

A Closer Look at the ACAE 2016 Clinical Education Forum

By Rupa Balachandran, Carol Cokely, Sumitrajit Dhar,
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On April 16, 2016, the first annual event in clinical education took place in Phoenix at the American Academy of Audiology conference. The ACAE hosted a four-hour program titled, *Securing the Future of Innovative Clinical Education in Audiology*. More than 100 audiologists attended from the United States and various countries to hear presentations from leaders in the field on innovative practices and on demonstrating outcomes in clinical education. The keynote speech, *The Journey's Not Over*, was delivered by Ian Windmill, PhD, president-elect, American Academy of Audiology, and the program was moderated by Lisa L. Hunter, PhD, chair, ACAE; and Jay W. Hall III, PhD, vice chair, ACAE.

For those unable to attend the forum and as a recap for those who did, the ACAE is publishing a summary of the meeting, including abstracts from the forum's presenters in this and the next two issues of *Audiology Today*. In this issue, we will provide abstracts from four participants.

These articles will keep the interest of clinical education alive and will continue the important conversations started in April. We also may publish a lengthier article or special issue devoted to this topic in this or a professional audiology journal in the near future. A critical outcome is to develop a clear strategy and trajectory for the future education and training needs of audiology students over the next year. ACAE plans to host its second annual event about this subject at AudiologyNOW! 2017 in Indianapolis.

The Abstracts

Moving From Time-Driven to Competency-Based Metrics in Audiology Clinical Education

Rupa Balachandran, PhD, Program Director, Doctor of Audiology Program, University of the Pacific

Audiology education is governed by standards that need to be met in different areas of clinical competencies. In clinical education we continue to struggle with legacies of time-based metrics. Some come from standards that require specific clock hours to be met to satisfy requirements. These time-based metrics have subsequently been adopted by agencies for licensing criteria. Clinical placement is similarly guided by clock hours at each practicum site and reporting is presented as contact hours per patient demographic.

Time-based measures are not adequate in describing the competencies required to meet standards specified by the audiology accreditation for audiology education. They are a poor indicator of student readiness for clinical practice.

The AuD program at University of Pacific is an accelerated program and has developed a clinical curriculum which is based on student competencies in each clinic area assessed. Clinical teaching is based on the individual needs of students. These steps include the following:

1. Identifying behavior that is consistent with the competency
2. Developing an individualized plan to develop each competency
3. Clinical instruction, mentoring, and supervision
4. Assessment of competency
5. Work on next competency

Student progression through the curriculum is based on achieving clinical competencies in each area before moving on to the next.

Evidence-based clinical education requires measuring student outcomes for each of the training protocols and assessing effectiveness of clinical education. We are currently working on evaluating the effectiveness of our clinical protocol and will have data to share with you on various aspects of clinical training as it relates to accreditation standards.

Outcomes in Clinical Education: Framework for Building and Measuring Competencies

Carol Cokely, PhD, Clinical Professor and Director of Clinical Education, The University of Texas at Dallas

Outcomes in clinical education must mirror the goals of the program, provide qualitative and quantitative data documenting trajectory of individual students and the program, and align with reassessment of the program and actionable items. Furthermore, clinic-rotation and externship guidelines must support desired outcomes. Clock hours, cumulative-competency ratings, and formative written/oral examinations are useful but are largely retrospective or are not indicative of in-action capabilities.

In addition to the above-named assessment standards, programmatic tools are in place that aid in determining whether students-to-graduates can be entrusted to

complete professional activities in action and engage in professional-growth activities commensurate with an independent health-care practitioner. The clinical-education framework requires documentation and uniform vetting of rotation and extern sites, recording of on-going tallies that document frequency of hands-on activities in practice, and provides for self-assessment of accomplishments, goals, and plans for self-directed growth. Protocols reflect equivalent and standardized guidelines rather than a student-by-student approach.

Programmatic, in-house, evaluations include a wide array of specific-skill readiness and a

Performance Assessment of Skills (PAS) that uses standardized patients alongside trained-faculty observers to assess clinical reasoning, patient-practitioner interactions, and patient-confidence. In addition, outcomes are gathered following a minimum of six months post-graduation and offer important metrics regarding professional preparedness, curriculum relevance, career satisfaction, and debt-to-salary ratio. Aggregate data have been instrumental in development of facility/preceptor guidelines, novel clinical instruction/assessment tools, and curricular changes.

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The ABCs of Innovation—Aspirations, Balance, and Creativity

Sumitrajit (Sumit) Dhar, PhD, professor and chair, Roxelyn and Richard Pepper Department of Communication Sciences and Disorders, Northwestern University

In this presentation, I argue that we need to consider serious and immediate innovation in audiology education for three reasons, among others. First, auditory and vestibular science is evolving more rapidly than ever before. Thus audiology education needs to adapt to a model where learning how to learn new information is the central skill attained. Second, new knowledge

and technology is emerging from non-traditional sources. Audiologists need to develop the ability to incorporate new information and technologies in a timely manner, but with appropriate discretion. Third, funding models of higher education, and especially professional education, are changing at a dramatic pace. Thus models of audiology education need to acknowledge

this new reality while respecting the financial reality of professional compensation in today's health care environment. I discuss possible solutions to these problems but argue that solutions need to be locally sensitive but globally applicable. I advocate for national standards for measuring outcomes, particularly for readiness to practice.

Assessment of Clinical Education: A Competency-Based Clinical Skills Evaluation Tool

Alyssa R. Needleman, PhD, Clinical Director and Associate Professor; Erica Friedland, AuD, Chair and Associate Professor, Department of Audiology, College of Health Care Sciences, Nova Southeastern University

One of the most significant aspects of the educational experience for students completing their AuD is the clinical experience. However, the diversity of clinical settings and clinical preceptors can vary widely. Some clinical settings can afford great opportunity for students to practice independently, while others, by nature of the setting and third-party contracts, cannot allow students the same level of independence. This creates significant difficulties in evaluating students' clinical and professional performance in their clinical experiences. Moreover, there is considerable diversity among community preceptors in how the student evaluation is approached and interpreted, even with training by the university.

In an attempt to better delineate student performance and expectations, an assessment tool has been developed that focuses on descriptive skill competency as opposed to skill proficiency ratings. Each clinical skill competency to be assessed (e.g., "efficiently performs and interprets tympanometry") is broken down into component skills that make up that competency (e.g., selection of probe tips, maintaining a seal, analyzing tympanogram). In this manner, preceptors are asked to make less of a judgment call based on ratings that require interpretation and definition, and are rather asked to score how many of the components of the skill the student can complete without preceptor guidance.

Outcomes indicate skill competency evaluation is an effective way to evaluate performance in externship, and individual preceptor evaluation can be normalized. Additionally, students have a better understanding of the required skills in order to achieve a specific competency level, removing ambiguity. Preceptors do not require the same training level to complete the evaluation due to the specificity of the descriptors, which saves time for both the preceptor and the university.

Conclusion

We will continue the series throughout this year, but in the meantime, we are interested in hearing your thoughts about the future for qualitative and consistent clinical education. Please feel free to respond to info@acaeccred.org. 

