interviews.

C. Survey Findings

1. Demographic Profile of PTs

The demographic characteristics of PTs that participated in this survey were comparable to the 2012 Canadian Institute for Health Information (CIHI) data on PTs in BC across a number of characteristics including gender, age, size of population of practice location, year of completion of PT training, and those working in the public or private sector. Noticeable differences in demographic characteristics that were observed between this needs assessment and the CIHI data included PTs in this needs assessment having a higher level of education obtained in physiotherapy, higher full-time versus part-time working status, and higher percentage of PTs who were international graduates. Overall, demographics collected in this study confirm a representative sample of PTs in BC was surveyed.

Further demographic details were analyzed to investigate differences between key demographic groups and various significant results were found. Female PTs worked more frequently in the public sector and male PTs worked more frequently in the private sector. Of those PTs with lower participation in CPD (ten hours or less per year), half never travelled for CPD and location of CPD was an influencing factor in their participation. However, location of practice (rural or urban) was not associated with the level of their participation. It should be noted that PTs' level of participation in CPD activities is associated to their age, with the majority of PTs who participated in one to ten hours of CPD in a typical year being 35-49 years of age.

Differences were found between part-time and full-time PTs that participated in this survey with most part-time PTs being female and slightly older, with approximately one-third in each age category (compared to full-time PTs with half under age 40 and about one-quarter in each of the other age groups). More full-time PTs had a Master's degree (just over one-third compared to less than a quarter of part-time PTs), whereas more part-time PTs had a Bachelor's degree (almost three-quarters compared to about half of full-time PTs), however, this may be due to age because the PT education requirements changed from a Bachelor's to a Master's degree in the early 2000s. Full-time PTs were more likely male (almost all compared to about two-thirds of female PTs working full-time). Additionally, about half of part-time PTs participated in less CPD (one to ten hours) whereas full-time PTs (more than three-quarters) were more likely to participate in more CPD (30 or more hours).

2. Attitudes and Beliefs

CPD and Career Development

Findings showed that PTs who responded to the survey see CPD as important for remaining up-to-date with PT practice. Additionally, although PTs were never directly asked about regulation of CPD, in comments provided numerous PTs suggested that CPD should be mandatory for the PT profession. This finding was particularly striking because there is currently no formal requirement or guidance structure for CPD participation for PTs in BC or other Canadian jurisdictions.

The Essential Competency Profile for Physiotherapists in Canada (2009) outlines the physiotherapist role of a "scholarly practitioner." A key competency within this role is for PTs to "incorporate lifelong learning and experiences into best practice," and the document further suggests an enabler to this competency is for PTs to engage "in professional development and lifelong learning activities (e.g., actively participates in the acquisition of new knowledge and skills; integrates new knowledge, skills and behaviours into practice)." Although this needs assessment revealed the majority of PTs were either not or only slightly familiar with the PT Essential Competency roles, findings demonstrate the PT professionals in BC intrinsically believe that CPD is important to their practice.

Workplace Support of CPD

Just over one-half of PTs were satisfied with the level of support they received from their workplace to participate in CPD; however satisfaction levels were higher for PTs working in the private sector compared to those in the public sector. Over three-quarters of PTs in the private sector indicated they paid the entire cost associated with CPD participation themselves in comparison to approximately one-third of PTs in the public sector who indicated the same – a sign that private-based PTs absorb greater financial costs to participate in CPD. Adding to the complexity of interpreting the data on workplace supports are the findings related to specific supports workplaces currently provide, and supports that PTs prefer to receive. For example, a substantially higher cohort of public-based PTs indicated their workplace currently supported CPD participation by[1]: allowing CPD participation during work hours (paid time), providing in-house CPD, and providing funds for CPD. Furthermore, when asked what supports they would prefer their workplace provide, a substantially higher cohort of PTs in the public sector indicated they preferred more workplace supports in comparison to their colleagues working in the private sector who did not indicate as high a preference for workplace support – possibly due to private PTs having different expectations than public PTs.

With regards to whether there was a statistically significant correlation between paid workplace support and CPD participation, more PTs whose workplace allowed CPD participation as 'unpaid' time participated in activities such as clinical hands-on courses, and peer study/practice sessions in comparison to those who were allowed to participate during work as 'paid time.'

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1 NOTE: the survey provided a pre-determined list of supports (current and preferred) that PTs were asked to select all that applied to them.

Organizational Roles in CPD

PTs were asked to indicate the roles various organizations should play in terms of funding, developing content, organizing and delivering, setting standards, and promoting CPD. Across these various roles, responses often indicated more than one organization was thought to have a role, with no single organization emerging as having principal responsibility.

With respect to funding, a higher percent of PTs identified the Health Authorities as having a role over the other organizations. This particular belief appeared to be driven by PTs in the public sector with over three-quarters of public-based PTs identifying Health Authorities as having a role compared to only one-half of PTs in the private sector selecting the same. Interestingly, there also appeared to be an association between year of graduation from PT training and belief in organizational role in funding, as more recent grads believed that the CPTBC and the PABC have a role in funding CPD.

With respect to developing content, both the UBC Department of Physical Therapy and knowledge experts were seen as having roles. PABC, independent CPD providers, and the CPA were seen as having a role in organization and delivery of CPD. When it comes to setting standards in CPD, substantially more PTs identified the CPTBC in comparison to other organizations. With respect to promoting CPD, more PTs identified the provincial and national physiotherapy associations (PABC and CPA) as having roles in promoting CPD.

Focusing on promotion of CPD, survey findings revealed that a high percentage of PTs turn to the provincial and national associations to find out about upcoming CPD. However, the data also revealed more PTs in the private sector turn to the aforementioned associations to find out about CPD activities compared to PTs in the public sector who are more likely to turn to the Health Authorities. This can be explained by the lower percentage of PTs in the public sector who are members of the professional association compared to almost all PTs in the private sector who are members.

3. Participation in CPD

Formats

PTs utilized a variety of educational formats when participating in CPD. More commonly used formats included self-study (e.g. conducting literature reviews, accessing clinical resources), clinical hands-on courses, lectures, online sessions (e.g. live webinar), and conferences. The specific frequency (i.e. weekly, monthly, etc.) of participation varied across activity formats listed in the survey, however, self-study stood out as the activity PTs participated in most frequently (i.e. just under one-half participate weekly or twice per month). By comparison, PT participation in traditional forms of CPD such as clinical hands-on courses and conferences occurred less frequently (i.e. twice per year or yearly). The frequency of attending activities that were lectures or online sessions was mixed. Of note, approximately one-half of PTs indicated they did not participate in activities such as certification-based courses, teleconferences, videoconferences, recorded vodcasts, mentoring, peer study, or journal clubs. In interpreting PTs' CPD usage and frequency levels, it is important to realize frequency of participation may be impacted by the availability of CPD offered in BC (and nearby jurisdictions) and the format in which they are delivered.

The demographic characteristics that had an impact on CPD participation levels included: more recent graduates (i.e. graduated in 2010 or later) participated in certification-based courses, clinical hands-on courses, and peer study/skills practice sessions more than PTs who were early-career (i.e. graduated 2000-2009), mid-career (i.e. graduated 1990-1999,) or late career (i.e. graduated 1989 or earlier). A possible explanation for this may be that PTs at the later stages of their career are more likely to have developed and established their skill sets in PT and completed associated certification requirements and their engagement in CPD may focus less on skill development and more on knowledge maintenance with respect to staying up-to-date with best practice methods.

Additionally, more PTs in the private sector participated in certification-based courses and clinical hands-on courses compared to PTs in the public sector. Conversely, more PTs in the public sector participated in CPD-based lectures and teleconferences. Possible explanations for these findings are provided by the demographic profile of PTs. Over three-quarters of PTs in the private sector identified their primary area of practice to be musculoskeletal/orthopaedics. In contrast, the primary area of public-based PTs' practice was spread across a number of areas including general practice, musculoskeletal/orthopaedics, neurology, cardiovascular/respiratory, etc. It would be expected that PTs in the private sector, who the data showed mostly focus on musculoskeletal/orthopaedics would seek certification-based and clinical hands-on courses to further skills in this area of practice, while public-based PTs, who showed varied in areas of practice, would participate in lecture and teleconference-based CPD offerings that may focus on a broader range of topics.

There were no statistically significant differences between PTs that practiced in rural areas (population 10,000 or under) and those that practiced in urban areas (population 10,001 or over) with respect to frequency of participation in CPD. Further, when asked what barriers limit participation in CPD, there also were no statistically significant differences in the attitudes of rural and urban-based PTs. This suggests that the geographic location of PTs is not a factor that hinders participation in CPD. That said, there were other areas where differences in attitudes between rural and urban-based PTs were observed, which are discussed in other sections.

Number of Hours

Most PTs spent one to ten hours in a typical year participating across each of the CPD activity formats listed in the survey, with between 33% and 61% of PTs spending one to ten hours in: online live sessions (e.g. webinars), lectures, recorded sessions (e.g. vodcasts), peer study/skills practice session, conferences, self-study (e.g. literature review, accessing clinical resources), and live videoconferences. Substantially more of the PTs with higher CPD participation hours (i.e. 31+ hours) were in full-time practice in comparison to those working part-time. Several factors were listed that influenced PTs' participating across various CPD formats including: time availability (e.g. external social/family responsibilities that must be balanced), ability to backfill PT staffing to attend CPD, timing and duration of CPD (e.g. on a weekend, weekday, etc.), location of CPD (i.e. how much travel is required and the associated costs of travelling), and the relevance of available course topics to PTs' respective area(s) of interest.

Travel for CPD

The environmental scan conducted at the beginning of the study revealed most CPD in BC was located in urban centres (i.e. the Lower Mainland or in Victoria). This was corroborated by the survey findings, which showed approximately two-thirds of PTs travelled over 100 km at least once within the past three years to participate in CPD. Further analysis revealed almost one-half of rural PTs had to travel more than 100 km 76% to 100% of the time to attend CPD activities, whereas less than one-quarter of urban PTs travelled the same frequency. This suggests a greater onus for rural-based PTs to travel in order to access CPD programming, in comparison to urban-based PTs.

Costs of CPD

Although, as previously mentioned, findings showed more rural-based PTs travelled a greater percentage of time to access CPD, there were no significant differences between rural and urban-based PTs with respect to expenses they expected to pay to access CPD. These expenses included payment for a one-day CPD activity of clinical content, lost income (per day), and travel and accommodation expenses. Interestingly, many of the qualitative comments from rural PTs indicated their location of practice was a barrier because travel and expenses are higher when coming from rural areas and less CPD courses are available locally, yet many rural PTs continue to travel to attend courses in spite of these barriers.

With respect to PTs in the public and private sector, there also were no statistically significant differences in attitudes towards expenses expected to pay for a one-day CPD activity of clinical content or for travel and accommodation expenses. Despite this finding, there were differences observed in the extent to which cost of CPD (i.e. registration, travel) was seen as a barrier to CPD participation between public and private-based PTs. Specifically, more PTs in the public sector indicated the cost of CPD (i.e. registration and travel) was more frequently a barrier to participation in comparison to PTs working in the private sector, despite more PTs in the public sector having workplaces that supported them by providing funds for CPD.

Differences were observed with respect to expected lost income (per day). Specifically, just under two-thirds of PTs in the private sector expected to experience lost income of $301 or more per day when participating in CPD, compared to substantially fewer (less than one-quarter) of public-based PTs who felt the same. Looking at PTs' barriers to participating in CPD, it was surprising to find a similar number (approximately just over one-half) of both public and private-sector PTs who found the cost of CPD (i.e. loss of income) to be more frequently a barrier to CPD participation. This indicates a substantial percentage of both public and private sector PTs find the cost of CPD (i.e. loss of income) to be a barrier that may impact CPD participation, however, the data also showed that more private-sector PTs expect the loss to be greater compared to PTs in the public sector. This difference likely comes from the fact that public PTs often get more workplace support for attending CPD during work hours (paid), while private PTs must take time off from clinical practice to attend CPD.

4. CPD Preferences and Learning Needs

Format

This survey asked PTs about their preferences and learning needs, including what formats of CPD they prefer. Preference levels were higher for clinical hands-on courses, followed by self-study (e.g. conducting literature review and accessing clinical resources), mentoring, self-paced online activity (i.e. online module), small group sessions (e.g. journal club), and lectures. The specific findings on preference levels suggest PTs have a higher preference for activities that are individually-based or that have smaller participant sizes, in comparison to larger formats such as conferences. These are arguably a comparison between CPD that is more focused on skills development (i.e. activities with smaller participant sizes offering more hands-on approach) versus CPD that is more focused on knowledge dissemination (i.e. activities that are larger-sized focused on transferring knowledge).

The findings identified differences in preferred CPD formats according to PTs geographic location, sector of practice, and year of graduation. For example, urban PTs showed a higher preference for lectures in comparison to rural PTs. Additionally, rural-based PTs demonstrated higher preference for live videoconferences and live online sessions (e.g. webinars) in comparison to urban-based PTs, possibly because of the ease of access from rural locations without needing to travel.

With respect to sector of practice, although overall preference level for clinical hands-on courses was high for all PTs, preference levels were moderately higher for PTs in the private sector. Further, PTs in the public sector had higher preference levels for conference and lectures.

Graduation year from PT training appeared to influence preferred CPD formats, with the more recently graduated PTs having higher preference for clinical hands-on courses and mentoring CPD.

Interpretation of the above findings on CPD format preference needs to consider the occasional disconnect between how an individual prefers to engage in CPD, versus the realities of what formats are available within the context of their practice or geographic location, and how frequently those formats are made available.

Identifying Learning Needs

Findings identified influences on how PTs identified their learning needs. Specifically, over three-quarters of PTs indicated the following factors as influential in their decision making regarding CPD: reflective practice, collegial discussions, patient encounters, and emerging practice. Few PTs indicated that processes such as the CPTBC self-report or workplace performance reviews influenced their determination of learning needs.

As the majority of influences on identifying learning needs were internally motivated, these findings support the notion that most PTs have an intrinsic desire to learn and that few participate in CPD as a reactionary response to external drivers or requirements.

5. Barriers to CPD

Within this needs assessment, the cost of CPD was found to be a barrier for the majority of PTs, with registration and travel more of a barrier than loss of income from participating in CPD. The majority of PTs also found social/family obligations and professional obligations (e.g. work commitments or time away from practice) to be barriers to participating in CPD. By comparison, less than one-half of PTs indicated factors such as the availability of CPD that matched interest, length/duration of CPD, or the availability of childcare were barriers to CPD participation.

More mid-career PTs (i.e. graduated 1990-1999) found social/family obligations to be a barrier to CPD participation in comparison to early-career (graduated 2000-2009), late-career (graduated 1989 or early) and recent graduates (graduated 2010 or later). Approximately one-third of early-career and mid-career PTs found the availability of childcare to be a frequent barrier, whereas few recent graduates or late-career PTs indicated the same.

A substantially higher cohort of PTs working part-time found social/family obligations and the availability of childcare to be frequent barriers to participation. By comparison, a higher cohort of PTs working full-time found professional obligations to be barriers to participation. These findings indicate that scheduling of CPD needs to consider work schedules for full time PTs and external competing interests for part time PTs.

Further analysis of the data did not yield any statistically significant differences in the attitudes of urban and rural-based PTs with respect to the extent to which factors listed in the survey were barriers to participation.

6. Enablers to CPD

Influential Factors

There were several factors the majority of PTs reported that frequently influenced their decision to participate in CPD. These included: topic area/learning objectives, an intrinsic desire to learn, desire to extend/change skills and knowledge or area of practice, a belief that CPD improves practice, desire to fill a gap in knowledge, the location of the CPD activity, and factors about the presenter.

There were no statistically significant differences in the attitudes of public and private-sector PTs with regards to the extent to which topic area influenced participation. As reported earlier, more PTs in the private sector preferred clinical hands-on courses and more PTs in the public sector preferred conferences and lectures. These differences suggest that format of CPD is as important, if not more important than topic/content of CPD delivered.

The location of CPD was frequently a barrier for a slightly larger cohort of PTs working part-time, than those working full-time. Further, rural and urban-based PTs shared similar attitudes in the extent to which the location of CPD influenced participation.

The results showed credentialing/certification offered influenced approximately one-third of PTs to participate in CPD, with approximately half of PTs early in their career being influenced by this factor. This suggests that credentialing/certification opportunities appear to be a higher driver for early-career PTs.

Impactful CPD

When asked what CPD topics had the most impact on their practice over the past three years, the most commonly identified clinical topics included orthopaedic/musculoskeletal/neuromuscular, neurology, acupuncture and IMS, sports/exercise, or paediatrics, with a smaller number of professional topics mentioned (e.g. research methods or leadership skills). Further, when asked to rate their level of interest in participating in certain CPD activities, most PTs indicated they were moderately or very interested in CPD on clinical content (e.g. spinal manipulation, treatment of stroke) and/or enhanced skills in evidence-informed practice. In comparison, interest in participating in CPD on professional content, educating/supervising PT students, or on boundary issues were considerably lower.

When asked what made a CPD activity impactful on their practice, the most common response was that the activity had clinical relevance or practical application. Other reasons frequently cited included the format content was delivered in, positive factors about the presenter (e.g. level of expertise or presentation skills), and that the CPD activity was evidence-based. The fact that CPD with clinical relevance was seen as the most impactful is consistent with the fact that clinical topics were seen as more popular than professional content topics.

7. Use of technology

The majority of PTs were proficient at an intermediate or expert level in technologies such as computers, tablets, and smartphones. These technologies were often used in clinical practice, with over two-thirds using technology to access education online, to access protocols or guidelines, and to access evidence of effectiveness of interventions.

Additionally, many qualitative comments indicated the importance of technology in learning and CPD attendance. Webinars and online courses were seen as important (especially for those practicing in rural areas) because of ease of access with no cost or travel requirements.

8. Finding out about CPD

When asked how they found out about upcoming CPD, over one-half of PTs relied on PABC, colleagues, independent course providers, and/or the CPA. Additionally, almost all PTs identified email as a preferred method for finding out about upcoming CPD activities.

9. Payment for CPD

Almost all PTs directly absorb at least some of the cost (i.e. tuition/registration fees) associated with CPD , with slightly more than one-half paying CPD tuition/registration costs themselves and just under one-third sharing payment with their workplace. Few PTs indicated their workplace paid the entire cost associated with CPD participation. In general, PTs working in the private sector were more likely to pay tuition/registrations fees for CPD activities they attended with their own money than those working in the public sector, while those in the public sector were more likely to share payment with their workplace. Interestingly, PTs in the private sector, who paid for more CPD with their own money and received less financial support from their workplaces, were more satisfied with workplace support of CPD than PTs working in the public sector who paid with less of their own money and received more financial support from their workplaces.

10. Further Involvement in CPD

PTs' involvement in CPD included slightly more than one-third being involved in teaching or supervising a PT student, and one-quarter were involved in developing, organizing, and/or teaching CPD. PTs involved in teaching or supervising a PT student were more likely to be working in the public sector and in full-time practice. They were also more likely to be working in a general hospital, rehabilitation hospital, or a hospital facility. PTs in their early, mid or late career were more likely to be involved in teaching or supervising a PT student in comparison to recent graduates, and there were no statistically significant differences between rural or urban-based PTs in their involvement in teaching or supervising a PT student.

The scope of roles for those involved in developing organizing, or teaching CPD mostly focused on teaching/facilitating education, organizing/developing educational activities, mentoring, and providing in-services or case studies in the workplace.

In interpreting the above findings, it is important to note few PTs described their primary role as education-based, with most indicating clinical practice (i.e. direct patient care) as their primary role. This suggests PTs involved in teaching or organizing CPD activities are doing so above and beyond their primary physiotherapy role. This is an indication that there are opportunities to grow capacity within the PT profession in BC to increase the number of PTs acting as clinical educators in teaching or supervising PT students.

These results indicate that faculty development is an important component for the physiotherapy profession, and in particular within the auspices of supporting those PTs who are involved in teaching/supervising PT students, and/or developing, organizing, teaching CPD.

11. Interprofessional Education Opportunities in CPD

PTs were engaged and interested in attending CPD with other health care professionals (HCPs). One-third frequently participated in CPD with other HCPs such as occupational therapists, physicians, nurses, massage therapists, or chiropractors on clinical (e.g. orthopaedics/ musculoskeletal/neuromuscular, neurology, sports/exercise, etc.) and professional (e.g. business skills, client management, communication skills, etc.) content areas. Further, most PTs were interested in participating in CPD with other HCPs in the future, an indication of the opportunity to integrate domains within the Canadian Interprofessional Health Collaborative Practice Competency Framework (e.g. fostering interpersonal and communication skills, patient-centred care, and collaborative practice) into CPD programming.

The findings also showed that while the majority of PTs in the public and private sectors were interested in attending CPD with other HCPs, interest levels for public-based PTs (who often worked in a hospital setting with a greater presence of other HCPs) were not substantially higher than those in the private-sector. This is an indication that interest in participating in CPD with other HCPs is not primarily influenced by working in the same setting as other HCPs, but rather, an intrinsic interest within the BC physiotherapy profession to engage in professional learning with colleagues in other disciplines.

12. Expertise in CPD

PTs provided the names of PTs they felt had clinical and/or teaching expertise in specific areas of practice. This generated an inventory of expertise in CPD across a number of clinical areas, with the most frequently mentioned areas of expertise being: orthopaedic/musculoskeletal/neuromuscular, neurology, and pediatrics. Frequently mentioned experts were Carol Kennedy, Diane Lee, Deb Treloar, Libby Swain, and Linda-Joy Lee. Several other areas of expertise and identified experts are provided within the report. It is important note that these results may be based on what is available and familiar to PTs. Along these same lines, while the most frequently mentioned experts work in orthopaedics, it is important to ensure that less mentioned specialty areas are not overlooked and to realize the lack of experts in those fields is an indication that more work may be needed within the physiotherapy profession to grow faculty capacity in those areas.

D. Synthesized Findings and Recommendations

Synthesized findings and recommendations are directed towards stakeholder organizations involved in the development and delivery of CPD for physiotherapists in British Columbia. They are grouped into six categories, addressing key findings from the Needs Assessment results.

1. Centralizing CPD

The UBC Faculty of Medicine (FoM) has a mandate to provide and support all departments and divisions of health care professionals (e.g. physicians, physiotherapists, occupational therapists, etc.) within the FoM. There is also a high priority for interprofessional learning within FoM's mandate.

1.1 Consider how one common neutral provincial body could support CPD for PTs by formalizing links between PT organizations and an academic institution.

> **1.1.1 Discuss** the potential to create networks to share processes and resources (e.g. developing content, sharing contact lists, databases and registration systems, videoconferencing facilities, learning venues, evaluation tools, etc.) as a more efficient and centralized way of providing CPD for PTs.
>
> **1.1.2 Recruit** a CPD coordinator in the UBC Faculty of Medicine's Division of Continuing Professional Development specifically for Physical Therapy CPD, with the goal of effectively and efficiently coordinating this collective effort.

2. Standards in CPD

Note: There are no formal CPD requirements for physiotherapy professionals across Canada, however, a large number of PTs who completed this Needs Assessment suggested that CPD should be more regulated and be required for licensure similar to other health professions.

2.1 Form a provincial working group to explore outlining CPD expectations and requirements for physiotherapists that would include representatives from CPTBC, PABC, CPA, and other identified stakeholder groups, including practicing PTs.

> **2.1.1 Clarify** and educate PTs on the continuing competency requirements and standards for PTs in BC and develop metrics to allow PTs to gauge appropriateness of their current level of CPD participation in a typical year for their area of practice.
>
> **2.1.2 Explore** the possibility of establishing standards for CPD content in order to facilitate evaluation of learning across a diverse landscape of CPD providers and courses.

2.2 Clarify the expectations of PTs associated with participation in the CPTBC's Quality Assurance Program (QAP) and how CPD can be a tool to drive professional focus.

> **2.2.1 Offer** in-person and technology facilitated information sessions (e.g. 'Town Hall' Meetings) and engagement strategies to create awareness and increase familiarity with aforementioned expectations and further address questions, concerns, or comments PTs may have about the QAP.

3. Strategies to Engage Physiotherapists in CPD

3.1 Increase the geographic distribution (i.e. 'close to home') of in-person CPD offered beyond the lower mainland or Victoria to facilitate local PT participation and reduce costs and time associated with travel for CPD.

3.2 Increase the availability of CPD activities which are shorter in duration and align with PTs schedules in order to facilitate increased participation.

3.3 Emphasize the direct practical benefits for learners and their patients to increase interest and participation.

3.4 Communicate with PTs through email and realize that PTs look to PABC, colleagues, independent course providers, and the CPA to find out about CPD opportunities.

3.5 Encourage workplaces in the private and public practice domains to investigate how they can better support PTs participation in CPD (e.g. increasing staff and locum coverage).

> **3.5.1 Facilitate** opportunities for PTs to participate in CPD during work hours (e.g. 'lunch and learn' sessions) to address any professional obligations that may hinder participation.

3.6 Establish learning networks across areas of clinical interest to allow PTs to create collegial networks so evidence-based knowledge and skills continues to be integrated into practice.

3.7 Expand opportunities for PTs to participate in CPD on clinical topic areas with other health professionals (e.g. OTs, physicians, nurses, etc.), which focuses on content that:

> **3.7.1 Promotes** active participation among healthcare professionals; enhances patient safety; fosters respect, communication, and understanding professional roles.

3.8 Develop readily accessible tools to support PT documentation of CPD learning needs as they are realized through reflective practice, collegial discussions, practice encounters, and/or emerging practice areas.

3.9 Connect PTs to reputable online resources where they can access clinical practice protocols, guidelines and evidence about effective (i.e. best practice) interventions.

> **3.9.1 Continue** current efforts to support those less experienced with technology with clear, concise, and easy to access tutorials on engaging in technology-based CPD.

4. Designing CPD Responsive to Needs of Physiotherapists

4.1 Share findings on PTs top preferred content areas with CPD educators and encourage providers to continue to integrate these identified needs into educational programming.

- Clinical: orthopaedics/neuromuscular/musculoskeletal; neurology; sports/exercise; pain management; paediatrics.
- Professional: clinical skills (e.g. charting); business skills (e.g. financial management, managing office staff, searching for literature, etc.), communication skills (e.g. conflict management, etc.); as well as client management (e.g. motivating clients, managing difficult clients, etc.).

4.1.1 Consider the relevant clinical content as perceived needs that CPD educators can use to draw PTs into interest in other topics that are considered more of an unperceived need (e.g. communication skills, etc.).
4.1.2 Investigate the possibility of a formal accreditation structure and process to accredit CPD courses for PTs (e.g. awarding study credits) which may be required for licensure.

4.2 Design and evaluate impactful evidence-informed CPD programming that:
4.2.1 Demonstrates the clinical relevance, practical usage of lessons learned or describes how practice will be improved.
4.2.2 Utilize speakers identified in the province-wide survey that PTs viewed as experts in areas of physiotherapy as a way to engage PTs in CPD.
4.2.3 Continue building this inventory in order to increase the number of champions engaged in educational delivery for PT students and practicing PTs.

4.3 Ensure format of CPD is tailored to meet learning preferences for PTs and follows best practices in continuing education (e.g. adult learning principles).
4.3.1 Continue to utilize CPD formats such as clinical hands-on courses, conference, and expand CPD offerings to include lesser utilized formats (e.g. live and recorded online sessions) that are readily accessible for the individual PT.

5. Funding Strategies

5.1 Encourage professional organizations such as PABC and CPTBC to advocate at the government levels for CPD funding for PTs in order to support programs and subsidize individual costs and level the playing field amongst all health care professionals.

5.2 Develop a provincial framework involving employers, physiotherapy organizations, and the government to explore funding strategies and models to support PT participation in CPD similar to other healthcare professionals including medicine (e.g. Physician Master Agreement), pharmacy, nursing, etc.

5.3 Mitigate high costs to the individual learner who participates in CPD activities (e.g. tuition) by:
5.3.1Exploring ways to provide lower costs delivery models (technology-enabled learning).
5.3.2 Working more with non-profit organizations with an educational mandate over independent course providers.

6. Linkages between Faculty Development and CPD

6.1 Realize there are key linkages between faculty development and CPD in terms of ensuring that clinical faculty supervising PT students are up to date with clinical practice.

- **6.1.1 Offer** CPD and faculty development to clinical faculty in order to enhance skills of PTs already involved in teaching or supervising PT students.
- **6.1.2 Support** PTs teaching and supervising PT student(s) in an ongoing way by providing paper-based and online tools and resources.
- **6.1.3 Recognize** that there is an opportunity to provide faculty development in order to draw and engage the large percentage of PTs who are not currently involved teaching PT students.
- **6.1.4 Identify** experienced PTs who may be interested in acting as supervisors for students and mentors for PTs new to practice and focus these efforts in rural areas in order to build capacity.

E. Summary

This needs assessment of CPD for PTs in BC is the first of its kind and provides a thorough overview of the CPD landscape, attitudes, and practices towards CPD. Most of the PTs thought CPD was important for practice with many suggesting it should be made mandatory as a requirement for licensure for the profession. Overall, more PTs preferred CPD in the format of clinical hands-on courses and self-study, with urban-based PTs preferring lectures, and rural-based PTs preferring live videoconferences and webinars. More than half of PTs indicated barriers to attending CPD included cost of CPD (i.e. registration, travel), social/family obligations, professional obligations, and cost of CPD (i.e. loss of income). No significant differences in barriers were observed between rural and urban-based PTs; however, more PTs in the public sector found the cost of CPD (registration, travel) to be a barrier to CPD than PTs in the private sector. Elements that motivated over two-thirds of PTs to participate in CPD were topic area/learning objectives, an intrinsic desire to learn, extend/change skills and knowledge or area of practice, belief that CPD improves practice, to fill a gap in knowledge, the location of the CPD activity, and the presenter. Over three-quarters of PTs identified their CPD learning needs through reflective practice, collegial discussions, patient encounters, or emerging practice. Qualities of CPD that PTs find impactful to practice are clinically relevant, evidence-based, and utilize effective presenters and formats. Approximately one-third were involved in teaching or supervising a PT student. Over three-quarters of PTs indicated they were interested in participating in CPD with other health care practitioners in the future. Most PTs had access to technology in clinical practice; however, less than one-half use it in clinical practice to access patient charts, clinical decision aids or to conduct patient assessments.

This study gave insight into implications and directions to meet CPD needs of PTs. The results offered suggestions for improving the organization and delivery of CPD for PTs in BC including: developing and making more CPD available, tailoring the format of CPD to match learning preferences and needs, increasing the geographic distribution of CPD offered, using technology to make CPD more accessible, encouraging workplaces to consider how they can better support PTs participation in CPD, increasing the availability of CPD activities that are shorter in duration, expanding interprofessional learning opportunities, offering mentorship to foster reflection and informal learning spaces, considering professional content such as practice management and dealing with challenging patients so that CPD is not solely focused on the clinical, and establishing a collaborative network of organizations that offer CPD as shared model to increase efficiencies and create standards.

While much information was collected through this needs assessment, there is room for further study and investigation into data that was not collected such as ways to improve CPD for PTs as well as how patient outcomes are impacted. Following-up with key stakeholders and the recommendations is an important step in improving CPD for PTs in BC.