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ORIGINAL RESEARCH

The Socialization and Development of the Coordinator of Clinical Education in Athletic Training

Shannon L. David, PhD, AT*; Ashley B. Thrasher, EdD, LAT, ATC, CSCS†; Laura E. Kunkel, EdD, LAT, ATC‡
*Health, Nutrition, and Exercise Science, North Dakota State University, Fargo; †Athletic Training Program, School of Health Sciences, Western Carolina University, Cullowhee, NC; ‡Kinesiology, University of Texas at Arlington

Context: Coordinators of Clinical Education (CCEs) play an important role in clinical education, yet they often receive little to no formal training in the role. The experiences of the CCE and preparation for their role is unknown; therefore, the purpose of this study was to explore the professional socialization of CCEs into their roles.

Methods: A total of 36 CCEs with a minimum of 1-year experience as a CCE (31 women, 5 men; 5.2 ± 4.7 years of experience as CCE) participated in this qualitative study. Data saturation guided the number of participants. Seven focus-group interviews were completed following a semistructured interview guide developed based on previous socialization research. Data were analyzed through consensual qualitative review, with data coded for common themes and subthemes. Trustworthiness was established via peer review and multianalyte triangulation.

Results: Two themes emerged: role and socialization. *Role* is described as responsibilities, collaboration, and challenges. Participants described responsibilities including complete oversight of clinical education, preceptor development, evaluation and assessment of clinical skills, and administrative duties. CCEs described the importance of collaboration, both internally and externally. CCEs faced challenges such as time management, conflict management, and navigating institutional policies. *Socialization* described preparation, integration into the role, resources, and needs. CCEs described minimal preparation, and most did not feel prepared to take on all aspects of the role. CCEs described role integration, which included meeting with the program director, reviewing the job description and the Commission on Accreditation of Athletic Training Education (CAATE) Standards, and trial and error. During socialization, they described a variety of resources such as conferences and the CAATE Standards to provide guidance. Last, participants identified needs including specific job description, a timeline for tasks, and professional development.

Conclusions: Overall, participants felt adequately prepared for some aspects of their roles, but less prepared for others. Additional professional development is necessary to make CCEs more successful.

Key Words: Role induction, role preparation, professional development

Dr David is Associate Professor and Program Director at North Dakota State University. Address correspondence to Ashley Thrasher, EdD, LAT, ATC, CSCS, Athletic Training Program, School of Health Sciences, Western Carolina University, 364 Health and Human Services Building, 3971 Little Savannah Road, Cullowhee, NC 28723. ashleybthrasher@gmail.com.

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KEY POINTS

- Coordinators of clinical education have many responsibilities associated with their role, including all aspects of managing clinical education experiences.
- Formal preparation for coordinators of clinical education is lacking and additional professional development would make clinical education coordinators feel more successful in their roles.
- Professional development related to managing clinical education experiences (eg, legal aspects, timeline to complete tasks, navigating accreditation requirements, institutional practices) is needed.

INTRODUCTION

Clinical education is a vital aspect of the professional preparation for athletic trainers (ATs), as students gain authentic learning experiences,[1,2] learn about the profession, apply knowledge and skills,[3,4] and develop excitement and commitment to the profession.[5] Organizing and maintaining education experiences can be very complex, because students must get varied and diverse experiences.[6] The coordinator of clinical education (CCE) is responsible for ensuring students are getting quality clinical education experiences.[7] The 2020 Commission on Accreditation of Athletic Training Education (CAATE) Standards[6] provide an overview of the role of the CCE in Standards 39–40. Standard 40 describes that the CCE's role is direct oversight of clinical education and responsible for all aspects related to student clinical experience. Whereas the CAATE Standards outline general roles and responsibilities of the CCE, institutional autonomy dictates that the role may be more nuanced than the Standard outlines. A recent study explored the duties and workload of the CCE,[7] and although many duties were on the list of roles of Standard 40, there were aspects of the role that were not captured with the Standard, such as managing conflict, developing and maintaining clinical contracts, and scheduling observation students.

Coordinators of clinical education play an important role in athletic training programs and clinical education experiences; however, the socialization process for CCEs is not understood. The CCE must be a core faculty member and must demonstrate effectiveness in teaching and evidence of scholarship.[6] Athletic training faculty members also have responsibilities to mentor students and serve the university and profession while navigating institutional policies and expectations.[8,9] Faculty members learn their expectations through socialization, which is a process by which an individual learns their roles and responsibilities and emerges as a member of the professional culture.[10,11] Socialization has 2 phases, anticipatory and organizational. Anticipatory socialization occurs before one takes the role and encompasses envisioning the role and formal role preparation.[10] For athletic training faculty members, role preparation may occur formally through education, including at the master's and doctoral level[12] or informally through gaining experience as an AT.[13] Often, doctoral education prepares ATs in the 3 basic tenets of higher education: teaching, research, and service[12]; however, this may be dominated by research or teaching experience and not always include preparation for administrative roles, such as serving as a program director or CCE. Administrative roles are often challenging for new faculty members.[14] In fact, junior faculty members report a lack of preparation for administrative roles[9,15] and balancing all aspects of the faculty role.[16] Lack of exposure to administrative tasks led to new faculty members feeling unprepared for administrative and accreditation responsibilities.[15] In addition, experienced faculty who are moving into administrative roles or changing institutions may face similar challenges.

The other aspect of professional socialization is organizational, which occurs once an individual enters their role, and consists of learning the role, adjusting, and gaining stability within the organization and role.[10] Organizational socialization facilitates learning of institutional policies, procedures, expectations, values, and culture.[17] As novice faculty transition into higher education, universities often provide orientation specific to the institution, which includes topics such as policies and procedures, university resources, and opportunities to connect with other new faculty members.[12,13,15] These can help the new faculty member feel less "lost"[13]; however, orientation does not always include all aspects of the role, including departmental policies and procedures or administrative information necessary for maintaining accreditation.

Socialization research in athletic training has explored the perceptions of clinicians,[10] preceptors,[18,19] new ATs,[20–24] students,[25,26] and athletic training faculty in general[27–37]; however, the research has not yet explored the socialization process into the administrative roles, such as CCE. The experiences of the CCE and preparation for their role is unknown; therefore, the purpose of this study was to explore the professional socialization of CCEs into their roles. Two research questions guided this study: (1) What processes are used to socialize clinical education coordinators into their roles? (2) What do CCEs need to be successful in their roles? This study was rooted in symbolic interactionism, which emphasizes how individuals attribute meaning to their experiences through dialogue and communication.[38] This framework guided the methodology of consensual qualitative review and methods of focus groups, allowing dialogue and communication through each step of the research process.

METHODS

Three female researchers currently serving as program directors in CAATE-accredited athletic training programs conducted the study. Two researchers (A.B.T. and L.E.K.) hold an EdD, whereas the third researcher (S.L.D.) holds a PhD. All 3 investigators have experience as a CCE and with qualitative research. All 3 investigators took part in the focus

groups and took field notes; however, 1 (A.B.T.) was the lead interviewer.

The theoretical framework for this study was symbolic interactionism, which emphasizes how the interaction, culture, and environment shape how an individual constructs meaning of experiences.[39] For this study, we used a consensual qualitative research methodology. We used 3 researchers to interpret the data. The goal of the focus groups was to understand the participants' experiences becoming CCEs. Institutional review board approval was obtained before initiating this study and participants provided informed consent before participating in the study. Focus-group interviews were conducted using a semistructured format[26,28–29] with a questionnaire guiding the interviews (Appendix).

Participants

The ATs serving as CCEs in all accredited athletic training programs were recruited for this study. Inclusion criteria consisted of CCEs who have been in the role for at least 1 year. A total of 36 CCEs (31 women, 5 men; 5.2 ± 4.7 years of experience as CCE) participated in this study. Individual participant demographics are presented in Table 1. Each participant was assigned a pseudonym. Demographic information is presented under the pseudonyms. Data saturation guided the number of participants.

Procedures

Participants were recruited via purposive sampling. A recruitment email was sent in fall 2020 to all CCEs in athletic training programs (n = 240; 10 were returned as undeliverable). This included all programs that were accredited at the time of the study, including programs in good standing, on probation, and transitioning program level. The recruitment email contained information about the study and a link to a demographic survey on QuestionPro (research edition; QuestionPro Inc). The CCEs who fit the inclusion criteria and were interested in participating in the study provided consent and filled out a demographic survey via QuestionPro. On the demographic survey, participants selected a time to participate in a focus group. A total of 57 CCEs responded to the survey and 36 CCEs were able to attend 1 of the focus groups. Participants were then contacted to confirm their group time and were provided with a Zoom link. Seven focus group interviews were completed following a semistructured interview guide (Appendix). During the focus groups, participants were asked questions related to their experiences and preparation as a CCE. There were 5–8 CCEs in each focus group. Focus group interviews lasted approximately 1 hour. Participants also had the ability to post additional comments into the chat. Interviews were recorded and transcribed verbatim. Data collection was completed when saturation occurred or when no new information was introduced and the findings from the data converged.[40] See the Study Procedures Flowchart in Figure 1.

Instrumentation

The semistructured interview guide (Appendix) was created based on the research questions as well as prior socialization research.[7,41–43] Before data collection, 3 experts in qualitative research methods, socialization research, and clinical education research evaluated the interview guide to provide content validity. We conducted a pilot-test focus group with 6 CCEs who fit the inclusion criteria for clarity, timing, and question flow. Minor modifications were made for clarity, comprehension, and content. None of the data gathered in the pilot study were included in the data analysis.

Data Analysis and Trustworthiness

Data were transcribed and any personal identifiable information was removed before coding occurred. Audio recordings were transcribed using Zoom transcription and were checked for accuracy by a member of the research team. Data were analyzed using consensual qualitative review, with data coded for common themes and subthemes.[44] Each of the 3 primary investigators individually reviewed the first 3 focus groups and then met to discuss the codes until a consensus was reached and a codebook was formed. Once the codebook was developed, researchers then went back to code all 7 focus groups. Each research team member was assigned to code 2 focus groups using the codebook. The other 2 team members then reviewed the transcripts and confirmed codes. Results from each research team member were discussed until consensus occurred and no major disagreements arose. A variety of credibility techniques were used to ensure trustworthiness including level connoisseurship[45] and multimember triangulation, which is the nature of consensual qualitative review. In addition, 2 external auditors with experience in qualititative research were used to evaluate the themes and subthemes. The research team used the Consolidated Criteria for Reporting Qualitative Research[46] to ensure necessary reporting criteria were addressed.

RESULTS

Two higher-order themes emerged: role and socialization into role. The higher-order themes were further broken down into subthemes. The first higher-order theme, role, describes the participants perceptions of various aspects of their role and was further divided into (1) responsibilities, (2) challenges, and (3) collaboration. The second higher-order theme, socialization, describes the processes by which the CCEs learned the responsibilities associated with their role, and it was further divided into 4 subthemes: (1) anticipatory, (2) organizational, (3) resources, and (4) needs. Supporting quotes for each theme are included in Figures 2 and 3.

Role

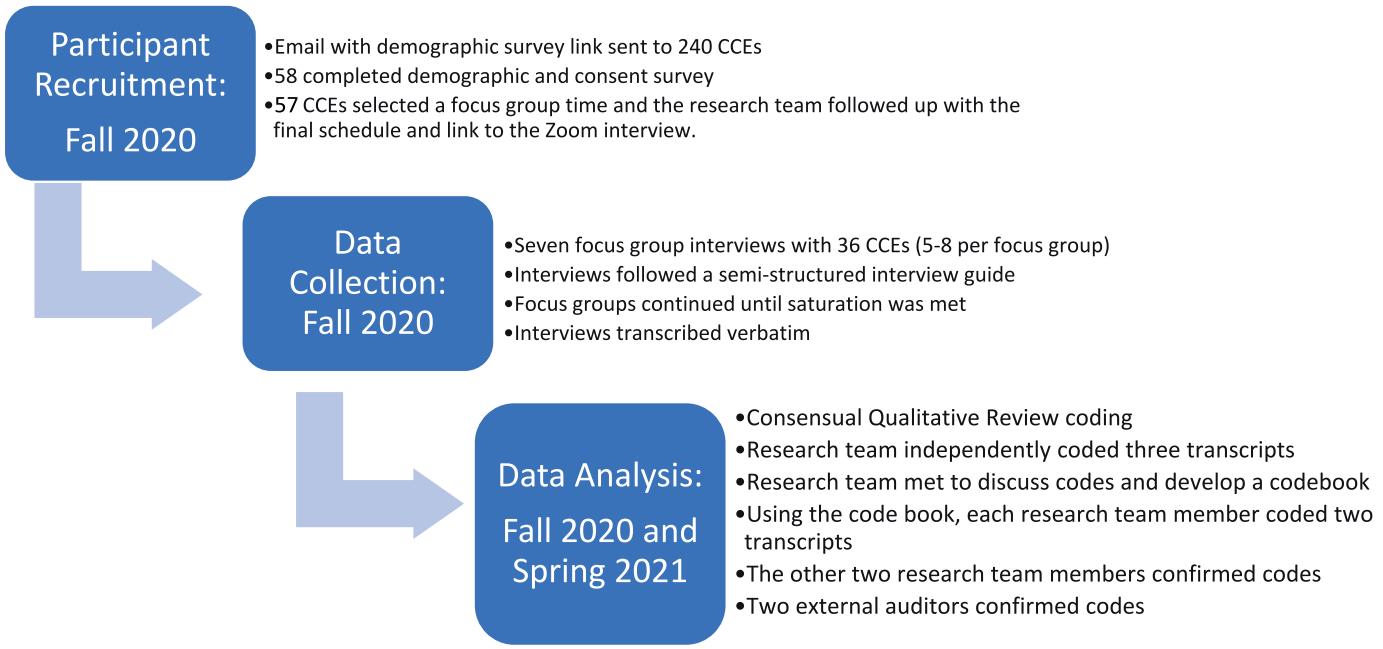
Responsibilities. The CCEs felt their responsibilities involved any aspect related to clinical education. Examples of responsibilities included placing and mentoring students, preceptor communication and development, evaluation and assessment of clinical skills and placements, clinical site visits, and administrative duties related to maintaining clinical contracts and accreditation. Judy commented, "I am tasked with basically all things clinical education from making sure that we're adhering to all the standards that apply to clinical education." In addition to coordinating clinical education experiences, participants discussed other roles based on institutional practices, contemporary expertise, and their specific rank and title such as research and managing

Table 1. Participant Demographic Information

Pseudonym	Gender	Age Range, y	Years as AT	Years as CCE	Length of Contract (mo)	Amount of Release Time (per Semester)	What Is the Appropriate Release Time?	Approximate No. of Preceptors
Grace	F	30–39	8	5	10	30%	My release feels appropriate	25
Frankie	F	30–39	11	4	10	4 credits	5 or half of load	25
Brianna	F	30–39	14	9	9	3 credits	3–6 credits	40
Vikki	F	30–39	17	3	10	3 credits	6 credits	50
Joan	F	30–39	10	2	9	45%	30%–50%	70
Daphne	F	30–39	12	3	12	1 course	50/50 teaching to clinical education duties	40
Pam	M	40–49	22	5	12	25%	25%	25
Emma	F	30–39	15	3	9	3 credits	6 credits	15
Chloe	F	30–39	13	1	10	3 credits (1 semester)	3 credits each semester	30
Mallory	F	30–39	8	2	9	3 credits	Not enough	20
Ruby	F	30–39	10	2	12	30%	30%	30
Saul	M	30–39	12	5	10	3 h	4 h	20
Erica	F	30–39	15	3	9	3 credits	At least 3 credits	20
Peggy	F	40–49	23	5	12	6 units	10–12 units	34
Penny	F	40–49	21	5	12	6 credits	6–8 credits	38
Paula	F	30–39	11	3	10	2	2	11
Ariene	F	30–39	10	1	NA	4 credits	6–8 credits OR $5k+	35
Madison	F	30–39	17	6	12	50% FTE	100%	25
Shawn	F	30–39	13	3	9	3 credit h	Dependent on number of students	45
Liz	F	20–29	7	2	10	1 course release	1 course release	11
Julie	F	40–49	20	10	9	25%	25%–50%	32
Nadia	F	30–39	15	13	10	25%, 3 credits	30%–40%	65
Robert	M	40–49	20	5	10	9 credit-h release	I feel as though I have adequate course release and compensation to perform my CCE duties	25
Janet	F	30–39	14	5	10	none	1 course release	15
Erin	F	50–59	35	8	10	15 h/wk	15–20 h, travel reimbursement	40
Kenneth	M	20–29	5	1	9	none/zero	5 h/wk	40
Ariah	F	40–49	22	10	9	3 credit h	3 credit h	35
Lindsey	F	30–39	8	6	10	3 credits	6 credits, specifically divided as 3/3, half for clinical or student observation and half for administrative	10
Barry	M	50–59	35	20	10	1 course per y	1 course per semester	15
Melissa	F	30–39	11	1	9	50%	50%	15
Skye	F	40–49	20	2	12	3 credit h	4–6 credit h	15
Marla	F	30–39	16	5	9	1 course per y	It's not appropriate	32
Judy	F	50–59	29	21	9	20%	25%	85
Elena	F	30–39	15	3	10	3 credits	more than 3 credits—at least 6, maybe more	100
Peter	M	30–39	10	2	9	3 credits	4 credits	15
Jane	F	50–59	31	3	9	3 credits	6 credits	47

Abbreviations: AT, athletic trainer; CCE, coordinator of clinical education; NA, not answered.

Figure 1. Study procedures flowchart. Abbreviation: CCE, coordinator of clinical education.



simulation centers. Table 2 includes a list of roles and responsibilities specific to the CCE role.

Challenges. Participants described many challenges as they navigated their roles, such as maintaining appropriate documentation, navigating institutional policies, conflict management, and balancing the administrative responsibilities with other aspects of their faculty position. Maintaining documentation was a challenge for the CCEs. Brianna said,

When I came into my role, I started to understand what they did prior to me. There were things that were not getting done or like literally not even getting done in like 5 years, or paperwork that didn't have a signature on it, and now we're going to make sure we're going to sign forms when the kids turn them in. Something as basic as that, we just created our own process.

Figure 2. Role. Abbreviation: CAATE, Commission on Accreditation of Athletic Training Education.

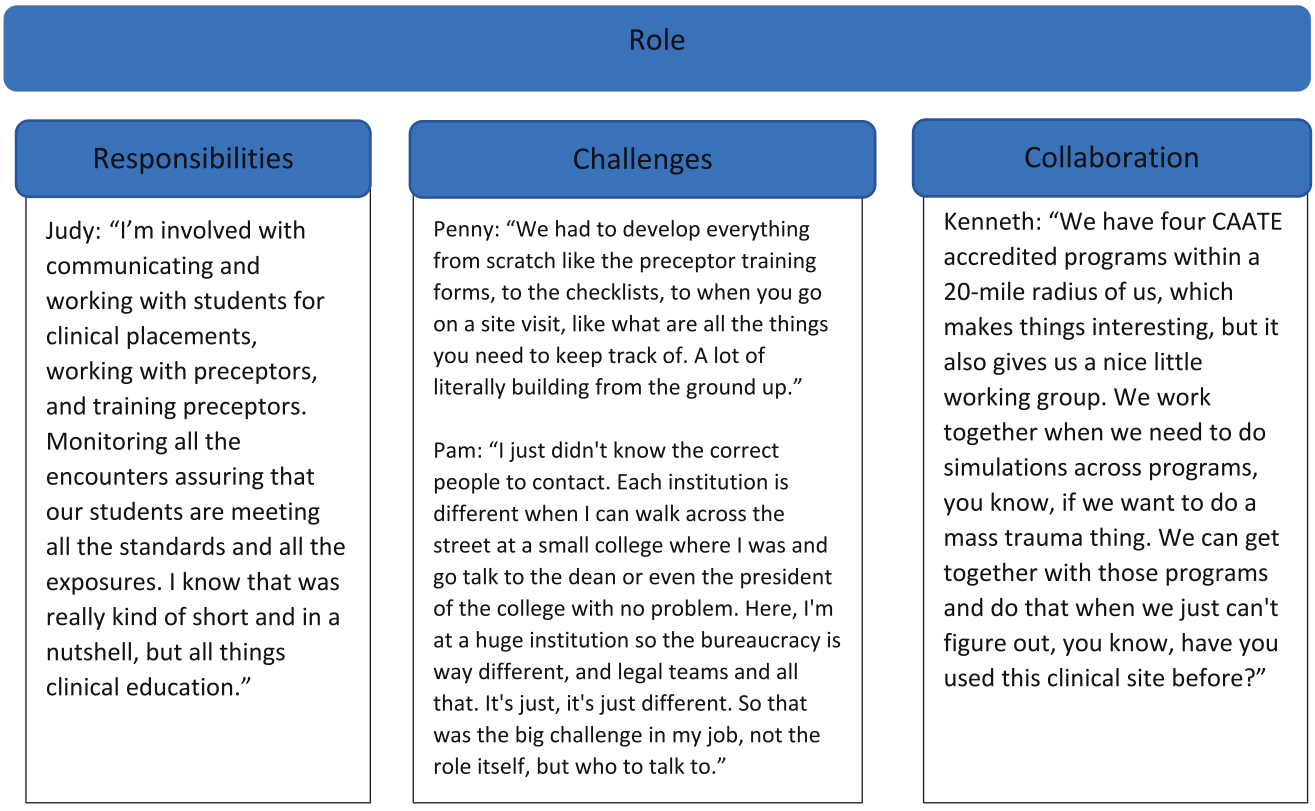
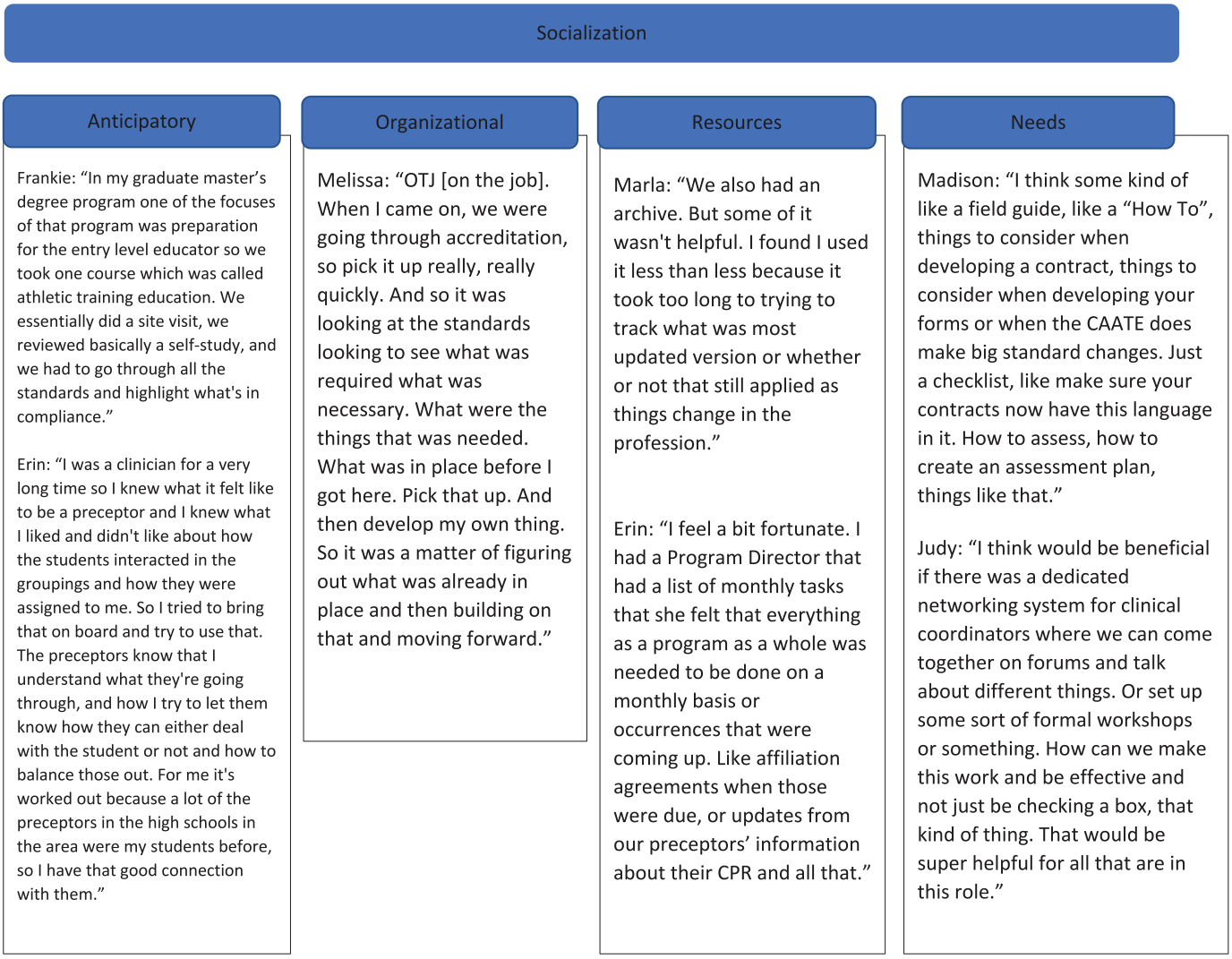


Figure 3. Socialization quotes.



Moreover, participants noted challenges developing organizational systems and policies and procedures for clinical education if they were not in place already.

Another challenge CCEs faced were navigating their responsibilities and institutional policies. Whereas many responsibilities were similar among CCEs, there were some institutional practices and policies that made the role more nuanced. Often, participants commented they did not understand all aspects of their role. Saul stated, "I learned each year that there's something else, and something else, and still now there's not really a clear distinction of what falls under my roles and what falls under my program director's roles." In addition to not completely understanding their roles, each institution was different, and although some participants had previous experience at another institution, they had to adjust to institutional policies when they assumed the role at a new institution. Jane shared, "Some of the administrative things that I didn't . . . I figured out how to navigate, but I stumbled quite a bit. It's very unique to your university or college or department."

The CCEs also handled conflict management. Many reported not being prepared for the amount of relationship interactions they would have to manage. Julie stated,

> *What I was not prepared for was being a counselor and a mediator and I don't feel like I had the background in that. I feel like I spend a lot of time listening to a lot of problems that there really is no solution for and so I think that that's a huge time suck.*

Another challenge discussed was the ability to navigate workload responsibilities and balancing all the duties of a faculty member, not just the administrative aspect of being CCE. Marla stated, "Balance. I think for me that was the hardest part. How do I just handle everything without feeling completely overwhelmed or dropping the ball on something else?" Participants felt the role of CCE was time-consuming and thought it challenging to fulfill all their job responsibilities, despite having some release time. Frankie commented,

> *Does it make sense to still have a large teaching load or not? I think we all know that the administrative responsibilities would be enough for a full-time position, but then most of us probably got into this for a love of teaching so what does that balance look like?*

Some felt the teaching load limited their ability to fulfill CCE duties, whereas others felt their CCE duties pulled them away from the classroom and fulfilling teaching duties.

Table 2. Common CCE Roles and Responsibilities

Common roles
- Identifying and developing new clinical education sites
- Developing and maintaining relationships with clinical sites and preceptors
- Communicating with preceptors and students
- Onboarding and maintaining onboarding systems
- Maintaining necessary paperwork (eg, CPR certification cards, immunizations, HIPAA form, blood-borne pathogen training, background checks, drug screening)
- Conducting student, preceptor, and site evaluations
- Overseeing issues or problems between students and preceptors
- Adhering to CAATE Accreditation Standards regarding clinical education
- Overseeing preceptor development
- Preparing CAATE Annual Reports
- Developing and maintaining contracts and affiliation agreements
- Tracking patient encounters regarding different types of patient exposure and conditions

Unique and less common roles
- Maintaining alumni connections
- Coordinating with lawyers and taking care of liability issues
- Providing stewardship, buying gifts, writing thank-you notes
- Providing support systems for students dealing with issues such as mental health
- Organizing simulations and standardizing patient experiences

Other faculty duties
- Teaching
- Posting on social media or media marketing
- Mentoring students
- Ensuring program outcomes are being met or implemented
- Implementing COVID-19 protocols and exposure protocols
- Participating in committee work
- Producing research

Abbreviations: CAATE, Commission on Accreditation of Athletic Training Education; CCE, coordinator of clinical education; CPR, cardiopulmonary resuscitation.

Collaboration. One aspect CCEs cited to be successful in their roles was collaboration, both internally and externally. The program director served as the primary internal collaborator, but others cited CCEs of other programs (ie, other health care professions) within their institution. Ruby said,

> *I'm in an entire health professions college. There's other PA [physician assistants], PT [physical therapists], health sciences, nursing, a whole bunch, but it was really nice because they actually had formed a clinical coordinators educators task force.*

Collaborating internally provided CCEs with resources, such as examples of documents (eg, affiliation agreements, clinical site evaluations, policies and procedures, clinical tracking systems) and helping CCEs understand institutional policies (eg, legal). Jane commented, "Check with your administration, check with HR [human resources], check with your legal department. These are people you need to have contact with because they all might have a role in contracts." Participants felt working with CCEs from other health care programs also helped with assessment, quality improvement, and brainstorming ways to handle complex clinical issues.

External collaborators included CCEs from other institutions and other athletic training colleagues. External collaborators allowed participants to bounce ideas off one another and provide support. Daphne commented, "As clinical directors it really helps us to dive into our network. I talked to a variety of different people that are in very similar roles to me on a regular basis and bounce ideas off each other." In addition to reaching out to our CCEs for support, some CCEs share resources and coordinate simulations with other programs in the area.

Socialization

The second higher-order theme, socialization, describes how participants were prepared for, introduced to, and integrated into their role. The theme was further divided into (1) anticipatory, (2) organizational, (3) resources, and (4) needs.

Anticipatory Socialization. Anticipatory socialization includes all aspects of previous preparation for the role of CCE, including feelings or preparation, formal preparation, and informal preparation. Most CCEs felt prepared for some aspects of their role due to previous experience as an AT or experiences in graduate school, but most did not feel adequately prepared for all aspects of their roles. Elena commented,

> *Overall, I would say I didn't feel prepared at all, but I think I did feel prepared for some aspects of the job. Just from being an athletic trainer seeing things being in the field, seeing how things worked, like clinical placements of the student in the broad sense of it. Maybe not the details of how we did everything from there. I had a good understanding of trying to match students and pieces like that just from being an athletic trainer and a preceptor myself. But the ins and outs of the job*

and every detail that went into it, I don't really think I had any clue.

Participants felt adequately prepared for some aspects of their roles such as assigning students to clinical sites, but less prepared for other aspects such as developing and writing articulation agreements, managing conflict, knowing legal aspects of the role, or managing time overall among administrative responsibilities, teaching, research, and service (depending on their role).

Formal preparation for the role was limited, but some participants received preparation in graduate school. Frankie described her graduate school experience (master's level) as it prepared her for the role: "In my graduate program one of the focuses was preparation for the entry-level educator. We essentially did a site visit, we reviewed a self-study, and we had to go through all the standards and highlight what's in compliance." Other participants received formal preparation through their doctoral education, whether that was through a role as a graduate assistant with the CCE or enrolled in a doctoral-level athletic training program. Melissa commented, "I had a little bit of help [with preparation] only because when I was going through my doctoral program and I did my internship with [the university's] athletic training program. I was working a lot with their CCE."

Others felt informally prepared through their former roles as a clinician, preceptor, or faculty member. Daphne described her preparation by saying, "I came from working clinically for 11 years and being an adjunct and being a preceptor for those 11 years, so I knew what it was going to look like. I was excited to put all the pieces together." Previous experience as a preceptor helped with various aspects of the role, such as developing relationships with preceptors and placing students with preceptors.

Organizational Socialization. The second subtheme that emerged was organizational socialization, which describes the process of learning and integrating into the roles as CCEs at their specific organization. As CCEs began their roles, they were integrated through organizational socialization. Similar to anticipatory socialization, organizational socialization included some formal aspects but was largely informal or absent for many CCEs. Formal aspects included meeting with the program director to learn role responsibilities. Chloe commented, "I had met with our program director. It was kind of, you're in charge of all the things clinical related and she's more the final signature on a lot of the didactic things." Liz also commented, "We sat down and had a meeting and there was a verbal this is what your role is, this is what you do." Whereas initial meetings with program directors were considered formal onboarding, meetings often continued informally as the CCEs integrated into their roles. Participants described informal meetings with the program director to help with socialization into the role. Barry stated, "The first time I served as coordinator clinical education, my program director [was] pretty involved and I learned a lot by just being able to ask questions and we kind of bounce things back and forth from each other."

Organizational socialization was largely absent for most participants. Many participants noted learning about their roles from seeing what needed to be done or when duties were missed. Mallory commented, "Yeah, when I didn't do something, they said, 'Why didn't you do this?' I didn't know." Brianna shared similar experiences:

But after a year, I was like, oh man, there's things I should have been doing and I clearly was not. Like I should have been evaluating clinical sites and I was not. That's crazy. With my current employer, I've been clinical coordinator for 8+ years. So clearly, I just felt comfortable because I've been in that role, but zero socialization.

Participants commented they learned their role through trial and error or reading the CAATE Standards to determine what was missing. Many reported that they learned most about their role through a self-study or a site visit. Participants felt they were not adequately socialized into the role at their specific institution; although, CCEs who had assumed the role after being at the institution or a CCE at another institution adapted to their role more quickly.

Resources. The third subtheme that emerged was resources, which describes the institutional and professional resources used by the CCEs to learn more about their roles. Institutional resources included policies, procedures, forms, binders, or other items provided to help CCEs understand their role. Professional resources included the CAATE Standards,[6] professional development conferences, research articles, or other items produced by the athletic training profession. Whereas this theme focuses on material resources, it also includes participants' descriptions of administration, colleagues, other CCEs, and alumni as resources for the role.

Institutional resources included items that were provided to participants to help them further understand their roles. Many participants were provided with either a binder or list of contact information. Frankie commented that she received a "giant binder and checklists and a step-by-step of how you go about securing a new affiliation agreement. Or here's how I've done site visits. Here's the chart that you can use." Although having resources was helpful, some participants felt too much information was counterproductive, because they spent more time trying to find something than if they just started fresh. Participants felt the most useful institutional resources were contact lists for preceptors and relevant institutional officials (eg, individual in charge of facilitating articulation agreements), checklists and step-by-step guides for completing clinical expectations, examples of clinical paperwork (eg, preceptor evaluation of student, site-visit checklist), and policies related to onboarding students for clinicals.

In terms of the profession, many CCEs felt the CAATE Standards[6] served as the primary resource to help them learn their role, but others cited current research related to clinical education as helpful. Vikki felt that CAATE defined the role of the CCE, stating, "Reading what CAATE kind of defines as the role of the coordinator of clinical education gives you at least a starting point to start to think about your role." Daphne commented, "A lot of reading those new standards probably a gazillion times over and over again to interpret them, going to all the CAATE meetings, going to anything the CAATE put out. Reading anything that I could." Elena concurred, "It's probably going through the standards and at least making sure we're hitting those at a minimum. Then from there, talking to others and learning from your failures

and figuring it out as we go." Shawn stated, "I've kept my eye out for different articles, especially the education journal articles that are coming out." In addition, CCEs sought development opportunities through the CAATE accreditation conference and Athletic Training Educators' Conference to learn ways to be more successful in their roles.

Needs. During the socialization process, participants identified many needs, including resources, development, and mentoring and support. Some of the necessary resources included specific job descriptions with an outline of functions, a flowchart or timeline to describe when functions needed to be completed, and institutional policies, procedures, and contact lists of common staff at their respective universities. Whereas some participants received binders and/or lists of information, some participants who did not receive the resources strongly desired them. Emma commented, "I would take a binder any day. A checklist would be amazing right now." Ariah concurred, "I would have appreciated just a list of expectations. If you could have spelled out a list. I could have knocked it out of the ballpark much earlier if I had known what was on the list of expectations." Others desired a guide that could be universal among all athletic training programs. Paula stated, "I would love a CAATE for dummies handbook or something because some of the way that the accreditation standards are written, I was like what does that mean? I don't know what this means!" Participants outlined a few "chapters" in which they feel would be beneficial in the CCE survival guide, including clear expectations, deadlines (eg, annual report, procuring preceptor documentation), developing clinical assessments, clarity on CAATE Standards, legal aspects of clinical education (eg, affiliation agreements, Title IX violations), how to write policies, and general clinical onboarding.

In addition to resources, participants discussed professional development needs to be more successful in their roles as CCEs. Many CCEs specifically felt more development on the 2020 CAATE Standards[6] would be beneficial. Aaron commented, "The CAATE can do more, as far as webinars or informational sessions. Like let's pull these 5 standards out and let's have a conversation or even a forum where people can share ideas." A few participants recalled workshops through the National Athletic Trainers' Association (NATA) that were specific to the role of program director or CCE, and others wished this training existed. In response to what professional development would be ideal, Julie commented, "A training for new program directors and training for new clinical education coordinators." Whereas many participants used the CAATE conference and Athletic Training Educators' Conference, others want more sessions related specifically to the role as a CCE.

Another socialization need of our participants was mentorship and support. Whereas some felt they had institutional mentorship and support, others felt they needed mentors who were also CCEs so they would understand some of the challenges and needs. Pam commented that she needed "Mentorship program or something like that." Some participants reached out to colleagues who are in the role but not everyone had that resource. Barry stated, "I didn't have anybody to learn from." Many participants agreed with the need for mentorship, but also expressed desire for a network of CCEs to collaborate and have a safe place to discuss challenges and learn from one another. Shawn stated, "I can see a benefit of having a network of people to bounce ideas off of a collective group. Get together on a zoom call you know once a month, just to have resources and to spark some ideas." Overall, participants felt they needed more socialization into their roles as CCEs and most desired more formal training through onboarding, mentoring, and additional professional development.

DISCUSSION

The position of CCE is a required role in accredited athletic training programs,[6] and CCEs report a variety of duties including teaching, clinical site visits, assessments and paperwork, conflict resolution, and preceptor training.[7] Whereas the role requires many administrative tasks, athletic training faculty have reported minimal preparation in administrative roles.[47,48] Socialization allows individuals to learn the roles and expectations of them by an organization.[49] Although perceptions of socialization by clinicians,[10] preceptors,[18,19] new ATs,[20–24] students[25,26], and athletic training faculty[27–37] have been studied, our research sought to discover what processes are used to socialize coordinators of clinical education into their roles and their needs. The environment and culture shapes how CCEs understand and construct meaning of their experience; thus, this study was rooted within symbolic interactionism.[38] The CCEs described their experiences exploring how relationships, community, and interactions guided their socialization process and understanding of their role.

Role

The CCEs engage in a variety of administrative tasks. The CAATE Standards indicate they must oversee the clinical education portion of the athletic training program, including oversight of student clinical progression, student assignment to clinical experiences, clinical site and student evaluation, communication with and professional development of preceptors, and preceptor selection and evaluation.[6] Our participants described their role in relation to 3 themes: (1) responsibilities, (2) challenges, and (3) collaboration.

Responsibilities. The role of CCE is very complex, and requires proficiency in administration, mentoring, evaluation and assessment, effective communication, and record keeping. Our participants described their responsibilities as including all aspects of clinical education. This is consistent with previous survey research exploring roles of the CCE.[7,50] The CAATE Standards include similar responsibilities such as oversight of student clinical progression, student assignment to clinical experiences, selection, professional development of, and communication with preceptors, and evaluation of preceptors, students, and clinical sites.[6] Additional literature has found similar responsibilities in comparable roles in other health care professions, such as physical therapy,[43] occupational therapy,[51] and nursing.[52]

Challenges. Participants also described challenges in their role as CCE, including maintaining documentation, navigating institutional policies, conflict resolution, and managing workload responsibilities. CCEs have many responsibilities related to maintaining accreditation, which has been cited as the most common stressor for both CCEs and program directors.[50] To better support CCEs in their roles, specific

guidelines with lists and timelines for documentation should be developed. For example, athletic training program faculty should determine which documents need to be collected for accreditation requirements (eg, evaluations of preceptors) and timelines for when they should be distributed and collected. This would help CCEs know which documentation is required and develop a plan for ensuring that appropriate documents are collected when needed.

Conflict management was also a challenge discussed by our participants and is a common part of the CCE role.[7] Conflicts may arise in clinical education, whether they are conflicts between preceptors and students, conflicts at the clinical education site, or conflicts with maintaining clinical partnerships. Not only did participants feel underprepared to manage these difficult situations, but they also felt unprepared for time and stress associated with mediation. Similarly, center coordinators of clinical education in physical therapy indicated they needed more development with managing crises and conflict in situations in which students were not meeting expectations in clinical education.[53] Effective communication with preceptors and clinical sites can mitigate some of these conflicts. Policies for conflict resolution should be developed to alleviate some of the stress.[7,54] In addition, conflict resolution is an important aspect of good leadership.[55] Institutions should provide leadership training for CCEs to assist with challenges associated with managing conflicts in clinical education.

Challenges with managing workload responsibilities are well established in the literature. Previous literature highlights challenges in balancing responsibilities by junior athletic training faculty,[17,31] as well as role strain in athletic training educators who are expected to pursue and maintain program accreditation while also meeting the demands of institutional expectations.[56] Radtke[7] found that approximately half of CCEs did not feel they were appropriately compensated for their CCE duties and suggested the size of the program and number of affiliated clinical sites should inform the reassigned workload time given to a CCE. Balancing work-life demands and having inadequate time to dedicate to all aspects of the CCE faculty role (eg, teaching, scholarship, and maintaining contemporary expertise) are some of the top stressors for CCEs[50] in athletic training and nursing.[57] Release time for our participants varied due to institutional policies, but most indicated the amount of release time was insufficient to meet the demands of the role. Participants who had more release time (ie, more than half of their load) felt they had adequate release. Future researchers should explore course release time and administrative requirements to ensure CCEs have adequate time to complete their duties.

Collaboration. The CCEs in our study described collaboration, resources, and development as integral in their success in their role. Like our participants, Sobralske and Naegele[52] described seeking help from others in similar roles for clinical coordinators of family nurse practitioner programs. Program directors also attribute success to having supportive colleagues around them.[58] In addition, interactions with colleagues have been found to be integral to the socialization of new faculty in athletic training and physical therapy.[19] A supportive collaborative environment allows for junior faculty to gain insights and advice from their colleagues. Institutions can support new CCEs by providing them with communities of practice. Communities of practice allow groups of people to work collaboratively and share and learn from one another[19] and have been shown to decrease feelings of isolation in junior faculty members.[59] A community of practice containing CCEs from a variety of health care professions within an institution or one with athletic training CCEs from multiple institutions may help athletic training CCEs better understand their role and provide ongoing support as CCEs face challenges.

Socialization

Socialization is the process by which an individual learns the roles and responsibilities of a professional position, acquires professional skills, and emerges as a member of the professional culture.[10,11] Through professional socialization, CCEs are oriented into their positions and gain understanding of specific roles. Our participants described their experience with socialization in 4 themes: (1) anticipatory, (2) organizational, (3) resources, and (4) needs.

Anticipatory. Anticipatory socialization occurred through graduate school experiences or from former roles as clinicians, preceptors, or faculty members. The literature suggests some athletic training educators are prepared for their role through graduate work, whereas others describe little exposure to administration and accreditation standards during their doctoral work.[48] Klossner et al[47] found that future athletic training faculty were not often exposed to administrative roles during their doctoral education, which was similar to our findings. In addition, a recent survey found CCEs only received on average 1.3 hours of formal leadership preparation.[50] Similarly, athletic training and physical therapy junior faculty members experienced limited preparation for administrative roles during their doctoral preparation, which was a challenge.[27]

Participants expressed that they felt prepared for some roles such as assigning students to clinical sites but were not prepared for other roles such as developing articulation agreements, managing conflict, or time management between administrative responsibilities. This was consistent with the literature, because Nottingham et al[48] and Mazerolle et al[12] found junior athletic training faculty members expressed being unprepared in administrative roles. Literature described mentorship as a means of socialization and understanding of the athletic training faculty role[12,13]; In contrast to the literature, our participants did not describe mentoring as a means of preparing them for their role as CCE; however, they did suggest mentoring would have been helpful to them. Doctoral programs with the aim of preparing athletic training faculty members should include specific training and mentoring on administrative roles within athletic training programs. Mazerolle et al[12] found that mentoring and authentic experiences provide a foundation for understanding the role, so providing opportunities for doctoral students to be involved in accreditation tasks (eg, annual report, self-study, site visit) can also assist in preparing CCEs for their roles. Providing experience with administrative tasks can expose CCEs to typical responsibilities and can provide information about the appropriate questions to ask and types of individuals to contact when they begin a new role. Although institutional differences exist, gaining prior experience in

administrative tasks can alleviate some of the stress during organizational integration.

Organizational. Organizational socialization provides individuals with the opportunity to gain on-the-job training specific to their role, which was informal for most of our participants. Although participants had formal orientations into their roles as faculty, they were not oriented into the role as a CCE. Most participants socialized themselves into their roles through trial and error; whereas, some learned their role through the reaccreditation process, like program directors as reported by Viesselman.[14] New athletic training faculty members often supplement organizational methods for socialization with individual mechanisms, such as seeking out mentoring and engaging in activities to help them learn their role.[32]

Onboarding and orientation are important aspects of organizational socialization; however, our results found that formal processes orienting CCEs to their administrative roles were largely absent. Previous research[13] with new athletic training faculty members has found timely orientation sessions can provide a clear overview of the position to assist with role transition. However, extensive orientation sessions that are heavy with information at the beginning of employment can be overwhelming and instead should spread information out over time. As new CCEs transition into their roles, formal orientation with clear job description, overview of duties, and timing of duties would alleviate stress of learning the role. However, challenges exist in determining who is responsible for orienting the new CCE. When new faculty members transition into their role, Human Resources, Academic Affairs, and administrators are often responsible for new faculty orientation. There is not a clear distinction of individuals responsible for orienting CCEs into the role, and this responsibility might fall on the program director, who may not be fully aware of all aspects of the CCE's role. Future researchers should further explore best practices in orientation for CCEs and provide general resources to assist with CCE orientation.

Resources. For our participants, the CAATE Standards[6] served as the primary resource to learning their role, as well as research related to clinical education and institutional policies and procedures, and an outline of the role. Institutional resources included binders of information or previously used forms and contracts, a flash drive or shared drive of documents, a stack of paper forms, or a list of contacts. Whereas this information can be helpful, it can be overwhelming and time-consuming to find relevant documents. Institution-specific resources can be very valuable during the socialization process, because they provide new employees with specific expectations, policies, and procedures necessary to be successful in their roles. For new ATs, being provided with a policy and procedure manual during orientation alleviates stress and allows them to feel comfortable in their role faster.[21] In addition, new ATs in the college setting are often not provided with written resources beyond a job description, so managing administrative tasks are learned through trial and error.[10] Whereas many CCEs are not often brand-new ATs, there is still a role transition which can be stressful. Providing resources can assist the CCEs in transitioning into their roles. In our study, participants who were provided with organized resources (eg, binder) and then an outline of tasks and specific due dates felt more prepared to take on their roles than those who received too little or too much unorganized information. As new CCEs are transitioning into their role, someone who knows the role (eg, program director, department chair, other CCEs) should provide current information, contact lists, and an outline of tasks that need to be completed with a timeline for completion.

Whereas some participants received institutional resources, others relied on external resources, such as the CAATE Standards[6] and professional development opportunities, such as conferences. Seeking out professional development has been found to be a common practice among junior athletic training educators,[37] particularly professional development directly related to their faculty roles.[31] Despite health care administration being the least preferred continuing education topic among ATs,[60] our participants found it valuable to help understand their roles. Participants recognized a need for continuing education related to being CCE, which is consistent with other ATs who select professional development opportunities on the basis of perceived needs and benefits.[61] In addition to gaining valuable information from sessions, participants also found collaborating with other CCEs and faculty members at conferences was a good resource.

Needs. Participants identified needs to assist in their socialization and continued development in their role as CCEs, including resources (eg, policies and procedures), professional development, and mentoring and support. Similarly, as new ATs transition to practice, they desire specific policies and procedures, protocols, and a detailed outline of expectations so they can be successful in their roles.[62] New graduate assistant ATs in the collegiate setting also appreciate having a manual to which they can refer when they have questions.[21] Many new faculty are provided with tenure and promotion expectations and teaching resources as a part of their socialization[12]; however, this often does not extend to administrative positions. Our participants overwhelmingly expressed a need for CCE specific resources. This is similar to physical therapy, in which center coordinators of clinical education desire programs and training specific to their role.[53] Athletic training program faculty and institutional CCEs should develop resources for incoming CCEs to help them navigate and be successful in the role. Moreover, current CCEs could organize their tasks with timelines for completion to ensure they meet deadlines and pass on these resources to future CCEs.

Participants noted both the CAATE Accreditation Conference and Athletic Training Educators' Conference as opportunities for professional development; although, there are not often talks specific to the role as a CCE. The NATA has historically provided workshops for CCEs and program directors; however, these have been discontinued. The Strategic Alliance should explore ways to support program administration, such as reinvigorating these workshops to assist with socializing the CCEs into their roles. Beyond a specific workshop, webinars and sessions at conferences specific to the CCE role would be beneficial. Topics include role expectations of the CCE, legal aspects involved with coordinating clinical education experiences, navigating the 2020 CAATE Accreditation Standards,[6] and writing the clinical aspect of the self-study, preceptor development, managing conflict, maintaining documentation, and tracking patient encounters. Future researchers should also explore

these topics so that educational sessions could be developed to better prepare CCEs.

Having a mentor was also identified as a need by many participants, and participants would benefit from both internal and external mentors. Internal mentors can assist with understanding institutional policies, meeting various individuals, and learning organizational culture. Whereas some participants had formal mentors, many developed informal relationships with program directors or CCEs from other programs. This is consistent with new faculty members who value guidance from departmental faculty members on an as-needed basis.[13,32] Having a mentor can ease transition stress and help new faculty members understand their roles.[13,10,16] Mentors also provide support and guidance,[16] which is vital to the socialization of CCEs. Our participants also noted the value of external mentors who were also CCEs, because some of their questions or needs were related to the role as CCE and were not institution specific. Because not all CCEs have mentors within their contacts, formal mentoring through professional avenues (eg, NATA Foundation mentoring program) can provide new faculty or new CCEs with support and guidance to help with their roles. The Strategic Alliance members could facilitate a mentoring network, whether through a committee or on GATher through the NATA (https://gather.nata.org). In addition, a network for CCEs on a forum such as GATher or peer-to-peer discussions can facilitate CCE socialization and help develop relationships.

Limitations and Future Directions

This study focused on the role of the CCE in general, and therefore we included CCEs who had been in the role for at least 1 year. Whereas we met data saturation within our focus groups, we had some individuals who had been in the role for 20 years and others who were newer to the role. Future researchers could explore perceptions of those who are new to the role to further explore their socialization. In addition, a longitudinal study with interviews occurring at multiple time points could provide a more in-depth perspective of the socialization process for CCEs. Another limitation in this study was the timing. This study was conducted in Fall 2020, shortly after the 2020 CAATE Standards[6] were implemented and in the middle of a global pandemic; many CCEs were focused on the complexity of the new standards, developing immersive experiences, and monitoring clinical experiences during a pandemic, which affected their socialization and role understanding. This study should be redone after the baccalaureate degree level is fully phased out and clinical experiences are not affected by a global health crisis. Future researchers should also explore unique challenges associated with developing and maintaining distance clinical education sites. As with most self-reported research, there is a possibility of response bias. Because the role of CCE can be demanding, it is possible that themes were missed by CCEs who felt they were too busy to participate. Moreover, various demographic information (eg, gender, length of time in role, type of terminal degree) may affect how CCEs experience their role. Future researchers could explore these factors.

CONCLUSIONS

Our participants described various aspects of their role as CCE, the processes by which they learned the responsibilities of the role and needs to be successful. They have many responsibilities that relate to all aspects of clinical education. They also expressed challenges with their role, which included maintaining documentation, navigating policies, resolving conflicts, and managing workload. Participants described experiences collaborating with others, including the program director, other health professions faculty, and other CCEs. They learned their roles through socialization and spoke of former roles and experiences that prepared them for their role as CCE. Participants also engaged in meetings with the program director and used a variety of resources to socialize to the role; however, they expressed a lack of orientation to administrative responsibilities.

Although CCEs have been resourceful in socializing themselves to their administrative role, there is more need for resources to better socialize CCEs to their role. Clearly written expectations, lists of necessary documents, timelines, and policies and procedures are needed. In addition, workshops specific to their role as CCE may be helpful in orienting new CCEs and should be considered for use by athletic training programs.

REFERENCES

1. Benes SS, Mazerolle SM, Bowman TG. The impact of clinical experiences from athletic training student and preceptor perspectives. *Athl Train Educ J*. 2014:9(4):156–165.
2. Radtke S. A conceptual framework for clinical education in athletic training. *Athl Train Educ J*. 2008;2(2):36–42.
3. Levy LS. Sexton P, Willeford S, Barnum MG, Guyer MS. Clinical instructor characteristics, behaviors, and skills in allied health care settings: a literature review. *Athl Train Educ J*. 2009;4(1):8–13.
4. Weidner TG, Henning JM. Historical perspectives of athletic training clinical education. *J Athl Train*. 2002;37(suppl 4):S222–S228.
5. Dodge TM, Mazerolle SM. Preceptors' influence on athletic training students' development of excitement and commitment to the field of athletic training. *Athl Train Educ J*. 2015;10(1):18–24.
6. Commission on Accreditation of Athletic Training Education. CAATE 2020 Professional Standards. Commission on Accreditation of Athletic Training Education. Accessed September 23, 2022. https://caate.net/Portals/0/Documents/Standards%20and%20Procedures%20for%20Accreditation%20of%20Professional%20Programs.pdf
7. Radtke S. The role and load of the athletic training clinical education coordinator. *Athl Train Educ J*. 2017;12(2):113–120.
8. Nottingham S, Mazerolle SM. Mentoring processes in higher education: perspectives of junior athletic training faculty members. *Internet J Allied Health Sci Pract*. 2018 3;16(4):article 1.
9. Nottingham SL, Mazerolle SM, Bowman TG. Junior athletic training faculty members' perceptions of doctoral education on their role transition. *J Allied Health*. 2018. 24;48(1):e35–e42.
10. Pitney WA, Ilsley P, Rintala J. Professional socialization of certified athletic trainers in the National Collegiate Athletic Association Division I context. *J Athl Train*. 2002;37(1):63–70.
11. Thrasher AB, Walker SE, Hankemeier DA, Pitney WA. Supervising athletic trainers' perceptions of professional socialization of graduate assistant athletic trainers in the collegiate setting. *J Athl Train*. 2015;50(3):321–333.

12. Mazerolle SM, Barrett JL, Nottingham S. Examining the factors that facilitate athletic training faculty socialization into higher education. *Athl Train Educ J*. 2016;11(4):208–218.
13. Bowman TG, Mazerolle SM, Kilbourne BF. Perceptions of employer socialization tactics during junior faculty transition into higher education. *Athl Train Educ J*. 2018;13(1):42–48.
14. Viesselman C. *The Socialization of First-Time Athletic Training Education Program Directors*. Doctoral thesis. Northeastern University; 2013.
15. Bowman TG, Klossner JC, Mazerolle SM. The doctor of philosophy experience of athletic trainers: facilitators and barriers to anticipatory faculty socialization. *J Athl Train*. 2017;52(10):925–936.
16. Nottingham SL, Mazerolle SM, Barrett JL. Roles of mentoring for novice athletic training faculty members. *Athl Train Educ J*. 2017;12(4):234–243.
17. Barrett JL, Mazerolle SM, Rizzo JJ. Exploring experiences of organizational socialization among physical therapy and athletic training junior faculty members. *J Phys Ther Educ*. 2019;33(4):273–281.
18. Mazerolle SM, Bowman TG, Dodge TM. The professional socialization of the athletic trainer serving as a preceptor. *J Athl Train*. 2014;49(1):75–82.
19. Hyland D, Cavallario J, Neil ER, Laursen M, Eberman LE. Socialization experiences of athletic training preceptors. *Athl Train Educ J*. 2020;15(2):102–112.
20. Thrasher AB, Walker SE, Hankemeier DA, Mulvihill TM. Graduate assistant athletic trainers' perceptions of professional socialization in the collegiate setting: part I. *J Athl Train*. 2016;51(10):758–770.
21. Thrasher AB, Walker SE, Hankemeier DA, Mulvihill T. Graduate-assistant athletic trainers' perceptions of the supervisor's role in professional socialization: part II. *J Athl Train*. 2016;51(10):771–779.
22. Mazerolle SM, Eason CM, Clines S, Pitney WA. The professional socialization of the graduate assistant athletic trainer. *J Athl Train*. 2015;50(5):532–541.
23. Singe SM, Bowman TG, Kilbourne BF, Barrett JL. Longitudinal examination of transition to practice for graduates of professional master's programs: socializing factors. *Athl Train Educ J*. 2020;15(2):148–155.
24. Kilbourne BF, Bowman TG, Barrett JL, Singe SM. A theoretical model of transition to practice for athletic trainers. *J Athl Train*. 2021;56(5):508–517.
25. Klossner J. The role of legitimation in the professional socialization of second-year undergraduate athletic training students. *J Athl Train*. 2008;43(4):379–385.
26. Mazerolle SM, Dodge T. Role of clinical education experiences on athletic training students' development of professional commitment. *Athl Train Educ J*. 2015;10(2):138–145.
27. Barret JL, Singe SM, Diamond A. Athletic training and physical therapy junior faculty member preparation: perceptions of doctoral programs and clinical practice. *Int J Allied Health Sci Pract*. 2020;18(3):article 4.
28. Brumels K, Andrea B. Role orientation of certified athletic trainers at institutions of higher education. *Athl Train Educ J*. 2008;1:5–12.
29. Gabriella MM, Richards AR. A longitudinal study of the transition from doctoral student to faculty member in physical education. *Res Q Exerc Sport*. 2019;90(4):699–711.
30. Mazerolle Singe S, Pike AM, Coleman KA, et al. Doctoral education in athletic training: pursuit of the degree and its influence on career aspirations. *Athl Train Educ J*. 2019;14(2):99–107.
31. Mazerolle SM, Bowman TG, Kilbourne BF. Exploring work-life balance of junior athletic training faculty members during role inductance. *Athl Train Educ J*. 2018;13(1):21–32.
32. Mazerolle SM, Nottingham S, Coleman K. Organizational socialization: experiences of junior faculty in athletic training education programs. *Int J Allied Health Sci Pract*. 2019;17(3):article 12.
33. Mazerolle SM, Nottingham SL, Barrett JL. Formal mentoring in athletic training higher education: perspectives from participants of the National Athletic Trainers' Association Foundation mentor program. *Athl Train Educ J*. 2018;13(2):90–101.
34. Nottingham SL, Mazerolle SM, Bowman TG, Coleman KA. Alignment of athletic training doctoral education and faculty workload. *Athl Train Educ J*. 2018;13(3):268–280.
35. Payne EK, Walker SE, Mazerolle SM. Exploring athletic training educators' development as teachers. *Athl Train Educ J*. 2017;12(2):134–145.
36. Singe SM, Nottingham S, Coleman KA. Athletic training junior faculty experiences with institutional expectations for tenure and promotion. *Athl Train Educ J*. 2019;14(3):198–207.
37. Kilbourne BF, Bowman TG, Mazerolle SM. A developmental perspective on behaviors of new faculty transition into higher education. *Athl Train Educ J*. 2018;13(4):348–358.
38. Crotty M. *The Foundations of Social Research: Meaning and Perspective in the Research Process*. Sage Publications; 1998.
39. Charmaz KK. Grounded theory methods in social justice research. In: Denzin NK, Lincoln YS, eds. *The SAGE Handbook of Qualitative Research*. 4th ed. Sage Publications; 2011:359–380.
40. Mason M. Sample size and saturation in PhD studies using qualitative interviews. *Forum: Qual Soc Res*. 2010;11(3):article 8.
41. Silberman N, LaFay V, Zeigler S. Practices of exemplary leaders in clinical education: a qualitative study of director and site coordinator of clinical education perspectives. *J Phys Ther Educ*. 2020;34(1):59–66.
42. Dahke S, O'Conner M, Hannesson T, Cheetham K. Understanding clinical nursing education: an exploratory study. *Nurs Educ Pract*. 2016;17:145–152.
43. McCallum C, Engelhard C, Applebaum D, Teglia V. Contemporary role and responsibilities of the director of clinical education: a national qualitative study. *J Phys Ther Educ*. 2018;32(4):312–324.
44. Hill CE, Thompson BJ, Nutt Williams E. A guide to conducting consensual qualitative research. *Couns Psychol*. 1997;25(4):517–571.
45. Brantlinger E, Jimenez R, Klingner J, Pugach M, Richardson V. Qualitative studies in special education. *Except Child*. 2005;71(2):195–207.
46. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*. 2007;19(6):349–357.
47. Klossner JC, Mazerolle SM, Bowman TG. Exploring barriers to the successful socialization of athletic training doctoral students into future faculty roles [abstract]. *J Athl Train*. 2015;50(suppl 6):S208.
48. Nottingham SL, Mazerolle SM, Bowman TG. Junior athletic training faculty members' perceptions of doctoral education on their role transition. *J Allied Health*. 2019;48(1):e35–e42.

49. Tierney WG, Rhoads RA. *Faculty Socialization as Cultural Process: A Mirror of Institutional Commitment*. Jossey-Bass; 1994.
50. Osgood CT. Factors impacting athletic training program directors' and clinical education coordinators' professional roles. *Athl Train Sports Health Care*. 2021;13(5):e280–e290.
51. Stutz-Tanenbaum P, Hanson DJ, Koski J, Greene D. Exploring the complexity of the academic fieldwork coordinator role. *Occup Ther Health Care*. 2015;29(2):139–152.
52. Sobralske M, Naegele LM. Worth their weight in gold: the role of the clinical coordinator in a family nurse practitioner program. *J Am Acad Nurse Pract*. 2001;13(12):537–544.
53. Fitzpatrick Timmerberg J, Dungey J, Stolfi AM, Dougherty ME. Defining the role of the center coordinator of clinical education: identifying responsibilities, supports, and challenges. *J Phys Ther Educ*. 2018;32(1):38–45.
54. Zimmerman E, Herzog V. Conflict resolution strategies and improving relationships for ATs. *Athl Ther Today*. 2009;14(4):36–39.
55. Franklin T, Nyland J. The importance of developing athletic training leadership behaviors. *Athl Train Educ J*. 2020;15(4):246–250.
56. Dewald L, Walsh K. Tenure track athletic training educators: are they being set up to fail? *Athl Train Educ J*. 2009;4(4):144–149.
57. Pinchera BJ, O'Keefe E, O'Shea M, Lawler KM. Clinical coordinator role in nursing education: challenges and rewards, perils and pitfalls. *Nurse Educ*. 2014;39(4):214–215.
58. Leone JE, Judd MR, Colandreo RM. Descriptive qualities of athletic training education program directors. *Athl Train Educ J*. 2008;3(2):43–49.
59. Pololi LH, Knight SM, Dennis K, Frankel RM. Helping medical school faculty realize their dreams: an innovative, collaborative mentoring program. *Acad Med*. 2002;77(5):377–384.
60. Babiarz AM, Edler JR, Neil ER, Eberman LE. Athletic trainers' selection behaviors related to multi-session continuing education conferences. *Athl Train Educ J*. 2021;16(1):59–70.
61. Edler JR, Eberman LE. Factors influencing athletic trainers' professional development through continuing education. *Athl Train Educ J*. 2019;14(1):12–23.
62. Thrasher AB, Walker SE. Newly credentialed athletic trainers onboarding needs during transition to practice. *J Athl Train*. 2019;54(6S):S207.

Appendix. Interview Guide

1. Please describe your role as a director/coordinator of clinical education at your institution.
2. What is expected of you in your role?
   a. How did you learn about these expectations?
3. How were you oriented into your role as director/coordinator of clinical education at your institution?
   a. What other ways have you been oriented to this role?
   b. Did you have any previous preparation (eg, graduate school) for this role?
4. How prepared did you feel to take on the role as director/coordinator of clinical education?
   a. How was it that you came to feel (not) prepared?
   b. In which aspects of your role did you feel prepared?
   c. In which aspects did you not feel prepared?
5. Who do you go to for questions in your role?
6. What resources were provided to you when you started your position?
   a. What resources did you find helpful as director/coordinator of clinical education?
7. What resources do you wish you had to assist you as you began your role as director/coordinator of clinical education?
8. How do you experience support in your role as director/coordinator of clinical education?
   a. What other ways do you wish you were supported?
9. Describe the challenges, if any, you have faced in your role as director/coordinator of clinical education.
   a. What strategies have you implemented to overcome these challenges?
10. What would be helpful resources to include as an information guide for directors/coordinators of clinical education?