The Role and Load of the Athletic Training Clinical Education Coordinator

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Context: The position of clinical education coordinator has been identified as a required one in athletic training education. However, the literature has yet to address the job responsibilities of clinical education coordinators and the commensurate work load/release time needed to accomplish these responsibilities in athletic training education.

Objective: To determine the current practices of clinical education coordinators in athletic training program, their current load compensation, whether or not they feel their load compensation is appropriate, and what their ideal load compensation should be.

Design: Mixed methods.

Setting: Commission on Accreditation of Athletic Training Education-accredited education programs.

Patients or Other Participants: A total of 120 clinical education coordinators.

Main Outcome Measure(s): A survey was administered including both quantitative and qualitative questions. Quantitative data were analyzed statistically and qualitative data were analyzed using an inductive approach, revealing themes.

Results: Statistically significant differences were found when comparing tenure with clinical track in the areas of scholarship and athletic training room coverage. Common job responsibilities for the clinical education coordinator were identified. The study also identified the current and perceived ideal load/release credit for clinical education coordinators based on their program size.

Conclusions: Clinical education coordinators are incredibly valuable to all athletic training education programs. This study attempted to solidify their value through identifying job responsibilities and load credit criteria to ensure quality clinical education experiences for students.

Key Words: Workload, responsibilities, management

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INTRODUCTION

Clinical education in athletic training professional programs has been recognized as vital to student learning and development, student retention, and student persistence.^{1,2} The quality of clinical education and athletic training student experiences is the responsibility of both the clinical education coordinator (CEC) and the program director (PD). The Commission on Accreditation of Athletic Training Education (CAATE) standards³ identify the CEC as a faculty member (the PD or other duly appointed faculty) who must be allowed release/reassigned workload to meet the institutional responsibilities for clinical education. The CAATE identifies the responsibilities of the CEC to include student clinical progression, clinical site evaluation, student evaluation, preceptor training, and preceptor evaluation. The CAATE standards also require a minimum of 1 full-time faculty member dedicated (100%) to the athletic training program in addition to the $PD.^3$

Other allied health education programs, such as nursing, physical therapy, and physician assistant programs, define their CEC position as clinical coordinator, clinical placement coordinator, academic coordinator of clinical education, or director of clinical education. Their position descriptions include placement, supervision and clinical education, communication and training, supporting and mentoring students, and evaluation.^{4–9} Hawkins¹⁰ suggested CEC was a more suitable title for athletic training than simply clinical coordinator, as CECs are responsible both for coordinating preceptors. Gage et al¹¹ suggested that the CEC in athletic training is responsible for the clinical education program and should spend a minimum of 2 hours per week visiting clinical sites with the appropriately recognized release time.

In 2009, Hoch et al¹² surveyed accredited PDs and CECs. At the time of the survey, there were 358 entry-level athletic training programs, and of those, 143 had both a CEC and a PD. The PDs in the study reported increasing productivity when they were able to delegate tasks to other members of the athletic training program, yet CECs felt empowered only 59% of the time when completing the assigned tasks. Without clearly identifying the job responsibilities of the CEC beyond CAATE's recommendations, CECs will continue to lack a foundational understanding of job expectations and will continue to struggle without legitimizing their role within athletic training programs.

Currently there is no research to support the actual duties of the CEC in athletic training programs. Additionally, there is no research defining the appropriate load for an athletic training CEC. It is essential to understand CECs' current practice as defined by their job responsibilities and both their current and perceived ideal workload. Other variables can also impact the role and load of CECs, including the program size, their responsibilities to the university overall, and whether they are clinical track or tenure track. The purpose of this investigation was to determine the current practices of CECs in athletic training programs. Secondarily, the purpose of the study to was determine their load compensation, whether or not they felt their load compensation was appropriate, and what their ideal load compensation should be.

METHODS

Participants

The electronic survey was sent to the CEC or PD of 382 athletic training programs via e-mail. Accredited athletic training programs were identified via the CAATE Web site and included both bachelor's and master's professional programs. A review of these program Web sites identified the CEC for 208 of the 382 programs. If the CEC was not specified on the program Web site, then the survey was sent to the PD. The survey requested the PD complete the survey if the PD fulfilled the responsibilities of a CEC, or else forward the survey to whoever had those assigned duties at the PD's institution. In the end, 382 individuals were e-mailed a request to participate in the study. One hundred thirty-six CECs responded to the survey, with 120 CECs fully completing the survey (31.4%). The majority of respondents were female, holding at least a master's degree. Demographic information is presented in Table 1. To articulate the size of the CECs' programs, the average number of students and the number of visits per year for the CEC were calculated (Table 2).

Instrumentation

After extensive review of the literature regarding the job responsibilities and load of CECs in other allied health professional education programs, a survey instrument was

Table 1. Demographics of Clinical EducationCoordinators

Variable	No.	%
Sex		
Male	53	44.2
Female	67	55.8
Degree ^a		
Masters	61	50.8
Terminal	41	34.2
Contract type ^a		
Tenure track	50	41.7
Clinical track	60	50.0
Athletic affiliation ^a		
NCAA Division I	39	32.5
NCAA Division II	28	23.3
NCAA Division III	27	22.5
NAIA	7	05.8
Total respondents	120	

Abbreviations: NAIA, National Association of Intercollegiate Athletics; NCAA, National Collegiate Athletic Association.

^a Some respondents chose not to answer all of the demographic questions.

Variable	Mean \pm SD	Median	Range
Students	$\begin{array}{r} 39.01 \pm 19.98 \\ 27.52 \pm 37.56 \end{array}$	36	93
Site visits		18	268

created to identify the duties, responsibilities, load, and perceived ideal load for the CEC. One former and 1 current CEC for athletic training reviewed the survey for clarity and accuracy. The survey was designed to identify the size of the athletic training program based on number of students and number of clinical sites, the duties of the CEC, load and compensation for CEC responsibilities, perceived ideal load, and views on the value of the CEC in an athletic training professional or postprofessional program (Table 3).

Analysis

Participant data were exported from SurveyMonkey (PRO, SurveyMonkey, San Mateo, CA) into Microsoft Excel (version 14.0; Microsoft Office Professional Plus 10; Microsoft, Redmond, WA) and then into SPSS Data Analysis Software (version 15.0; SPSS Inc, Chicago, IL). Descriptive statistics were used to determine means, standard deviations, and frequencies. Univariate, bivariate, and multivariate analyses of variance were conducted to assess associations between demographic groups, including sex and tenure versus clinical track, and subscale scores. A Pearson product moment correlation coefficient with an a priori .05 α level was used.

The responses to the open-ended questions were compiled under each question. Two qualitative researchers read the responses independently to gain familiarity with the responses and independently conducted an inductive analysis to identify emerging themes. During the independent analyses, each idea was given a 1- or 2-word description, or code. At the end of the coding, common codes were then combined and tallied to identify prevalent, common themes throughout the responses. Both researchers collaborated at length on the findings to identify similarities within the data. After deliberate and careful review, complete agreement was reached on the common codes and 3 themes that emerged from the data.

RESULTS

Of the 120 CECs who participated in the study, 109 identified 10 or more duties as part of their job description. The mean number of duties was 11.63 ± 1.85 , with a median of 12 and mode of 13 (Table 4). The most common duties included conducting site visits, managing clinical education assessment, maintaining clinical site paperwork, performing conflict resolution, and facilitating preceptor training. The CECs in the study were asked to report their loads (in percentages adding up to 100) for teaching, CEC, athletic training coverage, scholarship, and any additional duties. For each category, means were calculated by averaging the percentages for those that identified the category as part of their responsibility. The CEC mean load distribution based on percentage, of those who identified a category as part of their job, was teaching $59.76\% \pm 18.11\%$ (119 of the 120 respondents identified teaching as part of their responsibilities), clinical coordinator load $26.05\% \pm 11.84\%$ (116 of the

Table 3. List of Survey Questions

- What are the number of students enrolled in your athletic training program (ATP) and in a clinical site placement?
- How many clinical sites do you have in your ATP program and how many site visits do you perform annually?
- Please select all duties that apply to the clinical educator coordinator:
 - Schedule student observations
 - Coordinate schedules with clinical sites
 - Develop and maintain clinical contracts
 - Maintain clinical site records
 - Maintain student clinical education paperwork
 - Conduct site visits
 - Log and maintain student clinical experiences and hours Manage student clinical assessments
 - Manage preceptor assessments
 - Manage clinical site assessments
 - Perform conflict resolution
 - Perform preceptor training
 - Perform preceptor retraining
- What is your load (in percentages) for a) teaching, b) clinical education coordinator, c) sport coverage, d) any additional administrative duties (should add up to 100%)?
- Do you feel you are being appropriately compensated for your clinical education coordinator duties? Please explain.
- What do you feel is an appropriate load for the clinical education coordinator duties? (%) Please feel free to elaborate.
- How does the clinical education coordinator position impact the quality of athletic training student education? Please elaborate.

120 respondents identified a load for CEC), athletic training coverage 27.09% \pm 13.91% (34 of the 120 respondents identified athletic training coverage as part of their responsibilities), service to the university 13.51% \pm 12.11% (35 of the 120 respondents identified service to the university as part of their responsibilities), and scholarship 12.86% \pm 10.10% (20

Table 4.Clinical Education CoordinatorResponsibilities

Variable	No.	%
Conduct site visits	119	97.54
Manage preceptor assessments	118	96.72
Manage clinical site assessments	118	96.72
Manage student clinical assessments	117	95.90
Perform conflict resolution	116	95.08
Maintain clinical site records	114	93.44
Perform preceptor training	113	92.62
Conduct preceptor retraining	111	90.98
Maintain student clinical education paperwork	110	90.16
Coordinate schedules with clinical sites	100	81.97
Develop and maintain clinical contracts	96	78.96
Schedule student observations	92	75.41
Log and maintain student clinical experiences		
and hours	94	77.05
Total respondents	120	

Table 5. Clinical Education Coordinator Load Percenta

Variable	Teaching, Mean ± SD, %	Clinical Coordinator, Mean ± SD, %	$\begin{array}{l} \mbox{Athletic Training Duties,} \\ \mbox{Mean} \ \pm \ \mbox{SD}, \ \mbox{\%} \end{array}$	Service, Mean ± SD, %	Scholarship, Mean \pm SD, %
Sex					
Female	60.89 ± 17.30	27.67 ± 12.38	29.92 ± 14.55	18.38 ± 14.39	16.25 ± 9.97
Male	57.93 ± 19.29	24.67 ± 11.11	28.95 ± 14.18	16.75 ± 9.87	14.25 ± 10.68
Contract type					
Tenure track	62.25 ± 16.47	23.99 ± 9.49	25.29 ± 8.34	15.00 ± 10.54	18.28 ± 10.32
Clinical track	56.02 ± 19.59	27.43 ± 12.88	33.28 ± 16.80	19.63 ± 13.57	7.50 ± 2.74
Institution type					
NCAA Division I	58.87 ± 19.63	26.31 ± 12.07	29.78 ± 16.89	16.25 ± 7.19	17.96 ± 10.17
NCAA Division II	63.90 ± 15.92	23.69 ± 7.89	27.86 ± 9.94	21.00 ± 16.73	9.50 ± 4.47
NCAA Division III	57.78 ± 18.21	27.89 ± 11.85	30.63 ± 12.08	17.08 ± 13.05	10.00 ± 7.07
NAIA	55.71 ± 19.88	25.00 ± 12.58	23.75 ± 2.50	24.17 ± 22.41	12.50 ± 0.00

Abbreviations: NAIA, National Association of Intercollegiate Athletics; NCAA, National Collegiate Athletic Association.

of the 120 respondents identified scholarship as part of their responsibilities; Table 5).

Quantitative Findings

Using univariate and multivariate analyses of variance, there was no statistically significant difference found when comparing sex in teaching load ($F_{1,120} = .405$, P = .39), clinical coordinator load ($F_{1,120} = .434$, P = .17), athletic training coverage ($F_{1,120} = .890$, P = .85), service ($F_{1,120} = .134$, P = .70), or scholarship ($F_{1,120} = .817$, P = .66). There were statistically significant differences in the athletic training coverage load between tenure track (25.29 ± 8.34) and clinical track (33.28 ± 16.80 ; $F_{1,30} = 12.983$, P = .001) and in the scholarship load between tenure track (18.28 ± 10.32) and clinical track (7.50 ± 2.74 ; $F_{1,29} = 9.575$, P = .006). There were no statistically significant differences between tenure track and clinical track in teaching responsibilities ($F_{1,106} = 1.225$, P = .271), clinical coordinator responsibilities ($F_{1,103} = 7.244$, P = .119), or service ($F_{1,32} = .236$, P = .631).

Overall, the CECs who participated in the survey identified an ideal load release percentage of 36.84 ± 15.83 , regardless of

Table 6.Clinical Coordinator Perceived IdealCompensation (Based on Load Percentage)

Variable	Load Compensation, Mean \pm SD, %
Overall (N = 120)	
Mean	36.84 ± 15.83
Median	30.00
Mode	25.00
Sex	
Female	38.48 ± 16.39
Male	35.00 ± 14.57
Contract type	
Tenure track	33.71 ± 13.53
Clinical track	38.34 ± 17.21
Size of athletic training program,	
No. students enrolled ^a	00.45 + 40.04
\leq 36	32.45 ± 12.61
>37	41.02 ± 17.60
^a Statistically significant at $P = .005$.	

the size of the program. When comparing the size of the program, there were a significant difference at or above the median (Table 6). The median size of the athletic training programs reported in the study was 36 students. The median size of the athletic training program was also the predictor of ideal percentages for load compensation. If the athletic training program had 35 students or less, the ideal compensation was $32.45\% \pm 12.61\%$, compared with $41.02\% \pm 17.60\%$ for programs with 36 students or more ($F_{1,103} = 11.441$, P = .005).

Finally, 117 of the 120 responded to the question, "Do you feel you are being appropriately compensated for your clinical education coordinator duties?" Sixty-eight of the respondents answered no (56.67%) and 52 answered yes (43.33%). When comparing the responses based on sex, 29 men (54.72%) felt they were being compensated appropriately compared and 24 (45.28%) did not. This is in contrast to the women, with only 23 (34.33%) who felt they were appropriately compensated compared with 44 (65.67%) who felt they are not.

Qualitative Findings

One hundred ten participants responded to the question, "How does the clinical education coordinator impact the quality of athletic training student education?" Originally a number of subthemes emerged, which were then categorized into the following 3 themes: ensuring quality experiences, providing communication, and serving as a student mentor (Table 7).

The subthemes included in ensuring quality experiences were experiences for growth and development, variety of quality sites, and having highly qualified preceptors. The total number of times the theme of ensuring quality experiences was mentioned in the data was 58. One of the participants commenting on the role of the CEC in ensuring quality experiences stated,

The clinical experience the student receives is based solely on the quality of preceptors that are providing the experiences and in most cases the CEC is responsible for ensuring the student receives quality educational experience while at their clinical rotations with those preceptors.

Table 7. Impact of Clinical Education on Athletic Training Education

Themes	Examples of Responses
Ensuring quality clinical experiences (n = 58)	Promotes learning and student development at clinical placements Impacts the quality and variety of exposures Ensure students are working with quality preceptors that challenge students
Providing communication $(n = 32)$	Consistently monitoring the quality of clinical experiences Liaison between educational program and clinical sites
	Maintain a link between classroom theory and practical application Bridge the gap between athletic training faculty and preceptors Consistent communication between program, preceptors, and students
Student mentoring (n = 22)	Positive role model for athletic training students Advocate for the students during their clinical experiences Regular interaction with students allowing for professional mentoring

Another participant explained, "The CEC guides the preceptors to promote a positive learning environment in conjunction with the students. This includes training, tracking, and following up with outcomes."

The theme of communication was discussed 32 times and included subthemes of liaison between didactic and clinical education and conflict resolution. Several of the participants discussed the responsibility of the CEC as bridging the gap between the clinical education and the classroom. One participant commented, "The CEC impacts clinical education by providing a link between academia and clinical preceptors." In addition, a number of the participants believed CECs were responsible for conflict resolution through effective communication. Specifically, one participant stated, "If the CEC has a good relationship with clinical site staff than any problems that could arise are solved quickly with great communication."

The third theme of student mentor was mentioned 22 different times and included the subtheme of student advocate. One participant stated, "The CEC has a direct hand in each and every ATS that is in the athletic training program." Another added,

I think the CEC should teach the clinical education classes as well as plan and oversee the clinical sites and contracts/ agreements, and all other duties as listed above. In this way, when students have any questions regarding clinical education, the CEC will have all the answers and be the "go-to" person. This will also help with conflict resolution.

Finally, one of the participants believed, "The CEC is there to mentor students and help socialize them into their clinical setting."

DISCUSSION

The value of clinical education has been well documented in athletic training.^{1,2,13–15} Benes et al¹⁵ identified the value of clinical education in providing realistic experiences, awareness of the profession, facilitating positive experiences, and providing diversity in clinical experiences. However, the role of the CEC in facilitating clinical education is not well defined in athletic training education compared with other medical professional education programs, such as nursing, physical

therapy, and physician assistant.^{4–9} This study was designed to determine the roles of CECs in athletic training education programs in more detail than the CAATE standards.³ In addition, this study assessed the load credit CECs receive for clinical education responsibilities.

Role of the CEC

Clinical education coordinators responded to the survey by identifying their job responsibilities. The vast majority of the respondents identified teaching as a responsibility, as well as clinical coordinator duties including site visits, assessments and paperwork, conflict resolution, and preceptor training. This is similar to clinical coordinator duties in nursing educational programs, which include orienting students to clinicals, coordinating placements, monitoring experiences, acting as a liaison, and conducting evaluations.⁹ Clinical coordinators for physician assistant education programs complete a number of tasks as part of their position, including, from highest frequency to lowest, coordinating clinical seminars, scheduling assignments, addressing concerns and answering questions, orienting students, cultivating new clinical sites, and educating preceptors.⁷

Although the duties of the CEC were largely dependent upon their institution, there were a number of similarities in duties across all respondents. All but one of the CECs identified teaching as part of their job responsibilities. The vast majority had part of their load allocated to clinical coordinator duties. A much smaller percentage of CECs were required to perform athletic training coverage, service to the university, and/or scholarship. These duties were dependent on both the individual instructions and the type of institution.

Like teaching, site visits were identified as part of their duties by all but one of the CECs in this study. The CAATE requires that clinical education sites be evaluated on an annual basis and requires annual site visits.³ Similarly, the Council on Accreditation of Nurse Anesthesia Education Programs requires at least 1 on-site visit per year, ensuring quality learning environments for their students.¹⁶ Gage et al¹¹ recommend CECs spend a minimum of 2 hours each week visiting clinical sites, bridging the gap between academic and clinical athletic trainers. Site visits continue to be instrumental in ensuring effective communication, delivery of quality clinical education experiences, and conflict management. Participants in this study highlighted the important role they play in facilitating communication between the academic program and clinical sites. In addition, a number of the participants identified themselves as "mentors" or "liaisons" in ensuring the best experience possible both for the students and for the preceptors.

Another duty the vast majority of CECs in this study identified was managing clinical assessments. Of the 5 responsibilities the CAATE mandates for CECs, 3 are related to evaluation (site, student, and preceptor).³ Clinical education coordinators highlighted facilitating quality experiences as paramount in their responsibilities, as articulated in their qualitative responses. They believe they must monitor clinical education experiences to ensure quality preceptors who facilitate learning and development and to ensure quality experiences that offer a wide array of exposures. Quality experiences are measured and documented through site, student, and preceptor evaluations. These evaluations occur both formally and informally, and are embedded in student and preceptor feedback throughout their experiences.

Feedback is critical to ensuring clinical education effectiveness in medical education programs.¹⁷ Nottingham and Henning¹⁸ identified athletic training clinical education feedback occurring both formally and informally and existing for the benefit of correcting and confirming behaviors and developing knowledge and skills, essential for the professional development of the student. They also looked at the influences of feedback, including individual personalities and the learning environment itself. Nottingham and Henning¹⁹ suggest that CECs recognize and address these potential influences on feedback and then take those into consideration when evaluating and selecting clinical site placements for students.

There are also studies in athletic training addressing the validity, reliability, and quality of evaluating competencies in clinical education using performance assessments.^{20–22} However, the literature is lacking in valid and reliable tools to evaluate the effectiveness of the preceptors, their clinical sites, and even the CEC. In nursing education, Altman²³ provided preceptor selection criteria, orientation requirements, and an evaluation tool for preceptors. There is a similar model in a pharmacy residency program.²⁴

Conflict Resolution

The CECs in this study identified conflict resolution as part of their job responsibilities. Clinical coordinators from other medical professional programs have identified conflict resolution as part of their job responsibility, including addressing concerns from preceptors and students, managing disciplinary actions, and resolving conflict.^{7,8} Clinical education coordinators must facilitate mediation when there is a conflict between the preceptor and the student or when the student is behaving unprofessionally. Athletic trainers in clinical settings, in athletic settings, and in education programs all deal with relationships that can lead to potential conflict.²⁵ Clinical education coordinators in this study see themselves as advocates and mentors for students during their clinical experiences. In cases of student concerns expressed by either the preceptor or the student, CECs must mentor students through conflict resolution. Student concerns requiring mentoring are typically identified through poor evaluations, site visits, and other lines of communication. Conflict

resolution policies and practices should be implemented by the CEC to mediate the situation,²⁵ document the incident in the student's file, and communicate the incident and possible remediation plan with the athletic training PD. Depending on the size of the athletic training education program, conflict resolution can be a time-intensive responsibility.

Preceptor Training

The majority of the CECs in the survey identified preceptor training as part of their job responsibility. The CAATE requires the CEC to be responsible for preceptor training. In addition, the CAATE dictates, "A preceptor must receive planned and ongoing education from the program designed to promote a constructive learning environment."³ In order for CECs to educate preceptors on how to develop an effective learning environment, they must first educate themselves on best practices in clinical education. Although the literature in athletic training clinical education is growing, foundational knowledge in clinical instruction is also found in other medical education literature.

Once the content of the preceptor training is determined to promote learning in the clinical setting, the CEC must then determine the structure of preceptor training. One recent recommendation in the athletic training education literature is preceptor training through clinical conferencing. Groh²⁶ offers a 3-step model involving an initial conference between the CEC and the preceptor, then a clinical experience observation, and finally a follow-up feedback conference. This model offers collaboration between the academic program and the practitioner. The development and facilitation of preceptor training to ensure best practices in clinical education is an important responsibility of the CEC and one that could consume the CEC's time. A job description for CECs is provided in Table 8.

Load of the CEC

The CAATE mandates that CECs receive "release/reassigned workload" to fulfill the responsibilities of the clinical education program.³ One hundred sixteen of the 120 participants in the current study receive a separate load for CEC responsibilities. There is currently no published recommendation for the ideal load credit for clinical coordinator responsibilities. Perhaps because no standard formula exists for compensation, more than half of the participants in this study did not feel they were appropriately compensated for their clinical coordinator load. A precise formula is difficult to calculate because of the significant size differences in programs. Based on these survey data, the size of the program seems to be a factor. For example, for programs with 35 or fewer students, the load release could be lower compared with programs with 35 students or more. In addition, the number of clinical affiliate sites the CEC manages and visits could also impact the workload. Further research should be conducted to aid in calculating the appropriate workload for CECs in athletic training programs.

Limitations

This study did not differentiate between undergraduate and master's-level programs. With the move to a master's entrylevel athletic training program, the responsibilities of the CEC

Table 8. Proposed Clinical Education Coordinator JobDescription List

- 1. Maintaining clinical site records and contracts
- 2. Assessing the effectiveness of the clinical site
- 3. Assessing the effectiveness of the clinical preceptor
- 4. Assessing student development in clinical skills and professional attributes
- 5. Conducting preceptor training and ongoing development
- 6. Assigning athletic training students to a variety of quality clinical experiences
- 7. Mentoring and socializing athletic training students into the various clinical settings
- 8. Conducting regularly scheduled site visits
- 9. Acting as the liaison between the clinical sites and the academic program
- 10. Managing conflict resolution

may not change but the size of programs may change, influencing the amount of workload for the CEC. In addition, this study did not differentiate between professional and postprofessional education programs. Finally, this study did not differentiate Carnegie classifications for the participants. The participants were asked their athletic affiliation, and this is an inaccurate classification of an AT program, as it is not a characteristic of the academic environment, limiting this study's ability to draw certain conclusions about CEC responsibilities and load.

CONCLUSIONS

Clinical education is a critical component to athletic training education. The responsibility of ensuring quality clinical education for athletic training students ultimately falls on the CEC. This study identified the responsibilities of the CEC, including selecting appropriate clinical sites, managing contracts and paperwork, training preceptors, assigning the appropriate students to those preceptors, and visiting the sites and evaluating the sites, preceptors, and students. These responsibilities hold true for CECs regardless of the size of the athletic training program. This study also identified the ideal load for the CEC based on the size of the educational program.

Clinical education coordinators are incredibly valuable to all athletic training education programs. The job description for CECs should be clear and a load release appropriate for their responsibilities and the size of their programs should be equitable. The hope is that athletic training programs have job descriptions and load credit worthy of this most important position. In addition, developing criteria for faculty evaluation prescribed to fit the unique demands of the CEC would benefit the position and the athletic training program. A standardized job description, workload release commensurate with the size of the program, and an effective faculty evaluation framework all solidify the important role of the CEC in athletic training education.

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