Survey #4 Quantitative Results
(9/11/2024)

	Yes %	No %	Count
Priority 1 - Provide the highest quality, most innovative health professions education to ensure career-ready graduates			
Goal 1: Advance didactic education by integrating cutting edge practices into pedagogy across programs.			
Objective 1*: Leverage AI, simulation, and other emerging technologies*	91%	9%	(83Y/8N)
Objective 2: *Scaffold opportunities in IPE/IPP for all SHP students from entry through graduation*	86%	14%	(78Y/13N)
Goal 2: Enhance clinical training through innovation and partnerships			
Objective 1: *Increase the number and type of clinical placements across programs*	95%	5%	(82Y/4N)
Objective 2: *Expand and integrate SHP community clinics to support the patient experience as well as educational, research/scholarship activities*	97%	3%	(83Y/3N)
Objective 3*: Increase opportunities for clinical training through service learning and simulation*	91%	9%	(77Y8N)
Priority 2 - Foster Growth of Research and Scholarship			
Goal 1: Increase Scholarly Productivity			
Objective 1: *Foster team scholarship to support NTT advancement*	97%	3%	(67Y/2N)
Objective 2: *Foster cross-departmental mentorship and collaborations*	84%	16%	(58Y/11N)
Goal 2: Increase impact, sustainability, and reputation of SHP research and scholarship program			
Objective 1: *Increase R01 equivalent awards and federal grants*	88%	12%	(59Y/8N)
Objective 2: *Enhance administrative and analytical support for research and scholarship*	88%	12%	(59Y/8N)
Priority 3 - Build Healthy, Vibrant, and Inclusive Communities			
Goal 1: Workplace Community: Evolve SHP's work environments to bring core values and DEI principles to life			
Objective 1*: Build tailored workplace wellness plan for SHP aligned with HHS framework*	84%	16%	(52Y/10N)
Objective 2: *Enhance professional development, advancement, and recognition for faculty and staff*	95%	5%	(59Y/3N)
Objective 3: *Build capacity of leaders at all levels to promote inclusive climates and a positive work culture*	90%	10%	(56Y/6N)
Objective 4*: Build awareness and knowledge sharing throughout SHP.*	94%	6%	(58Y/4N)
Goal 2: Student Community: Enhance the student access and experience from admissions through graduation			
Objective 1*: Create more seamless transition from RU undergrad into SHP program.*	95%	5%	(59Y/3N)
Objective 2: *Expansion and enhancement of tailored programs (i.e., part-time programs, short certificates), pathways, and practices to attract and retain target student populations (i.e., Veterans, Second Career, First Gen, First Gen, EOF)*	94%	6%	(58Y/4N)
Objective 3*: Support programming and services that optimize student health, wellness, and resilience*	95%	5%	(59Y/3N)
Goal 3: Surrounding Communities: Implement a substantive and sustainable community engagement strategy aligned with SHP's core mission			
Objective 1: Build mutually beneficial partnerships within the communities we live and serve	97%	3%	(60Y/2N)
Objective 2: Build mutually beneficial partnerships within the communities we live and serve	89%	11%	(55Y/7N)
Priority 4 – Strategic Stewardship and Sustainability			
Goal 1: Achieve financial sustainability while serving the current and future workforce needs in the region.			
Objective 1*: Determine optimal depth and breadth of academic portfolio for long-term sustainability and impact,*	98%	2%	(65Y/1N)
Objective 2*: Build and share financial models of sustainability to support SHP decision-making at all levels of leadership.*	95%	5%	(63Y/3N)
Objective 3: *Revitalize and deploy a robust philanthropic strategy*	94%	6%	(62Y/4N)
Goal 2: Advance regional and national reputation			
Objective 1*: Build awareness of SHP programs, research, quality, and accomplishments*	97%	3%	(63Y/2N)
Objective 2*: Focused efforts to attract highest level teaching and research faculty*	92%	8%	(60Y/5N)

Goal 1 OBJ 1 Comments

- To a large extent "yes". but clarity is needed that the challenges and opportuntiies presented by AI are at least two-fold and in some ways very different: 1) academic integrity being threatened; 2) androgogical (pedagogy for adults) or teaching opportunity for clinical documentaiton, simulated communication with patients, and clinical problem solving among other
- Most faculty are already using AI, simulations, etc. as part of teaching, in our program as appropriate. Goal 1 seems like a good goal but the objective seems detached from the goal and is overly specific, with a focus on AI?
- 1. Recommend Priority 1, Goal 1 be revised to "Advance education..." rather than "Advanced didactic education...". These tools and strategies can be used across educational settings, not just in the classroom.

  2. AIthough AI and related technologies may be helpful in the classroom, the primary benefit of AI is to augment human performance on time-consuming administrative tasks. For example, AI could be leveraged to manage admissions processes, develop schedules, or respond to external inquiries. This would free up faculty and staff to focus on pedagogy, thus improving the quality of pedagogy and the efficiency of administrative processes. An action could be "Incorporate AI and other technologies into administrative processes."
- We probably should include something regarding the use of AI for research and scholarships: both efficiencies and challenges
- The AI technology is moving very fast. By the time a taskforce is set up and comes up with its report, the report will be outdated.
- I think we need to include AI experts from outside SHP in the Taskforce
- "cutting edge practices into pedagogy" is wordy... just cutting edge pedagogy or cutting edge approaches for pedagogy?
  "Reach out" is an odd verb.. contact? Engage?
  The taskforce needs to have representation from external partners that have experience and expertise in AI, not just homegrown.
- I would like to see the term 'evidence based' inserted in the Goal statement. Cutting edge is not always best practice and a lot of money might be spent updating/acquiring equipment and training folks that in the end fizzles out.
- Partner with resources/other faculty at Rutgers such as the engineering, computer science, and/or data science/analytics departments.
- This is a heavy lift and will require resources in the form of grant funding and time (in-kind) allocations.
- Support grants to foster creative technology-driven pedagogy.
- The planned action items for the stated objective look very apt

- Looking forward to being a part of this process! I think this is a great direction for SHP
- Instead of annual training workshops provide training workshops every six months. Then update any policy annually.
- Consider how AI can be use to enhance student facing teaching and help with faculty-facing assessing of curriculum, for example, qualitative theme identification.
- Although alumni, current students, and clinical partners are great resources, the premier internationally-r ecognized resource is also the SSIH (Society for Simulation in Healthcare)-they have a dedicated curriculum for health professions programs to integrate not only simulation but other innovative technology including AI, VR, AR, etc into curricula. Is there an opportunity to have faculty also attend IMSH (International Meeting on Simulation in Healthcare) where they showcase learning, research and scholarship. The scholarship elements specifically will allow us to gain insight into objective measurements of success.
- Perhaps we do not need to limit the taskforce to "emerging" and keep the name as "Technology Taskforce" since some of these methods have been around for a while. I have heard the phrase "augmented intelligence" instead of "artificial intelligence". Maybe the taskforce should name themselves.
- Also reach out to computer science coders who can help develop AI solutions for our programs.
- Not just AI, but the technologies that we are using without training can be included. For example, even for the telehealth medium such as zoom or phone call, we can include more in the curriculum how we can train practitioners to excel in those service provision.
- We can use social media to reach out to alumni and send them surveys to collect information on how AI is utilized in their jobs.
- not sure you need the word didactic- I find it confusing
- reach out to ... students on internship ... this language is unclear. Would we want to hear from students in clinical settings or enrolled in clinical internships? Also to assess faculty knowledge in these areas?
- Outreach to alumni and students on intern to ask for guidance seems a bit off. Shouldn't we be conducting an assessment of higher quality industry partners? It reads as if the only reason we are reaching out to alumni and student is because they went to Rutgers. Doesn't seem like a qualification for feedback.
- Create working groups for the development and adoption of these technologies.
- While AI use needs to be incorporated in educating students, AI use in the education needs to be carefully implemented in developing graduate and

doctoral students' competencies as professionals. Clear guidelines for when to use and when not will be necessary.

- This objective is crucial. Especially for things that take a lot of faculty time and does not show up on calendar. (ie formulating test questions, grading open ended (or MC) questions if we provide the rubric, etc). As important is knowledge of how the students are or can use AI.
- this is highly focused on "AI" but that is merely the breakthrough of the day - there are sure to be others. By being more broad, we can prevent these from being outdated.
- Technology and AI should be the focus to advancing our education process
- I would like to see some considering for active learning strategies, or building technology into active learning.
- If a taskforce is to be created, it needs clearly defined goals. AI is a rapidly changing technology and we want to stay on top of how to best integrate it into the classroom.
- Expand the task force's role to continually assess technology trends for sustainable pedagogical innovation. Pilot AI-driven tutoring systems, AR-based medical simulations, and personalized learning platforms to adapt to student needs. Establish feedback loops and partnerships with healthcare tech companies to prepare graduates for evolving technologies. Offer certification programs for faculty proficient in AI and emerging technologies, and facilitate peer-led sessions for sharing best practices.

Goal 1OBJ 1 Measures

- We need access to data sources at low cost for students to successfully implement emerging practices. Rutgers CRDW/ EPIC Cosmos etc.
- We need a measure that can objectively assess how AI impacted student outcomes - not so much a qualitative outcome but quantify our outcomes
- User-friendly tools will be offered to faculty with orientation, training that can be integrated with CANVAS and used in the classroom. Faculty report increased confidence in integrity of student work and that the teaching tools improve instruction, as doe students.
- To start, creation of established interdepartmental committees or task forces that are interdisciplinary in nature and who will be able to set a concrete agenda/steps that begin this process.
- To be able to inform/teach, update and capture mis-use information.
- The answer to this is likely more complicated than we'd like. We would have to start with the accrediting bodies of the various programs and align them with existing technology/gaps. Suresh Narayanan (Narayanan et al., 2023) proposed various approaches to integration of technology in medical education and pedagogy such as Chatbots, an Intelligent tutoring system (which would be so helpful!), or procedural skills such as IV line insertion or suturing being assessed through VR where a learner is asked to execute a procedure.
- Success= data demonstrates that new technologies (rolled out in pilot trials) are actually more effective for student mastery than current approaches.
- Students show high self-efficacy in using those technology applications
- Students choose SHP over other schools based on the innovative technology integrations in our programs
- Student satisfaction: Measured with student surveys.
- Since AI in academia is still an emerging practice there maybe a lot of innovative measures and practices we may come up with ourselves suiting the different departments in our School - which is perfect and affords an opportunity to be a role model ourselves for other schools/institutions.
- Publications, recognition as effective 'adopters' of the technologies.
- Perhaps these measures fall under this objective (or another):
  - budget evaluation of existing and emerging technology to show whether functionality of these technologies is being optimized. For example, I wonder if Canvas, examsoft, eValue, microsoft excel and newer technologies have overlapping functions that we could optimize functionally and economically.
  - training for staff and faculty for technologies to optimized time and teamwork in designing and implementing use of these technologies
  - collaboration with those who have curriculum design credentials would be helpful for the taskforce
- Increased enrollment and placement upon completion of studies. Also, increased quality of care.
- I can imagine that success will look different for different stakeholders. For students, perhaps guidance for how to effectively and ethically use AI in their studies and courses. For instructors: perhaps workshops on "helpful practices" for using AI to develop course or evaluation materials. For researchers, workshops or resources for enhancing common research tasks (increasing efficiencies in qualitative or quantitative research) and perhaps even project management (not

sure what that last one would look like, but perhaps). For administrators: no idea, haven't really thought that direction but it would be very cool if we can figure out how to gain some administrivia efficiencies using AI.

- Hold regular meetings of emerting technology taskforce. Regular suveys of faculty, alumni, students enrolled in clinical internships. Capture metrics of trainings and attendence. Consider assessing faculty interest in training and perceived needs.
- Equip the classrooms with modern technology, including AI-powered tools and VR/AR systems, to support interactive learning experiences. The task force will integrate new technologies to ensure continuous innovation and collaborative partnerships will keep our curriculum aligned with real-world advancements. Faculty integrating AI and simulation tools into teaching, and students engaging with these tools, showing increased engagement and improved problem-solving skills.

  Success can be measured through improvements in educational outcomes, including student performance and alumni surveys. The aim would be to increase scholarly research and development in educational technology, positioning our institution as an innovative leader. Tracking higher adoption rates of technology in the classroom and increased research output related to AI and educational technologies.
- direct, hands on support from IT faculty/staff. Didactic faculty in programs will need technological support to implement these strategies. IT classroom infrastructure should also be as user friendly as possible.
- AI improves student learning AND improves efficiency for faculty members who deliver the curriculum.
- 1. Number of programs that implement curricular components that involve AI,
  2. Survey feedback from students that they feel prepared to implement AI in their careers,
  3. Survey feedback from alumni that they their education prepared them to leverage AI and other technologies in their current role,
  4. Throughput and productivity metrics for administrative tasks.

Goal 1 OBJ 2 Comments

- What is IPP?
- This is close. IPE/IPP is relevant to every discipline, but in different ways. So a universal IPP or IPE is not possible or relevant because every profession interacts with different professions and specialties, and actually in different types of contexts. As examples: PA's need to work with all types of specialists from various medical specialties; Informatics deals with both management and clinicians, but not clinically, but to provide them access to key clinical information. Counselors have more interaction with other behavioral health clinicians than other professions. Every profession might)or might not) need interact with such clinicians, but not on a daily basis.
- This is a heavy lift and will require resources in the form of grant funding and time (in-kind) allocations.
- There is no mention of space requirements and disparate student body sizes to ensure that all students have quality experiences. If community clinics were increased and all appropriate professionals had roles in those clinics, then the IPE experiences would be more impactful learning opportunities than the forced large group discussions. As well, since the modules are just getting rolled out, it seems that there should be an action item to study the impact of those modules on learning and attitude changes, but we know those don't always translate into behavior changes. Finally, since the large IPE experiences have been going on for a while, it seems there should be some follow-up with alumni about what impact the experiences had on their current practice and what would they recommend for making the experiences more useful.
- The above set of actions doesn't take into account issues of workload allocation, curriculum requirements by accreditation agencies. Anything common forced upon all programs will not be an advantage in promoting innovation and integrity of the curriculum. IPE/IPP should be made extra-curricular (like HIPAA, Title IX training sessions) and not forced upon the programs many of which are already inter-professional by their very nature and the roles and responsibilities of its practitioners.
- Provide enough resources, space, and time for faculty to develop interdisciplinary courses that will meet the above objectives.
- optimistic
- Needs to be realistic and contain virtual options for distance learners.
- More collaboration, reaching out to other departments/institutions to learn.
- It is unclear how often these IPE activities will be offered or required. The tasks appear unrealistic due to the diversity of programs and specific accreditation standards. For lock-step clinical programs doing IPE well, this may disrupt curriculum delivery and create scheduling hurdles without added value beyond what already exists.
- It is important to strenghten relationships with the industry, so that is faster for our students to get interships and job opportunities.
- IPE may be well suited for summer intensive semesters where teaching traditional courses is more challenging. Some IPE is geared to make the students better clinicians, but not necessarily necessary for licensure exams.
- I would keep the general IPE faculty group separate from a faculty group that deals specifically with the free clinics. Certainly, a rep or two from the free clinics should be involved in the larger IPE group, but I think that there are so many logistical and specific clinical issues involved with facilitating IPP within the clinics, that it requires a separate group that can focus on these particular issues. Truth is, we already have something like the free clinic faculty group in place (and have had for about a year now). But, I wouldn't conflate the groups. There are more general IPE curricular concerns that would be less applicable to interprofessional practice.

- I welcome this and would add that there should be an emphasis on inclusion of all students and faculty in all disciplines.
- I think the only "improvement" here (and improvement is in quotes because these actions are already excellent, nothing to improve there!) is to determine if there is a way to execute some of these shared course team teachings using simulation. The more IP-based simulation we do, the strong our students will be. We are beyond the days of learning something out of a book-lecture combination, take a test, then fly out of the nest and "Best of luck!" We really need to use simulation and IPE combined to do assessment. A great example is a TOSCE (which I believe Dr. Paparella-Pitzel has in her curriculum).
- I feel that common courses and school-wide times for IPE would create an unnecessary burden. Smaller, targeted IPE activities with departments that work together in practice, to achieve specific objectives, would be the most effective use of time and resources. IPE for the sake of IPE runs the risk of further burdening already time-constrained curricula. I recommend that we focus on implementing IPP in SHP clinics and other clinical experiences.
- I feel like this is already happening in our program. I am not sure the objective matches the goal and I believe that many of the IPE/IPP activities are dated and need revision. I think more didactic interactions are very static and are missing a bigger vision for a more advanced IPE/IPP. I believe the school has an IPE committee and they have spend 6+ years working on a 1 credit course for material that was already covered in our program. Our students report little to no benefit from the large format, IPE events. I think we move too slowly and are too slow to adopt new approaches that many schools of health profession have already adopted.
- Common times and courses are a great idea
- Common courses will be difficult to achieve especially for accredited programs. Timing of course curriculum is also an issue. I think the the IPE/IPP experiences are achievable but the others may not be as courses may not align. Not so sure post-professional programs require this - they students are already practicing interprofessionally
- Clarifying faculty roles, providing incentives, and offering training for cross-departmental team teaching will improve the objective of scaffolding IPE/IPP opportunities. Faculty should have clear expectations, and cross-departmental collaborations should be supported with training workshops and recognition for those who lead IPE courses.

  Offering virtual IPE opportunities alongside flexible scheduling models will ensure wider accessibility and participation. Standardizing the IPE curriculum across programs with clear learning objectives and alignment to national standards will ensure consistency and quality in interprofessional learning.

  Expanding IPE opportunities in community clinics is another key improvement, with structured, role-based experiences that mimic real-world healthcare environments, allowing students to collaborate in meaningful ways.

  It is equally important to increase access to dedicated IPE learning spaces, such as simulation labs, equipped with advanced technology to support both in-person and virtual collaborations.

  Tracking the effectiveness of IPE/IPP programs through formal assessment tools will help ensure continuous improvement. This data-driven approach will measure student outcomes, collaboration skills, and career readiness, allowing for ongoing refinement of the curriculum and learning environments (Also allow research to be developed).

- Agree for clinical practice courses. But there should be caution for some other courses. Graduate students enroll in specific programs to gain knowledge and competency in the specific field that they are interested to become a professional. Creating common courses may make them feel like the programs are more like undergraduate programs. For example, students have shared feedback that examples more relevant to their field practice in taking research methods courses are much more helpful in understanding and applying the methods they learn.

Goal 1OBJ 2 Measures

- Well, believe it or not, it will be easier to measure IPP compared to IPE. The IPP measurement of intervention would require a large data set of patient outcomes. For example, if the HOPE Clinic collaborates with a PT resource, Nutrition resource, and Psych rehab resource, things like blood glucose, serum cholesterol levels, various behavioral health patient surveys of self-progress are great ways to measure outcomes collectively. For IPE, there are various validated and non-validated ways to measure outcomes. They do have observational tools if the goal is to assess teamwork behaviors and interactions. One great way for our students to have reflective writing and approach it qualitatively as well. IPE assessment can be a big lift because it may involve multiple assessors including faculty from each program involved. The success for this approach may require dedicated faculty time.
- Success=alumni data that the experiences helped them in some way in their current clinical practice roles, and current student data on the immediate impact on awareness and knowledge.
- success will require complete re-structuring of how classes are scheduled and coordinated.
- Students take class(es) from other department or co-taught by IPE team
- Students graduate with immersive IPE/IPP experiences that rival actual work experience in their fields
- Relevant IPP/IPE tailored for each professions. Not all experiences can be fully shared, some can, some are not relevant to some professions. Faculty and graduates report that the IPP/IPE is relevant to their clinical settings and helps them.
- Provide enough resources, space, and time for faculty to develop interdisciplinary courses that will meet the above objectives.
- Number of alums with full-time employment.
- Moving the IPE curriculum from the classroom to the clinical site.
- More space for simulation activities. Collaboration between faculty-student free clinics within SHP.
- Meaningful IPE/IPP experiences. I think IPP is much more advantageous than a zoom room with many students reviewing a case. Students need more real life experiences which would require more faculty - not sure if this is realistic
- interprofessional collaboration will be so routine that students won't even realize that it is special.
- Increased quality of care as a result of a wider range of expertise.
- Identify and hold faculty group. Hold IPE course with relevant features for all departmental specialty. Identify shared courses which will use team teaching. Utilize best practice methodology/protocol for IPE. Identify recommendations for IPE/IPP i clinics.

- I've done more thinking about this regarding IPP in the free clinics. Specifically, (1) I'd like to see a coherent curricular plan for IPP--what, in particular, do we want students to get out of these experiences, and how would we measure that?), (2) I'd like to see a shared EMR and some way to link the educational outcomes of students across clinics and programs (e.g., if PT has different curricular goals and measurement approaches than PA or SLP or behavioral health, or, if we are trying to get different EMRs to "talk to each other", then it's going to be a hot mess to try to tell a coherent story down the line), (3) I'd like to see an institutionalize referral system between clinics that was designed in such a way that we aren't assuming that patients from Plainsfield would have to travel to Newark or vice versa, (4) I'd like to see a handful of shared clinic days a semester (e.g., where we have PT at HOPE or where we have PAs at the PT clinic, behavioral health at both, etc.) where we could do "warm handoffs" as needed, (5) I'd like to see a coherent plan for a "scholarly agenda" for the clinics--i.e., a reasonably well defined set of a prior questions that we can then work toward answering rather than merely coming up with ad hoc questions.
- Excellent faculty with exceptional skills and connections
- 1. Measure the number of SHP students who participate in IPP activities.
  2. Survey feedback from current students and alumni that demostrates preparedness to deliver clinical care in interprofessional teams.
  3. Survey feedback from employers that SHP graduates work effectively in interprofessional teams.
- - report or other accessible database of IPE/EPP events
  - documentation of participation of several departments within the school and, additionally incorporating units outside of SHP (pharmacy, nursing, medical school, social work, perhaps even non-medical disciplines)
  - patient centered cases discussed in events, conferences, and activities that represent need for collaboration
  - incorporation of concrete skills to build collaboration - writing of orders and prescriptions, reporting of key information through notes and verbal presentations, outcomes-based goal setting for the patient that is communicated effectively to all members of the interprofessional team
  - examples of real-life teams that deliver optimal care

Goal 2 OBJ 1 Comments

do not know what OGC is?

Can we build on our IPE relationships and push for placement of not just SHP students but other Rutgers Health students who all come with a higher floor of expertise and IPE experience. This would be a better value-added resource for placement sites.

what's OGC? Why outside NJ, not inside NJ? In our experience, not really contracting/legal requirements are the barrier, just the approval time for even standard wording. Much more important is that sites see the mutual interest in workforce development.

Explore options to create contracts with hospitals/clinics/institutions in New York City, especially for students who are coming from there. They often would like to go home to do full-time clinical experiences and not have to pay for room and board in NJ during this time.

Improved turn around time from legal - seems like they need additional help

I know we've talked about building links between the SHP clinics and other health systems/organizations, but I'm afraid this sort of thing is outside my area of expertise. This is obvious, but I'd punt this to the clinic directors and staff.

I do not think that expanding clinical affiliations outside of NJ should be our priority. There is capacity within NJ (and within our affiliate partners) for clinical placements, but 1) potential training sites are not appropriately incentivized, and 2) SHP students are de-prioritized relative to other Rutgers Health students. Implementing incentive programs and obtaining placement commitments (via contracting) would allow the school to retain students in-state, which in turn will help build our future clinical educator workforce within the state.

Goal 2OBJ 1 Measures

Success=guaranteed spots reserved for Rutgers health care students from all programs in Rutgers Health affiliated hospitals and clinics. We still compete with outside universities to place students in spots at Rutgers Health affiliates. They did this for the medical students but have not done this for SHP.

Appropriate administrative support and credit to faculty managing the clinics

Faculty are well connected to community practices for their teaching and research practice.

Rutgers Health IPP Student Placement Center led by SHP

More working affiliations with committed sites. Fast approval of the usual rudimentary agreements.

Established contracts at major hospital systems in New York City to broaden opportunities for students' clinical experiences (NYC Health and Hospitals Corporation, NYU Langone Health, NY Presbyterian Weill Cornell, Mount Sinai Hospital, Northwell Health).

Unfettered access to clinical training sites/experiences for all SHP programs where we have stated premier partnerships (i.e. RWJBH)

We should consider having an SHP assistant/associate dean for clinical placement or for health system liaison to lead a group focused on increasing opportunities for SHP students within RWJ Barnabas and beyond.

Quicker review of contracts, better communication within Rutgers for student placement.

Increased quality of care due to "real world" experience.

Part of the purpose of the free clinics is to enhance healthcare access. We've begun to develop metrics for this (with the help of some colleagues at the business school), but if I understand correctly (and I may not), this is related to relationships with hospitals within our different clinic catchment areas.

1. Are programs able to meet accreditation standards pertaining to clinical experiences?
2. Are programs able to grow the number or variety of clinical experiences?
3. Improved quality of clinical experiences (student, faculty, and clinical educator feedback).

- clarification of accreditation standards or other administrative barriers that may currently restrict broader placement of students
- interprofessional collaboration the Dean level and beyond that supports the importance of every learner
- guidance and training for preceptors that builds the pool of potential preceptors
- participation in medical conferences that cross over hospital/school affiliations and unite preceptors and others with a focus on student education
- practical solutions with technology that alleviate the administrative coordination of placing learners
- more centralized administrative support with collaboration from each program