

Professional Socialization and Development Needs of Coordinators of Clinical Education

Ashley B. Thrasher, EdD, LAT, ATC, CSCS*; Shannon L. David, PhD, LAT, ATC†; Laura E. Kunkel, EdD, LAT, ATC‡

*School of Health Sciences, Western Carolina University, Cullowhee, NC; †Health, Nutrition, and Exercise Science, North Dakota State University, Fargo; ‡Kinesiology, University of Texas at Arlington

Context: Coordinators of clinical education (CCEs) play a vital role in ensuring effective clinical education experiences, including developing and maintaining clinical affiliation agreements, developing preceptors, evaluating students, preceptors, and clinical education sites, and managing conflict. However, CCEs are often not formally trained for the role. The purpose of this study was to understand the processes used to socialize CCEs and to identify professional development needs.

Methods: All 291 CCEs of accredited athletic training programs were purposively recruited through direct e-mails, and 132 CCEs participated in this cross-sectional online survey. The survey consisted of 4 sections: (1) demographics, (2) role induction (RI), (3) usefulness of RI (URI), and (4) socialization needs (SN). For RI, participants identified items that were included in the orientation into their roles (eg, overview of duties, resources provided). For URI, participants identified how useful each orientation tactic was. For SN, participants identified how helpful they would find topics if they were included in a formal CCE development workshop. A panel of experts established content validity of the survey, and it was piloted with 8 CCEs. Reliability was established via Cronbach $\alpha = 0.86$.

Results: Common RI tactics were receiving contact information for current preceptors, overview of the duties as CCE, and review of clinical education documentation. All tactics included in RI were rated at least *moderately useful*. Topics that would be helpful as part of CCE training include assessing clinical skill development, analyzing clinical data, and navigating difficult conversations and conflict.

Conclusion(s): Many tactics are used to socialize CCEs into their administrative roles, but orientations vary based on the institution. Providing CCEs clear direction could lead to better student outcomes and overall job satisfaction. Therefore, programs should develop detailed onboarding for their CCEs specific to their roles within the program and institution.

Key Words: Role induction, role preparation, professional development

Dr Thrasher is currently Associate Professor in the School of Health Sciences at Western Carolina University. Address correspondence to Ashley Thrasher, EdD, LAT, ATC, CSCS, School of Health Sciences, Western Carolina University, 3971 Little Savannah Drive, Cullowhee, NC 28723. abthrasher@email.wcu.edu.

Full Citation:

Thrasher AB, David SL, Kunkel LE. Professional socialization and development needs of coordinators of clinical education. *J Athl Train Educ Pract*. 2025;21(2):94–104.

Professional Socialization and Development Needs of Coordinators of Clinical Education

Ashley B. Thrasher, EdD, LAT, ATC, CSCS; Shannon L. David, PhD, LAT, ATC; Laura E. Kunkel, EdD, LAT, ATC

KEY POINTS

- Formal onboarding into the CCE role is limited, despite the importance of the role to student success and program adherence to accreditation standards.
- Participants identified areas in which they received training for their roles as well as areas in which training would be helpful.
- Participants identified development related to maintaining accreditation standards to be most helpful.
- Many socialization tactics participants identified as potentially being helpful can be accomplished through professional development.

INTRODUCTION

Clinical education is an important component in professional preparation of future athletic trainers (ATs). The role of the coordinator of clinical education (CCE) includes ensuring students are provided with quality clinical educational experiences with a variety of patient populations and medical conditions in alignment with accreditation standards.¹ In addition, the CCE often must manage conflict; develop and maintain clinical affiliation agreements; train and develop preceptors; and evaluate students, preceptors, and clinical education sites. Administrative roles can be challenging for new faculty members, and master's or doctoral education does not always include preparation for administrative roles such as CCE.² In fact, junior faculty members report a lack of preparation for administrative roles and feeling unprepared for administrative and accreditation responsibilities.^{3,4}

Authors of a previous study explored the socialization and development of the CCE in athletic training and verified the roles and socialization of the CCE.⁵ Coordinators of clinical education reported on the challenges they faced and often reported learning their roles through on-the-job training and trial and error, causing stress and sometimes mistakes. While CCEs reported feeling adequately prepared for some aspects of their roles, such as placing students at clinical sites, they reported feeling less prepared for others, such as obtaining articulation agreements, managing conflict, navigating legal aspects of the role, and balancing the load. Coordinators of clinical education also outlined various resources that were provided as well as those that would have been helpful when they began their roles as CCEs including a timeline for task completion, clearly written expectations, and standard operating procedures (SOPs) for various aspects of the role.⁵

Professional socialization is the process by which individuals learn of the roles and responsibilities of their positions and emerge as members of the professional culture.⁶ *Organizational socialization* focuses on role aspects specific for the individual position within an organization, while *anticipatory socialization* prepares an individual for the role. As an important part of organizational socialization, new faculty orientation is common practice for institutions to acclimate faculty

to their roles; however, new faculty orientation is only a small aspect of socialization. Some institutions also provide formal mentoring to junior faculty, while at others, junior faculty seek out mentoring relationships.⁷ However, these institutional mechanisms often do not address the specific responsibilities of CCEs; rather, they address more general information about university policies and promotion and tenure expectations. On average, CCEs receive less than 2 hours of formal leadership training, and nearly half of CCEs do not feel competent in their roles until the end of the first or second year.⁸ It has been suggested that formal training for the role of CCE should be conducted and that this training may need to come from outside the CCE's institution.⁸ The purpose of this study was to understand the processes currently being used to socialize CCEs into their roles and to identify professional development needs of CCEs to better socialize them into their roles. By exploring the development needs of CCEs, recommendations for role-specific training can be developed to better socialize CCEs into their roles.

METHODS

Design and Setting

In this study, we used a cross-sectional design with an online survey to explore the organizational socialization tactics for CCEs. This study was approved by the University's Institutional Review Board.

Participants

A total of 132 (39 males; 87 females; 3 selected *prefer not to answer*; 3 declined to answer) CCEs participated in this study. Inclusion criteria included serving as a CCE for an athletic training program and at least 18 years of age. Exclusion criteria included anyone unable to read and write in English. E-mail addresses were obtained from the publicly accessible Commission on Accreditation of Athletic Training Education (CAATE) Website (n = 291), and we had a 45% response rate. Two e-mails were deemed undeliverable, and 7 had automatic-reply away messages.

Instrumentation

The survey consisted of both open- and closed-ended questions with the following sections: demographics, role induction (RI), usefulness of RI (URI), and socialization needs. For the RI section, participants identified which tactics and resources were used to socialize them into their roles and the usefulness of each tactic on a Likert scale (1 = *not useful*, 4 = *very useful*). For the socialization needs section, participants rated how helpful various topics would be if they were in a training or development session on a Likert scale (1 = *not helpful*, 3 = *very helpful*). The survey was developed based on previous literature.^{5,6,9-13} After instrument development, the instrument underwent validation by 3 experts in survey and athletic training clinical education research. All feedback was reviewed, and the survey was modified accordingly. Reliability was established via Cronbach

$\alpha = 0.86$. Lastly, the survey was piloted with 8 CCEs before data collection to ensure survey flow and gauge timing. Pilot data were not included in the final data analysis.

Procedures

Participants received an e-mail requesting participation in the study. Participants were able to click the link within the e-mail to complete the survey. The link took participants to a Qualtrics survey for completion, and the consent form was on the first page of the survey. Reminder e-mails were sent at 2 and 4 weeks to encourage participation.

Data Analysis

Data from the survey were analyzed using SAS (version 9.4; SAS Institute Inc). Descriptive statistics (mean, standard deviation, frequency, and percentages) were calculated for each value in the RI and socialization needs sections. Additionally, χ^2 tests were performed to determine if differences between variables existed (eg, length of time as a CCE, academic rank, degree earned, years of experience as an AT, type of orientation provided). The level of significance was set at $P = .05$.

RESULTS

A total of 132 CCEs participated in this study. Demographic information is found in Table 1. Many CCEs were relatively new to the role, as approximately 63% of participants have been in the role of CCE for less than 5 years, with 15% being in the role less than 1 year. On average, CCEs receive $23.5\% \pm 11.8\%$ of course release time for the role, ranging from 0% to 60%. Participants reported spending an average of 12.4 ± 6.7 hours per week on CCE duties, but that number varied if they were conducting clinical site visits. Fifteen percent ($n = 19$) of participants had clinical practice responsibilities as part of their roles, while the majority ($n = 108$; 85%) do not or did not indicate ($n = 5$; 3%).

Role Induction

Most participants either did not receive any training ($n = 62$; 49%) or received informal training ($n = 54$; 42.5%) for the role of CCE. Three (2.3%) participants noted they had a formal orientation or training for their roles, while 8 (6.1%) noted a combination of formal and informal methods.

Many tactics were included in RI, both formal and informal. The most common tactics involved in CCE socialization included receiving contact information for current preceptors ($n = 102$; 82%), overview of the duties as CCE ($n = 98$; 79%), and review of clinical education documentation ($n = 98$; 79%). The least common were training on how to identify potential clinical education sites ($n = 19$; 15%), development on navigating relational conflicts with key stakeholders ($n = 19$; 15%), and training on how to facilitate ongoing preceptor development ($n = 23$; 19%). Most tactics involved obtaining information, while the least common tactics involved training or development on how to complete various tasks. The full list of tactics included in RI are listed in Table 2.

All tactics included in orientation were rated at least moderately useful. Participants noted the most useful tactics involved receiving contact information for preceptors ($3.63 \pm 0.61/4.0$) and

Table 1. Participant Demographic Information

	No.
Gender	
Man	39
Woman	87
Prefer not to answer	3
Declined to answer	3
Age	
20–29	1
30–39	53
40–49	52
50–59	20
60–69	3
Position line	
Tenured or tenure track	63
Nontenure track	66
Rank	
Instructor of lecturer	16
Assistant professor	78
Associate professor	26
Full professor	9
Highest degree	
Master's	26
Academic doctorate	75
Clinical doctorate	28
Length of time in current role as CCE	
<1 y	20
1–3 y	31
4–5 y	30
6–10 y	28
11–15 y	13
16–19 y	5
20+ y	2
Length of time as AT	
<1 y	0
1–5 y	1
6–10 y	15
11–15 y	32
16–19 y	23
20+ y	56

Abbreviations: AT, athletic trainer; CCE, coordinators of clinical education.

meeting current preceptors ($3.49 \pm 0.75/4.0$). The least helpful tactics centered around using data management systems: training on using data management systems ($2.98 \pm 0.90/4.0$) and resources for teaching others to use data management systems ($3.0 \pm 0.88/4.0$). Even if tactics did not occur frequently, they were still rated as useful. One of the least commonly occurring tactics, navigating relational conflicts with key stakeholders, was rated as the fourth most useful tactic ($3.44 \pm 0.71/4.0$). Training on demonstrating compliance with accreditation standards was also highly rated ($3.52 \pm 0.55/4.0$); however, it was only included in RI for a little over a third of participants ($n = 48$; 37%). Usefulness of each tactic is outlined in Table 2.

Professional Development

Most CCEs noted they received professional development for their roles by reading the CAATE standards ($N = 102$; 77%), attending CAATE conferences or Webinars ($N = 93$; 70.5%),

Table 2. Activities Included in Role Induction and Their Perceived Usefulness. 1 = Not Useful; 4 = Very Useful

Please Indicate if You Received Information or Training on the Following During Role Induction:	Yes	No	NA	Usefulness
Role induction: information provided				
Description of duties as CCE	98	26	1	3.09 ± 0.79
Procedures for completing CCE tasks (eg, establishing new clinical education sites, preceptor training)	71	53	1	3.12 ± 0.78
Timeline for completing CCE tasks	35	89	1	3.06 ± 0.90
Contact information for current preceptors	102	20	2	3.63 ± 0.61
Introductions to preceptors (virtually or face to face)	69	54	1	3.49 ± 0.75
Access to data management system (eg, ATrack, EXXAT, Typhon, E-value)	89	22	13	3.21 ± 0.86
Resources for you, as CCE, to use data management systems	57	59	8	2.98 ± 0.90
Resources to teach others how to use data management systems (eg, students, preceptors, administrators)	33	83	8	3.0 ± 0.88
Documentation related to clinical education (eg, active affiliation agreements, EAPs, preceptor agreement)	98	23	3	3.28 ± 0.77
Documentation related to individual student requirements (eg, previous clinical experiences, current student records, background checks, vaccinations, FERPA)	90	32	1	3.34 ± 0.74
Processes for demonstrating compliance with standards (eg, tracking contemporary expertise and credentials for preceptors, tracking student experience and exposure)	59	63	2	3.27 ± 0.80
Role induction: training				
Identifying new clinical education sites	19	104	1	3.33 ± 0.69
Establishing new clinical education sites (eg, articulation agreements)	44	78	1	3.16 ± 0.89
Assigning and documenting student clinical education experiences	55	67	1	3.22 ± 0.90
Developing and initiating legal agreements (eg, affiliation agreements, MOUs, articulation agreements)	41	76	5	3.39 ± 0.70
Onboarding students to clinical sites	40	81	1	3.10 ± 0.74
Maintaining necessary student trainings (eg, CPR certification, immunizations, HIPAA/FERPA training, BBP training, background checks, drug screening)	48	68	5	3.38 ± 0.70
Managing data management systems (eg, ATrack, EXXAT, Typhon, E-value)	50	64	8	3.20 ± 0.76
Conducting clinical site visits	40	81	1	3.13 ± 0.79
Completing initial preceptor development	43	78	1	3.29 ± 0.81
Facilitating ongoing preceptor development	23	98	1	3.43 ± 0.79
Communicating with preceptors	46	75	1	3.15 ± 0.67
Evaluating preceptors' effectiveness as clinical educators	30	91	1	3.23 ± 0.77
Evaluating clinical education sites to meet the needs of the program	34	88	1	3.39 ± 0.61
Demonstrate and document compliance with accreditation standards related to clinical education	48	74	1	3.52 ± 0.55
Navigating relational conflicts between students and preceptors	25	97	1	3.33 ± 0.76
Navigating relational conflicts with key stakeholders (eg, other health care providers, other students, patients, alumni, coaches, administration)	19	103	1	3.44 ± 0.71
Navigating logistical conflicts that arise at the clinical education site (eg, reassigning students, adherence to program policies)	25	97	1	3.21 ± 0.83

Abbreviations: BBP, bloodborne pathogen; CCE, coordinators of clinical education; CPR, cardiopulmonary resuscitation; EAPs, emergency action plans; FERPA, Family Educational Rights and Privacy Act; HIPAA, Health Insurance Portability and Accountability Act; MOUs, memoranda of understanding; NA, not available.

and reading articles or doing their own research independently ($N = 83$; 63%). A full list of professional development activities is in Table 3.

In response to what topics would be helpful if included in a CCE training or development session, each topic was rated at least somewhat helpful. Participants reported the most helpful development topic groups were maintaining accreditation standards ($2.48 \pm 0.15/3.0$), followed by managing student experiences ($2.38 \pm 0.20/3.0$), managing preceptors and clinical education sites ($2.36 \pm 0.21/3.0$), and finally balancing their roles ($2.24 \pm 0.13/3.0$). The most helpful individual development topics included assessing preceptor effectiveness ($2.69 \pm 0.53/3.0$),

facilitating ongoing preceptor development ($2.67 \pm 0.60/3.0$), and demonstrating and appropriately documenting compliance with CAATE standards ($2.66 \pm 0.56/3.0$). The least helpful topics are related to tracking and maintaining clinical documentation, including monitoring clinical education experience logs ($1.86 \pm 0.76/3.0$), coordinating schedules with clinical education sites ($1.93 \pm 0.79/3.0$), and balancing work-life demands ($2.03 \pm 0.81/3.0$). Tables 4 through 7 outline the perceived helpfulness of professional development topics.

No significant differences were found in the perceived helpfulness of most professional development topics and length of time in role or highest degree obtained (eg, master's, clinical

Table 3. Professional Development Activities Used by CCEs. These Options Were “Choose All That Apply,” so the Percentage is >100%

Professional Development for Role as CCE	
Professional Development Activity	No. (%)
NATA Athletic Training Educators' Conference	68 (51%)
Commission on the Accreditation for Athletic Training Conference or Webinars	93 (70.5%)
Association for Athletic Training Education conferences or Webinars	17 (13%)
Formal mentoring within the institution	8 (6%)
Formal mentoring outside of the institution	5 (3.8%)
Informal mentoring within the institution	74 (56%)
Informal mentoring outside of the institution	39 (29.5%)
CCE group within institution	13 (9.8%)
CCE group outside of institution	13 (9.8%)
Sessions hosted by NATA (eg, CCE chat series)	21 (16%)
CAATE standards	102 (77%)
Reading articles independently	83 (63%)
Social media/GATher	20 (15%)
Other (examples listed: nonathletic training leadership workshops, doctoral coursework, district conferences, former Clinical Instructor Educator workshop, experiences as preceptor)	8 (6%)

Abbreviations: CAATE, Commission on Accreditation of Athletic Training Education; CCE, coordinators of clinical education; NATA, National Athletic Trainers' Association.

doctorate, or academic doctorate). A few significant differences were found between perceived helpfulness and age. For younger CCEs (aged 20–39), significant differences were found in the perceived helpfulness of topics related to balancing role, with younger CCEs rating topics in this area as more helpful than older CCEs (Table 7). Additionally, younger CCEs scored development related to balancing work-life demands as significantly more helpful than the older groups. Almost half of CCEs aged 20 to 39 rated balancing work-life demands as very helpful, while 41% in the oldest age group (50 to 69) rated this as not helpful. Other areas related to balancing roles, in which the youngest group rated as more helpful serving as a liaison between clinical site and program, maintaining contemporary expertise, and developing a timeline for task completion. While not significant, 64% of the oldest group of CCEs rated professional development in engaging in program recruitment and marketing as very helpful.

In preceptor and clinical education site management, 67% of younger CCEs rated developing legal agreements (eg, affiliation agreements, memorandum of understanding [MOU]) as very helpful, while less than one-third of the other age groups rated this as very helpful ($\chi^2 [4, n = 120] = 22.68 P = .0001$). Younger CCEs also demonstrated significant differences in perceived helpfulness for monitoring preceptor contemporary expertise ($\chi^2 [4, n = 119] = 13.11 = P = .011$). Additionally, CCEs in the oldest (50–69) and youngest (20–39) age ranges rated development related to maintaining directory information on an online accreditation platform (eg, eAccred) for annual reporting ($\chi^2 [4, n = 119] = 10.39 = P = .03$), maintaining clinical site records and contracts ($\chi^2 [4, n = 120] = 9.76 = P = .04$), and process for establishing clinical education sites in emerging settings (eg, military, occupational, hospital; $\chi^2 [4, n = 120] = 19.72 = P = .0006$) as significantly more helpful than CCEs in the 40 to 49 age range.

DISCUSSION

The purpose of this study was to understand the processes being used to socialize CCEs into their roles and to identify

professional development needs to better socialize them into their roles. Our results provide an overview of the tactics included in orientation and onboarding for CCEs. These results will be discussed within the context of the Pitney et al framework of socialization, which includes anticipatory and organizational socialization.⁹ Anticipatory socialization begins before the individual takes on the role and encompasses envisioning the role and formal role preparation. Organizational socialization begins when the individual takes on the role and includes organizational entry, role evolution, and role stability. Professional socialization is complex, and many individuals and groups contribute to successful socialization and gaining stability within the role and organization. In this study, we focused primarily on the organizational tactics used to socialize CCEs into the role and further developmental needs.

Role Induction

Orientation and onboarding are common socializing factors to assist new employees in understanding the roles and responsibilities of their positions. In athletic training, both formal and informal methods are used.^{14,15} Our results suggest that organizational socialization for CCEs is largely informal or absent. Nearly half of our respondents reported not having any training as they entered their roles, yet they are expected to complete vital tasks for student clinical education experiences. Previous researchers have found that it takes CCEs at least 12 to 24 months to feel competent in their roles because training specific to the role is lacking.⁸ Authors of a recent study examining the immersive clinical education experience found that some CCEs reported experiences that do not align with accreditation standards.¹⁶ Role expectations are associated with serving as CCE, and these are in place for student success and safety. If CCEs are not being appropriately trained for these roles, students may face negative consequences.

Table 4. Perceived Helpfulness of Topics Related to Maintaining Accreditation Standards

Maintaining Accreditation Standards	Differences by Length of Time in Role (P Value)			Differences by Degree Type (P Value)		Differences by Age (P Value)
	Not Helpful	Somewhat Helpful	Very Helpful	Mean (X/3.0) ± SD		
Demonstrating and appropriately documenting compliance with CAATE standards	5	30	84	2.66 ± 0.56	.741	.448
Demonstrating compliance with program policies	11	37	71	2.50 ± 0.62	.567	.291
Maintaining directory on eAccred for annual report	23	39	57	2.29 ± 0.77	.593	.034 ^a
Monitoring preceptor contemporary expertise	12	40	67	2.46 ± 0.67	.237	.011 ^a

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

^a Denotes significance at $P < .05$.

Although CCEs are not always being formally trained, many do receive resources as they begin their roles. Our results suggest that socialization focuses more on providing resources and information instead of training and development, as the top 9 tactics reported were related to role information (eg, contact lists, policies and procedures). This is consistent with previous researchers, who stated most CCEs received information from the previous CCE or program director (PD), but most of the training was through trial and error and on-the-job learning.⁵

Formal, intentional orientations have been shown to have positive effects on understanding role expectations, role integration, increased confidence, and decreased stress during role transition, while inadequate role preparation can lead to role strain and burnout.^{11,17} For new clinicians, structured orientations with more content correlates with feeling better prepared for their roles, improved communication and leadership skills, support, and professional satisfaction.^{10,14} While CCEs are likely not new clinicians, they may be new to the faculty role or new to academia. In our results, some CCEs had been ATs less than 10 years, and most were at the assistant professor or instructor or lecturer rank, which could indicate they are newer to academia. Previous researchers have shown CCEs also have previous clinical practice before transitioning into academia and taking on the role.^{5,11} Previous clinical experience is important to translating practical knowledge to the role; however, challenges exist when transitioning to academia when formal RI is not employed.¹¹ Authors of a recent study with new nursing faculty found the transition from clinician to faculty can be overwhelming, and many feel unprepared.¹² One department implemented an onboarding quality improvement initiative with new nursing faculty to assist with the role transition and found the intentional onboarding program resulted in 100% retention to the next 2 years, and both participants and mentors considered it a success. They employed socialization tactics including an orientation checklist, formal mentoring, and professional development workshops and found these were key in new nursing faculty gaining confidence and competency in their roles.

As new CCEs transition into their roles, organizations should employ formal orientations to relay information. Institutionally, new CCEs should learn about policies and procedures, such as the process for developing articulation agreements at the specific institution or developing new clinical education sites. Current CCEs could develop SOPs to streamline their roles and help with role transition for the next CCE. On average, athletic training program administrators (eg, PDs, CCEs) are not spending most of their careers in the role. Nynas and Myers reported that most PDs are in the role between 7.5 and 9 years, while Osgood reported most CCEs were in the role 5.14 years.^{8,13} Our findings are consistent, in which 61% of our participants were in the role less than 5 years. Coordinators of clinical education should assist with developing a transition plan, so the institutional knowledge related to the role is not lost when they change positions. Many of our participants were socialized informally by meeting with the PD or other faculty member who was previously CCE. If SOPs existed, this could streamline and formalize some of the orientation process for CCEs entering the role. Departments and colleges also play a role in formally orienting CCEs to the role. If a specific process for the whole college exists (eg, forming articulation agreements or policies and procedures), SOPs should be developed and distributed across the college. New

Table 5. Perceived Helpfulness of Topics Related to Preceptors and Clinical Education Sites

Preceptors and Clinical Education Sites	Not Helpful	Somewhat Helpful	Very Helpful	Mean (X/3.0) ± SD	Differences		
					by Length of Time in Role (P Value)	Differences by Degree Type (P Value)	Differences by Age (P Value)
Selecting preceptors	25	59	36	2.09 ± 0.71	.846	.927	.995
Completing initial preceptor development	15	32	73	2.48 ± 0.71	.379	.473	.143
Facilitating ongoing preceptor development	8	24	88	2.67 ± 0.60	.062	.885	.766
Managing preceptor evaluation and assessment of student	8	55	57	2.41 ± 0.62	.514	.894	.498
Assessing preceptor effectiveness	4	29	87	2.69 ± 0.53	.498	.512	.914
Providing formal feedback to preceptors	8	42	70	2.52 ± 0.62	.478	.245	.230
Understanding preceptor communication style and needs	18	50	52	2.28 ± 0.71	.784	.452	.486
Process for establishing integrated clinical education sites	20	49	49	2.25 ± 0.73	.347	.231	.202
Process for establishing immersive clinical education sites	17	48	55	2.32 ± 0.71	.116	.184	.203
Process for establishing clinical education sites in emerging settings (eg, military, occupational, hospital)	11	33	76	2.54 ± 0.66	.287	.123	.0006 ^a
Developing legal agreements (eg, affiliation agreements, MOUs)	28	40	52	2.20 ± 0.80	.369	.154	.0001 ^a
Maintaining clinical site records and contracts	31	48	41	2.08 ± 0.77	.751	.193	.045 ^a
Coordinating schedules with clinical education sites	42	45	33	1.93 ± 0.79	.119	.545	.217
Assessing the effectiveness of the clinical site	9	48	63	2.45 ± 0.63	.456	.549	.091
Conducting clinical site visits (eg, determining what to evaluate, completing the evaluation)	12	51	57	2.38 ± 0.66	.468	.295	.275
Intervening when students are not meeting expectations	10	41	69	2.49 ± 0.65	.534	.275	.319

Abbreviations: MOUs, memoranda of understanding.

^a Denotes significance at $P < .05$.

Table 6. Perceived Helpfulness of Topics Related to Managing the Student Clinical Education Experience

Managing Student Clinical Education Experience	Not Helpful			Somewhat Helpful		Very Helpful		Mean (X/3.0) ± SD	Differences by Length of Time in Role (P Value)	Differences by Degree Type (P Value)	Differences by Age (P Value)
	Helpful	Not Helpful	Helpful	Helpful	Helpful	Helpful					
Programmatic process for determining student clinical placement based on needs	11		53	56			2.38 ± 0.65	.971	.139		.405
Tracking clinical education site specific onboarding requirements for students and preceptors (eg, orientation)	13		50	57			2.37 ± 0.67	.719	.486		.624
Helping preceptors initiate student onboarding to clinical education sites	12		53	55			2.36 ± 0.66	.387	.320		.673
Maintaining clinical education documents (eg, HIPAA, FERPA, OSHA, CPR)	28		52	40			2.10 ± 0.75	.878	.192		.266
Overseeing student clinical progression through clinical education	7		47	65			2.49 ± 0.61	.953	.705		.448
Assessing student development in clinical skills	7		29	84			2.64 ± 0.59	.412	.414		.054
Assessing professional attributes (eg, communication, confidence)	12		38	70			2.48 ± 0.67	.530	.351		.260
Managing and evaluating student clinical assessments (eg, preceptor evaluation of student, student evaluation of preceptor)	9		45	66			2.47 ± 0.64	.521	.979		.661
Tracking patient encounters of students	20		53	47			2.23 ± 0.72	.095	.146		.447
Analyzing collected clinical data (eg, patient encounters, assessment data)	11		38	71			2.50 ± 0.66	.319	.153		.673
Monitoring clinical education experience hour logs	44		49	27			1.86 ± 0.76	.725	.757		.103
Handling student disciplinary actions	13		44	63			2.42 ± 0.68	.305	.436		.881
Navigating difficult conversations between student and preceptor	9		43	68			2.49 ± 0.64	.286	.577		.870
Navigating student safety issues (eg, compliance with Title IX, harassment, discrimination)	11		43	66			2.46 ± 0.66	.883	.056		.066

Abbreviations: CPR, cardiopulmonary resuscitation; FERPA, Family Educational Rights and Privacy Act; HIPAA, Health Insurance Portability and Accountability Act; OSHA, Occupational Safety and Health Administration.

^a Denotes significance at $P < .05$.

Table 7. Perceived Helpfulness of Topics Related to Balancing Role

	Not Helpful	Somewhat Helpful	Very Helpful	Mean (X/3.0) ± SD	Differences		
					by Length of Time in Role (P Value)	Differences by Degree Type (P Value)	Differences by Age (P Value)
Balancing role							
Developing a timeline for task completion (eg, developing sites, placing students, preceptor development)	22	52	46	2.20 ± 0.73	.837	.890	.009 ^a
Resolving conflict	13	57	50	2.31 ± 0.66	.302	.796	.133
Balancing clinical coordination with other aspects of faculty role (eg, teaching, service, scholarship)	19	40	60	2.34 ± 0.74	.459	.970	.602
Engaging in program recruitment and marketing	19	39	62	2.36 ± 0.74	.543	.908	.076
Balancing work-life demands	37	42	41	2.03 ± 0.81	.953	.766	.032
Maintaining contemporary expertise	28	49	43	2.13 ± 0.76	.502	.553	.01
Serving as liaison between clinical sites and program	20	51	59	2.24 ± 0.72	.471	.113	.02 ^a
Developing support network for CCE role	16	36	68	2.43 ± 0.72	.094	.114	.463
Complying with college and university rules and regulations (eg, faculty role, university policy and procedures)	30	48	42	2.10 ± 0.77	.064	.570	.113

Abbreviation: CCE, coordinators of clinical education.

^a Denotes significance at $P < .05$.

ATs report having written policies and procedures assists with role transition.^{6,17} Having clear, specific procedures could assist with CCE role transition and alleviate stress. The National Athletic Trainers' Association (NATA) Professional Education Committee developed infographics to help new CCEs transition into the role.¹⁸ Department chairs could use these as a starting point to develop formal orientations.

Professional Development Needs

Our results indicate CCEs would benefit from professional development in many areas, including topics related to maintaining accreditation standards, managing student experiences, managing preceptors and clinical education sites, and balancing their roles. Our participants sought out developmental opportunities through professional organizations (eg, NATA, CAATE, Association for Athletic Training Education [AATE]). Many also do individualized professional development (eg, reading articles, reading the CAATE standards). It was also noted some CCEs who had been in the role longer participated in NATA workshops geared toward the role of the CCE; however, these workshops no longer exist, and the Athletic Training Educators' Conference has transitioned to a virtual format. Additionally, these are geared toward educators in general and not necessarily specific to administrative roles. Previous researchers have outlined the lack of professional development opportunities for administrative roles.^{5,8}

Some of the topics rated as most helpful in a development session were related to maintaining accreditation and demonstrating compliance with accreditation requirements. In a study about PDs, it was found that accreditation and administration are large contributors to occupational stress, with accreditation being the leading cause of occupational stress.¹³ Osgood found similar results with CCEs, and the top stressor was maintaining accreditation standards.⁸ While we did not examine stressors in this study, our participants noted the helpfulness of professional development related to accreditation, which is consistent with previous studies.^{5,16} Commission on Accreditation of Athletic Training Education conferences were noted as a way CCEs received professional development, but the CAATE conference has transitioned from a large conference to smaller workshops. The CAATE currently provides Webinars and workshops to educate program administrators on various aspects of their roles. As the CAATE Educational Committee develops additional trainings, they should consider the needs of CCEs related to accreditation to help alleviate stress.

Some areas that were rated as less helpful were related to monitoring clinical education experience hour logs, placing students at clinical education sites, and coordinating schedules for clinical education. This is consistent with previous researchers who found CCEs feel more comfortable with student placements and monitoring progression, but other nuances of the role are more complex.⁵ Areas in which CCEs need more development are related to preceptors and facilitating preceptor development, assessing their effectiveness, and providing formal feedback. Preceptors are vital to the success of clinical education experiences, yet they are not often formally trained for the role.¹⁹ Commission on Accreditation of Athletic Training Education accreditation standards provide a great deal of flexibility and institutional autonomy for programs to determine the best way to evaluate and develop preceptors.¹ Resources exist for preceptor development, such as the

NATA Master Preceptor program, but it has an associated expense, and it is marketed directly to preceptors, so it does not provide professional training to CCEs for developing preceptors. Further resources or train-the-trainer type programs, like the former clinical instructor educator training that was available to CCEs historically, should be developed to assist CCEs.

Interestingly, our results for developmental needs did not show any differences in length of time in the role, which could potentially be due to the fact CCEs may have switched institutions but had previous experience in the role and felt more confident with some of the noninstitutional information. However, differences were noted between ages and developmental needs, especially related to topics in the balancing role section. Younger participants felt development related to balancing the role would be very helpful, while older participants did not. This is consistent with new athletic training faculty members who feel unprepared for managing faculty life while balancing administrative roles.⁴ Junior faculty members serving as PDs also feel more role strain earlier in their careers.^{3,20} We are seeing greater developmental needs in younger CCEs, as they are balancing being new to academia while also having administrative duties. Formalized RI and mentoring can facilitate balance in junior faculty members.²¹

While in this study we focused on organizational socialization, previous researchers have demonstrated many faculty do not have anticipatory socialization for administrative aspects of their roles.^{3,22} Some CCEs learned about administrative aspects of their roles through their doctoral work, but this was inconsistent, and not all CCEs had that development before assuming the role.⁵ Some Doctor of Athletic Training (DAT) programs prepare students for roles as educators and with administrative roles but not all.²³ This is consistent with academic doctorates, as some prepare for administration, while others do not.^{3,5,22} Doctoral training is inconsistent across programs and types of degree, which could be why our results did not show any differences between types of degrees with helpful development topics, as they do not vary by degree type but instead vary by program. To better prepare future CCEs, they should have authentic experiences in administration throughout their anticipatory socialization. For example, some CCEs from specific doctoral programs described having opportunities to do mock self-studies or help the CCE at the institution they received their degree perform administrative tasks.⁵ While not currently required for the CCE role, athletic training educators have the option to obtain academic or clinical terminal degrees. If they are interested in faculty positions, they could consider doctoral programs that provide socialization into those roles.

While many CCEs reported development needs in many areas of their roles, it is unknown who has the ultimate responsibility to train new CCEs for their roles. The role of CCE is complex, as institutional, relational, and professional knowledge is required to be successful in the role. Anecdotally, it appears that no one group is taking ownership of socialization for administrative faculty roles, and this is reinforced by our results and previous research.^{5,22} Coordinator of clinical education socialization cannot rely on any one group to ensure it occurs. At the organizational level, CCEs should be oriented into the specific policies and procedures and provided continued socialization through formal mentoring and regular professional development workshops. At the professional level, professional organizations are responsible for supporting the members, and one way is through

professional development of CCEs. The CAATE offers many workshops specific to the standards, but other members of the Strategic Alliance or the AATE have an opportunity to step in and provide development specific to administrative roles. Coordinators of clinical education should continue to seek out and administrators should provide funding for professional development specific to the CCE role. The NATA Foundation has developed a formal mentorship program that pairs junior faculty and doctoral students with experienced faculty to provide support. What started as primarily research support has grown to include all aspects of the role.²¹ Mentoring has been shown to be valuable to junior faculty members, and CCEs should also seek out mentoring opportunities specific to administration roles.^{21,24} Having an institutional mentor can assist with institutional practice, while having a mentor who is an experienced CCE can provide professional guidance. Novice CCEs should seek out mentoring for their roles, and the NATA Foundation Mentoring Program is a good resource to provide this connection.

LIMITATIONS

As with any research study, some limitations exist. One limitation is self-report bias. Because we used a survey as the main data collection source, self-report bias is possible. Additionally, this study was limited to CCEs. Therefore, it is unclear how the results of this study would translate to other leadership roles within athletic training or other health related professions. Future researchers should continue to focus on additional data collection sources at multiple timepoints to support conclusions drawn. Unfortunately, we did not include previous clinical experience as a demographic question, and therefore, we do not know if clinical experience or experience as a preceptor affects the socialization process or needs of CCEs. Future researchers should explore the effect of previous clinical and preceptor experience on CCE preparedness and socialization. Authors of future studies should also focus on development of formalized training to enhance and support CCEs.

CONCLUSIONS

The purpose of this study was to understand the processes currently being used to socialize CCEs into their roles and to identify professional development needs of CCEs to better socialize them into their roles. Our results suggest limited formalized onboarding into the CCE role despite the numerous role responsibilities. Formalizing training and socialization into these roles can improve confidence, decrease burnout, and potentially improve student experience. Additionally, many participants reported wanting in-person professional development opportunities specifically focused on education and networking for support. Although participants wanted more professional development, they mentioned it has been more challenging to find those in-person opportunities since some of these resources no longer exist. Lastly, many CCEs reported a wide variety of professional preparation before taking their roles due to the variation in degree requirements. Therefore, formalized mentorship is necessary to address gaps in education and preparation.

Financial Disclosures

The authors report no conflicts of interest. This study was funded by the Mid-American Athletic Trainers' Association. This study was approved by the North Dakota State University Institutional Review Board.

REFERENCES

1. CAATE 2020 Professional Standards. Commission on Accreditation of Athletic Training Education. Accessed February 7, 2025. <https://caate.net/Programs/Professional/Professional-Program-Standards>
2. Viesselman C. *The Socialization of First-Time Athletic Training Education Program Directors*. Dissertation. Northeastern University; 2013.
3. 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.
4. 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.
5. David SL, Thrasher AB, Kunkel LE. The socialization and development of the coordinator of clinical education in athletic training. *Athl Train Educ J*. 2022;17(4):349–362.
6. 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.
7. 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.
8. Osgood CT. Factors impacting athletic training program directors' and clinical education coordinators' professional roles. *Athl Train Sports Health Care*. 2021;13(5):e280–e290.
9. Pitney WA, Ilsley P, Rintala J. The professional socialization of certified athletic trainers in the National Collegiate Athletic Association Division I context. *J Athl Train*. 2002;37(1):63–70.
10. Rush KL, Adamack M, Gordon J, Janke R, Ghement IR. Orientation and transition programme component predictors of new graduate workplace integration. *J Nurs Manag*. 2015;23(2):143–155.
11. 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.
12. Groth SM, Duncan R, Lassiter J, Madler BJ. Onboarding orientation for novice nurse faculty: a quality improvement pilot project. *Teach Learn Nurs*. 2023;18:212–218.
13. Nynas S, Myers CB. Occupational stress for athletic training program directors. *Internet J Allied Health Sci Pract*. 2015;13(1):10.
14. Thrasher AB, Walker SE. Orientation process for newly credentialed athletic trainers in the transition to practice. *J Athl Train*. 2018;53(3):292–302.
15. Thrasher AB, Walker SE, Cavallario JM. Newly credentialed athletic trainers' onboarding process during the transition to practice. *J Athl Train*. 2025;60(1):70–81.
16. Calvert K, Thrasher AB, Gessel CL, Rosen AB. Immersive clinical education experiences in athletic training: a report from the NATA Professional Education Committee. *Athl Train Educ J*. 2024;19(4):237–244.
17. Walker SE, Thrasher AB. The impact of onboarding during transition to practice for newly credentialed athletic trainers. *J Athl Train*. 2021;56(6s):S-99.
18. National Athletic Trainers' Association. Coordinator of clinical education infographics. [nata.org](https://www.nata.org/professional-interests/job-settings/higher-education/resources). Accessed February 7, 2025.
19. Groh N. Preceptor training through clinical conferencing. *Int J Athl Ther Train*. 2015;20(2):20–23.
20. Walter JM, Van Lunen BL, Walker SE, Ismaeli ZC, Onate JA. An assessment of burnout in undergraduate athletic training education program directors. *J Athl Train*. 2009;44(2):190–196.
21. 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.
22. Barrett JL, Singe SM, Diamond A. Athletic training and physical therapy junior faculty member preparation: perceptions of doctoral programs and clinical practice. *Internet J Allied Health Sci Pract*. 2020;18(3):4.
23. Schweitzer AJ, Rivera MJ, Welch Bacon CE, Eberman LE. Preparedness of Doctor of Athletic Training (DAT) credentialed athletic trainers to take roles in academia. *Internet J Allied Health Sci Pract*. 2023;21(2):13.
24. Nottingham S, Mazerolle SM. Mentoring processes in higher education: perspectives of junior athletic training faculty members. *Internet J Allied Health Sci Pract*. 2018;16(4):1.