
AVTE ANNUAL CONFERENCE
Building the Bridge
School–Clinic Partnerships for Student Success
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Clinical Learning & Development | Ethos Veterinary Health

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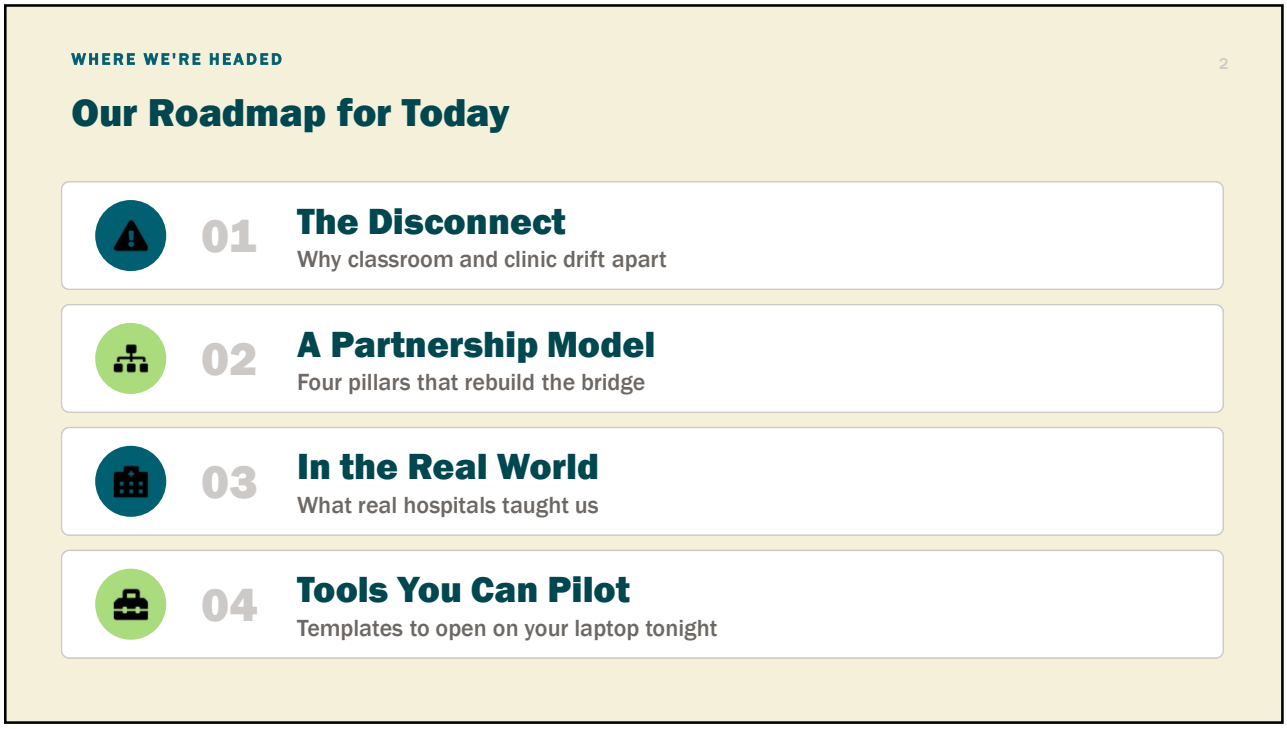
WHERE WE'RE HEADED
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Our Roadmap for Today
01
The Disconnect
Why classroom and clinic drift apart
02
A Partnership Model
Four pillars that rebuild the bridge
03
In the Real World
What real hospitals taught us
04
Tools You Can Pilot
Templates to open on your laptop tonight

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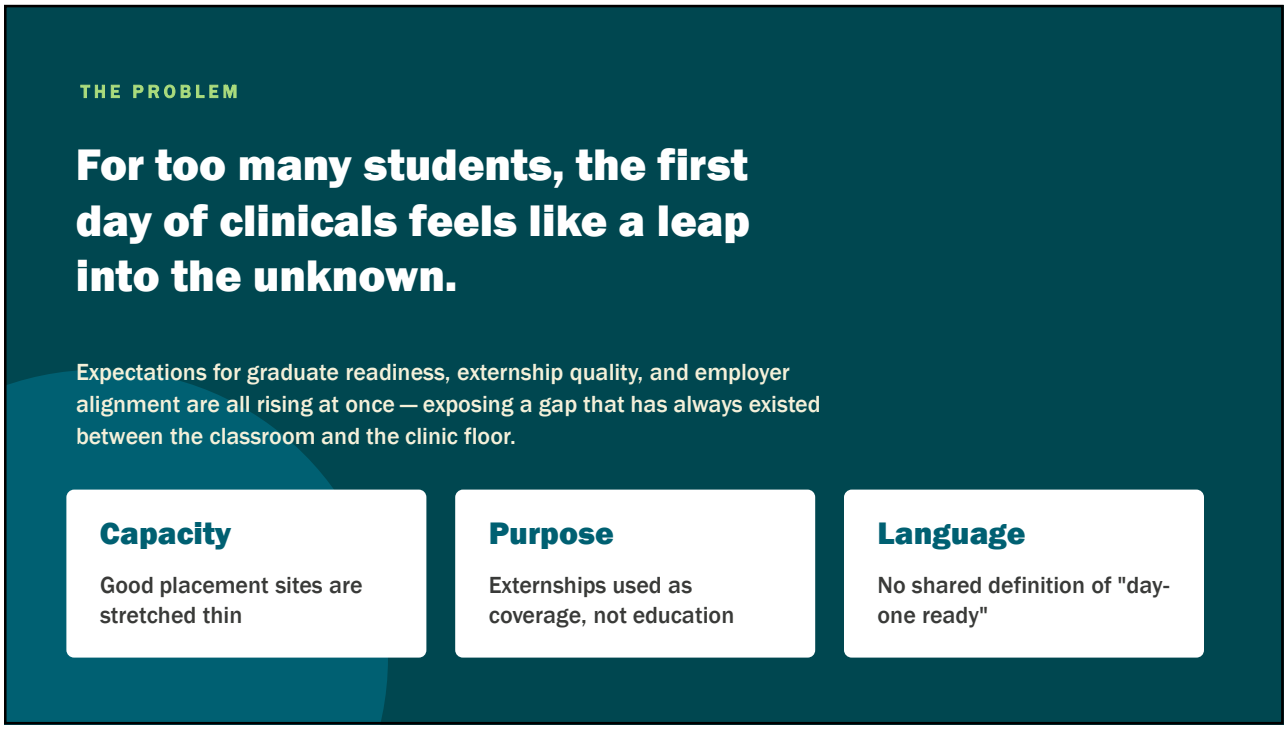
THE PROBLEM
For too many students, the first day of clinicals feels like a leap into the unknown.
Expectations for graduate readiness, externship quality, and employer alignment are all rising at once — exposing a gap that has always existed between the classroom and the clinic floor.
Capacity
Good placement sites are stretched thin
Purpose
Externships used as coverage, not education
Language
No shared definition of "day-one ready"

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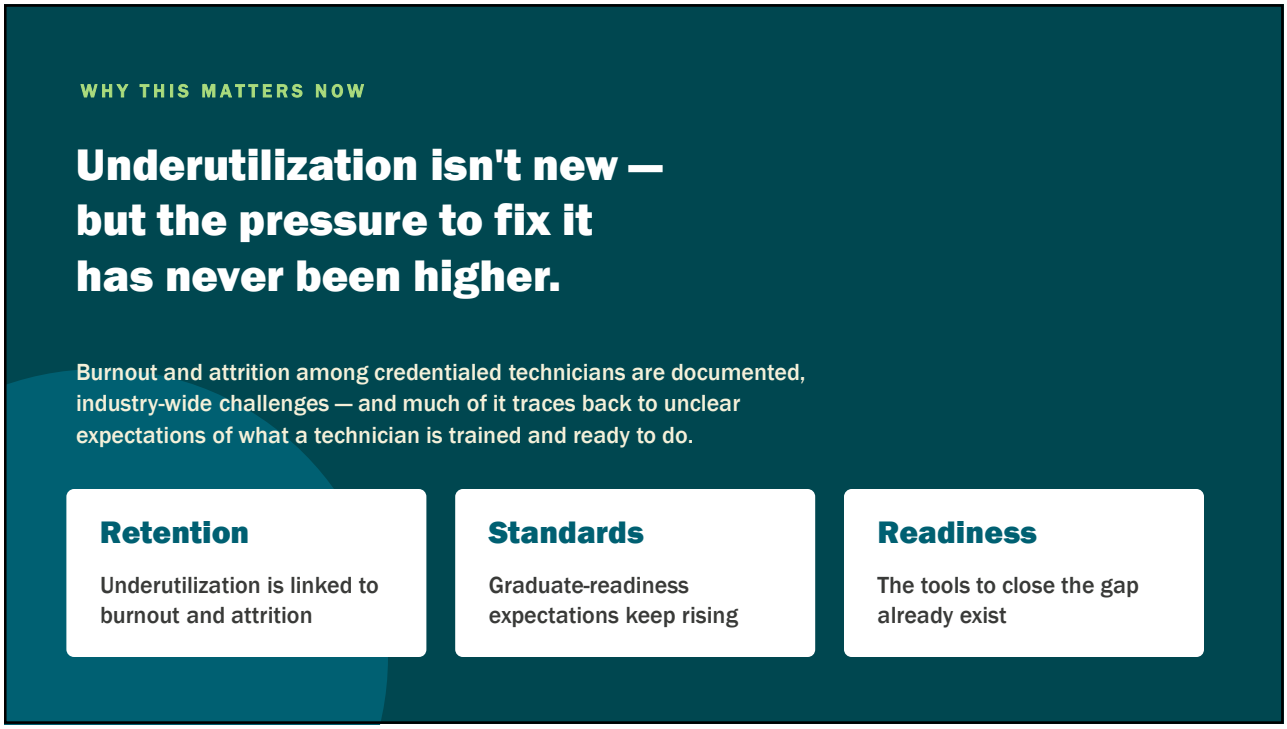
WHY THIS MATTERS NOW
Underutilization isn't new — but the pressure to fix it has never been higher.
Burnout and attrition among credentialed technicians are documented, industry-wide challenges — and much of it traces back to unclear expectations of what a technician is trained and ready to do.
Retention
Underutilization is linked to burnout and attrition
Standards
Graduate-readiness expectations keep rising
Readiness
The tools to close the gap already exist

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WHAT YOU'LL LEAVE WITH

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Session Objectives

Identify the disconnects

Name the common gaps between academic curricula and clinical expectations — and how they shape student readiness and externship outcomes.

Build the partnership

Develop actionable strategies between programs and hospital networks: shared expectations, assessment criteria, and communication structures.

Design the structure

Design a clinical education program with competency validation tools, mentor matching, and bidirectional feedback that improves graduate readiness.

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A CASE TO ANCHOR US

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Meet Maya

Maya

Second-year vet tech student

Top of her class in the skills lab. First clinical rotation starts Monday.

What Maya brings

- A validated skills checklist from her program
- Confidence with restraint, venipuncture, and monitoring
- An assumption that the clinic will know what she knows

What Maya meets

- A mentor who has never seen her checklist
- No shared language for what she's ready to do
- "Just watch today" — for the whole first week

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THE OTHER SIDE OF MONDAY

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Meet Dana

Dana

Hospital practice manager

Fourteen-person general practice. Has said yes to four students this year.

What Dana wants to give

- A student who leaves better than she arrived
- A team that enjoys teaching, not dreading it
- A first look at someone she might hire

What Dana actually got

- An email in July and a student in September
- No idea what Maya has already been signed off on
- Her best mentor on vacation, no backup named

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OBJECTIVE 1

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Where the Bridge Breaks Down

Competency mismatch

School validates skills the clinic never sees documented.

One-way feedback

Sites evaluate students; programs rarely hear back in time to adjust.

Unstructured placement

Learning is left to whatever walks through the door.

Faculty–clinic gap

Educators and mentors work in parallel, never together.

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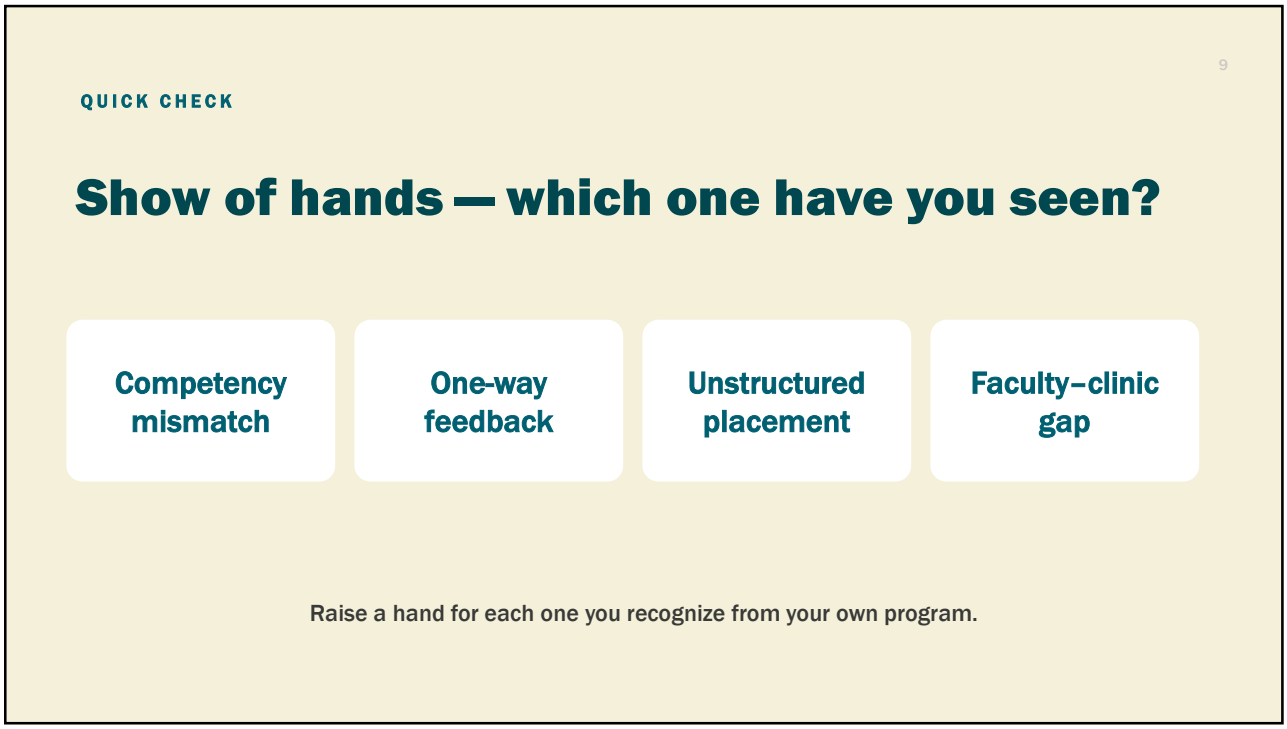
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QUICK CHECK
Show of hands — which one have you seen?
Competency mismatch
One-way feedback
Unstructured placement
Faculty–clinic gap
Raise a hand for each one you recognize from your own program.

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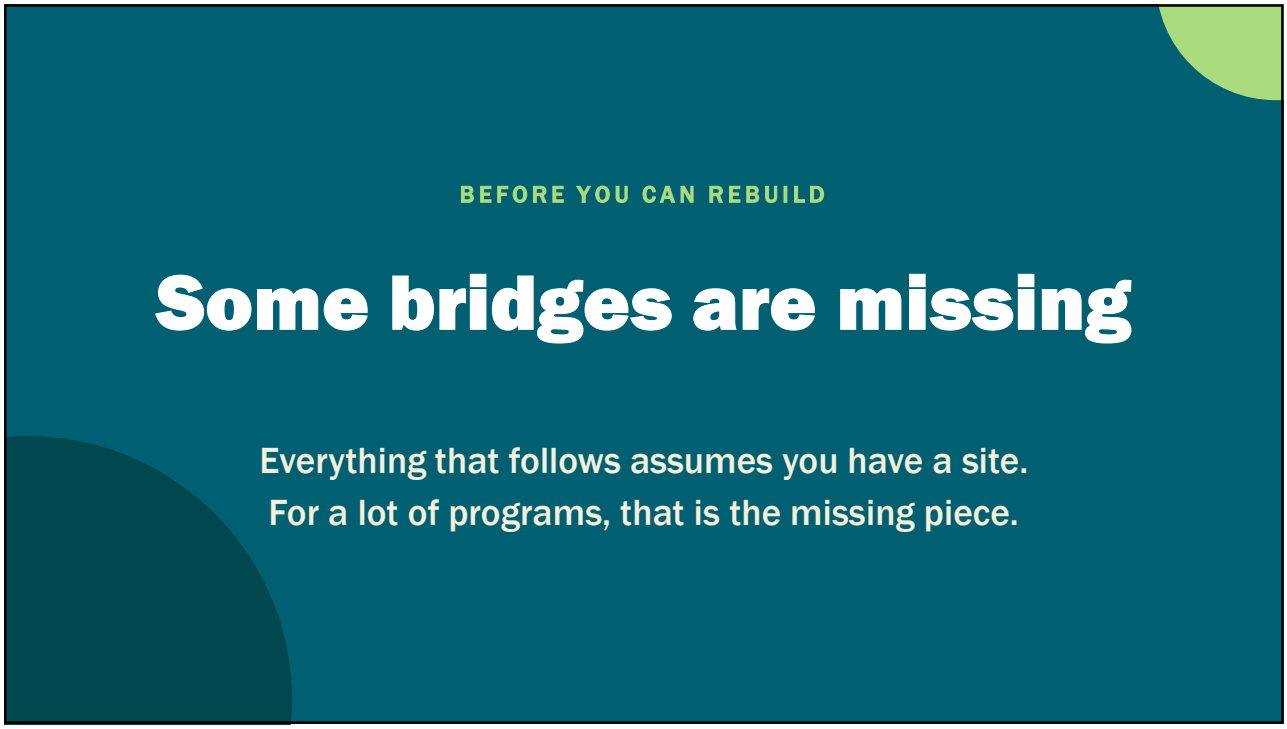
BEFORE YOU CAN REBUILD
Some bridges are missing
Everything that follows assumes you have a site.
For a lot of programs, that is the missing piece.

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WHERE YOUR SITE LIST ACTUALLY STANDS

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The Three States of a Site

Cold

Never hosted a student, and quite possibly does not know your program exists. This one needs an introduction, not an ask.

Lapsed

Hosted once or twice, then quietly stopped answering. The cheapest bucket to fix, and the one almost nobody works.

Passive

Still on your list, still technically takes students — but nothing has actually happened there in two years.

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QUICK CHECK

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Which bucket is biggest for you?

Cold

Lapsed

Passive

All three, honestly

Count silently. Most programs find the lapsed pile is the biggest one.

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THE REAL OBJECTIONS

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What "No" Usually Means

1	"No time"	**They do not know the number** Publish it: coordinator 30-60 min a week, mentor the same.
2	"Too small"	**They think they must offer everything** Partial sites and shared rotations. One department is enough.
3	"We tried"	**Something went wrong and nobody called** That is a re-engagement conversation, not a sales call.
4	"Liability"	**Nobody ever explained the coverage** A one-page agreement, proof of coverage, a named contact.

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PROSPECTING

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Where the Sites Actually Are

Your own alumni
Graduates 3-5 years out now supervise

Students who already work
A warm introduction sitting in class

Advisory committee
Ask each member for one name

Multi-hospital groups
One talent contact can open a region

Referral partners
The specialty practice your sites use

Your own lapsed list
Prospecting you have already paid for

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MAKE THE ASK SMALLER

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The Tiered On-Ramp

1	Tier 1	**Teach, do not host** Guest lecture or mock interviews. No student in their building.
2	Tier 2	**One day** A single observation placement. Low risk, real exposure.
3	Tier 3	**Two weeks** A short, skill-focused rotation — dentistry only.
4	Tier 4	**Full rotation, then full partner** Advisory committee, co-teaching, mentor training.

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THE LAPSED SITE

16

Re-Engaging the Site You Lost

Do the exit interview

"You hosted Jordan in 2023 and we never asked how it went."

Name what changed

And something has to have actually changed since then.

Ask for less

Drop them to Tier 1. A smaller ask is a different question.

Close their open loop

If they had a complaint, tell them what you changed.

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TWO MINUTES, WITH A NEIGHBOR

Name one site you lost

- Which bucket is it in?
- What went wrong?
- What would you change first?
- Who makes the call?

Ninety seconds each direction. Then we build the bridge itself.

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THE HONEST PITCH

What They Actually Get

A hiring pipeline
Sixteen weeks beats a 45-minute interview

Shorter onboarding
Trained in their protocols before day one

A ladder for mentors
Advancement that is not management

CE and teaching hours
Documented, and worth something

Employer brand
"Teaching hospital" recruits for them

First look at grads
Before anyone else posts the job

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THE PART PROGRAMS SKIP

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The Reciprocity Ledger

Thank-you letters
Student-written, copied to leadership

Where they are now
Your extern is credentialed and working

Mentor recognition
Certificates, and a name read at pinning

Seats in your labs
CE and skills space they do not have

Mentor training
You train their people. Real value.

A seat at the table
Advisory committee, first hiring look

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KEEP IT WARM

20

A Relationship Calendar

1 **August** — **Kickoff and mentor orientation**
Set expectations before anyone shows up on a Monday.

2 **October** — **Mid-rotation calibration**
Fifteen minutes, while there is still time to fix something.

3 **December** — **Letters and outcomes**
Thank-you letters go out. So does what their feedback changed.

4 **April** — **Recognition and the next ask**
Honor the mentors and book next year while they remember.

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OBJECTIVE 2 — THE FRAMEWORK

Four Pillars That Rebuild the Bridge

PILLAR 1
Shared Competency Validation
One language for what "ready" means

PILLAR 2
Structured Externship Design
Intentional rotations, not coverage

PILLAR 3
Bidirectional Feedback
Both sides learn and adjust

PILLAR 4
Faculty–Clinic Collaboration
Educators and mentors, one team

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PILLAR 1

Shared Competency Validation

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When school and clinic use the same words for "ready," the guesswork disappears.

The tool

- A shared competency rubric both sides sign off on
- Skills grouped into entrustable activities, not isolated tasks
- A portable record that travels with the student

How to start

- Map your program's skills list to the clinic's day-one expectations
- Pick 5–8 high-frequency competencies to validate first
- Agree on what "entrusted to perform" actually looks like

Maya's checklist becomes a shared document her mentor already understands.

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PILLAR 1, DEEPER

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Anatomy of a Portable Rubric

An observable verb

"Places an IV catheter" — not "understands vascular access." If you cannot watch it happen, you cannot sign it off.

Context-neutral wording

It has to mean the same thing in a GP, an ER, and a specialty floor. Species and setting belong in the example, not the competency.

A level, not a pass

Replace pass/fail with how much supervision this student still needs. That is the number a mentor can actually give you.

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THE SHARED LANGUAGE

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What Mentors Already Say

2	Level 2	**"I need to be in the room."** Student performs, you are physically present and watching.
3	Level 3	**"Come get me when you are done."** Student performs; you check the work before it goes further.
4	Level 4	**"She can do it and tell me after."** Student performs and reports by exception. This is entrustment.
5	Level 5	**"She is showing the new hire."** Student performs and supervises. Rare, and worth naming.

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ONE ROW, FULLY WORKED

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Peripheral IV Catheter Placement

The same skill, said two ways — and the line at the bottom is what makes both of them portable.

What your checklist says

- Places a peripheral IV catheter
- Demonstrated three times in lab
- Instructor signed, week 6

What the clinic needs to know

- Can she place one on a moving patient?
- How much supervision does she still need?
- Who signs off when she is ready?

One competency, one milestone, one supervision level — on one page both sides read.

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COMING SATURDAY

A shared language for “ready” already exists

A newly published, workforce-validated framework — 94 competencies across 18 domains — now exists for credentialed veterinary technicians.

FULL FRAMEWORK, SATURDAY

Building the Bridge: How Competency-Based Education Creates a Shared Path from Classroom to Clinic

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PILLAR 2

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Structured Externship Design

A rotation with a plan turns "just watch today" into deliberate practice.

The tool

- A rotation map with weekly competency targets
- A mentor-matching system based on teaching strength
- Entry, mid-point, and exit checkpoints

How to start

- Write learning objectives for each rotation block
- Name a single point-of-contact mentor per student
- Schedule a 15-minute mid-rotation calibration

Maya's first week has targets — not just a chair in the corner.

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PILLAR 2, DEEPER

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What Tuesday Actually Looks Like

1	Ten min	**Before the shift** — Name the one competency this student is chasing today.
2	All day	**During the shift** — Normal caseload. The mentor flags whatever matches the target.
3	Once	**One deliberate rep** — A single supervised attempt at the target skill. Not five. One.
4	Five min	**End of shift** — What level was that? Write it down before anyone goes home.

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HOW A STUDENT MOVES

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Progressive Release

Observe

Watch it done well, once

Assist

Hands on the task, not the decision

Perform supervised

You are in the room the whole time

Perform with oversight

You check after, not during

Teach it back

The fastest proof that she has it

Move on readiness

Not on the week of the calendar

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THE THREE THINGS THAT BREAK IT

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Matching, Capacity, and the Slow Day

Match on temperament

Not on department. The strongest clinician on the floor is not automatically the best teacher — and never assign the person who has never volunteered.

Capacity is a ratio

It is mentors-to-students, not building size. A four-doctor practice with two willing mentors has more capacity than a big hospital with none.

Plan for the slow day

Caseloads die. Keep a bench ready — records review, skills practice, a case to present tomorrow — so the quiet hours are not wasted.

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PILLAR 3

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Bidirectional Feedback Systems

Feedback that flows both ways lets the program adjust while it still matters.

The tool

- A short, structured mid-rotation feedback form
- A channel for clinics to flag curriculum gaps
- A loop that returns clinic data to faculty each term

How to start

- Replace the end-only evaluation with a mid-point check
- Ask clinics one question: "What did we not prepare them for?"
- Review that answer at your next curriculum meeting

What Maya's site learns this term reshapes next lab session.

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PILLAR 3, DEEPER

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Three Channels, Deliberately Separated

Aggregate and anonymous

Patterns across all your sites, never one student or one incident. Delivered as an annual partner report every site receives — feedback as a benefit.

Benchmarked and private

Each site sees its own numbers against the network average. No student attached, no accusation. Just data — and sites get quietly competitive about it.

Named and immediate

Reserved for safety, supervision, or professionalism. Program director to site leadership, by phone, that week. Never email, never the student.

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THE PART THAT PROTECTS THEM

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Feedback That Cannot Follow a Student

Delay the release

Nothing opens until grades post and the hiring window closes.

Set a minimum

No site-level report until three students have rotated there.

Strip the details

"The neuro case in March" names her as surely as a name.

Split the roles

Whoever collects the feedback does not own the relationship.

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SAY IT WITHOUT BREAKING IT

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Six Ways to Open the Conversation

Curiosity first

"What would make hosting easier?"

Make it yours

"We are not preparing them for X."

Always paired

Never give without asking in return

Blame the system

"Our data shows," not "they said"

Bring the fix

Every gap arrives with help attached

Report what changed

Feedback into a void stops coming

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PILLAR 4

35

Faculty–Clinic Collaboration

Educators and mentors who plan together stop handing students back and forth.

The tool

- A standing faculty–clinic partnership agreement
- Faculty externships / mentor guest-teaching swaps
- A shared calendar of touchpoints across the term

How to start

- Host one joint planning call before placements begin
- Invite a clinic mentor to co-teach one lab session
- Put both names on the student's success plan

Maya's instructor and mentor are now on the same team.

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PILLAR 4, DEEPER

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The Agreement That Outlives the Person

Most partnerships live in one enthusiastic person's inbox — and end the week that person leaves.

What the agreement names

- Roles, hours, and the escalation path
- Evaluation forms, timelines, and liability
- Term, renewal, and how either side exits

How to survive a departure

- Two named contacts at every site, minimum
- Written onboarding for the next mentor
- A copy that lives with the program, not a person

If you only do one thing from this pillar: name a second contact at every site you have.

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MAKE IT GO BOTH WAYS

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What Makes a Clinic Feel Like a Partner

Faculty on the floor

One shift a term. Currency and relationship at once.

Mentor in your classroom

Invite them to co-teach one lab. It is the swap that lands.

An advisory committee

An agenda, a pre-read, and decisions actually recorded.

Mentor training

Teach their people to teach. Their biggest fear, solved.

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OBJECTIVE 3 — IN THE REAL WORLD

From framework to field

We didn't mandate this across the network.
We built something hospitals could choose to use.

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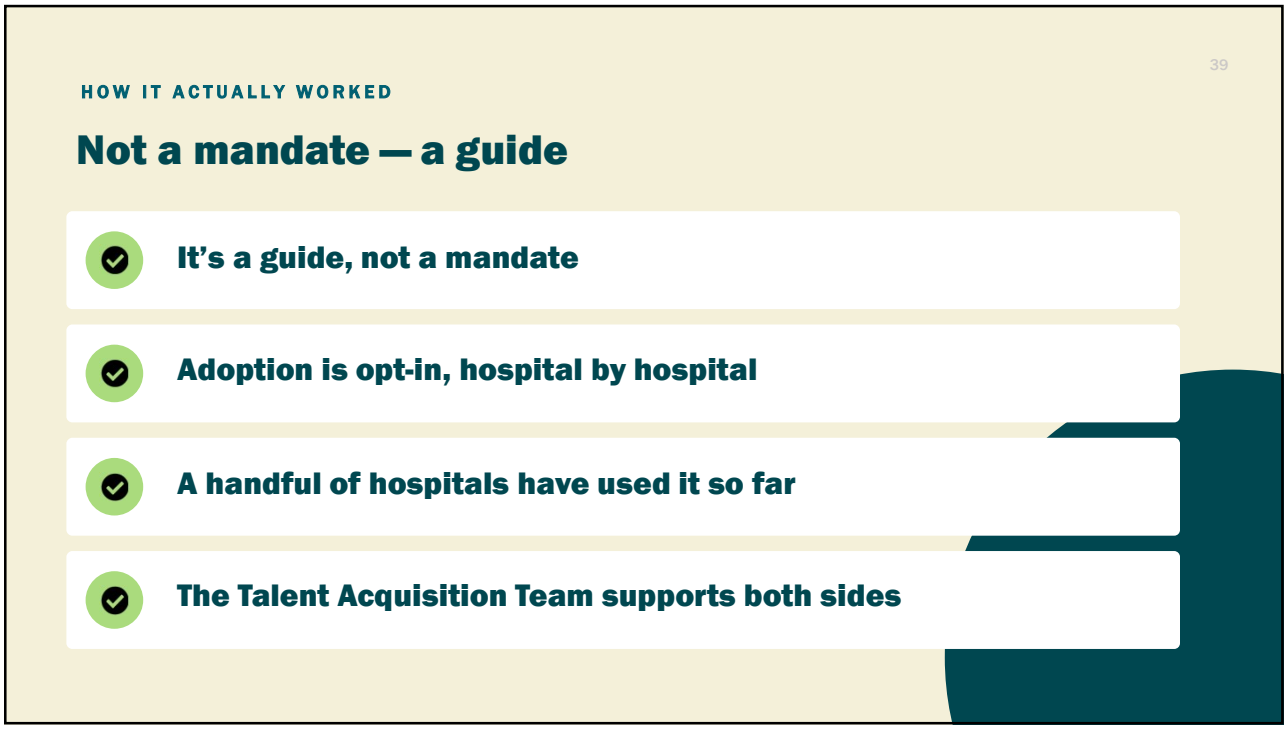
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HOW IT ACTUALLY WORKED
Not a mandate — a guide
It's a guide, not a mandate
Adoption is opt-in, hospital by hospital
A handful of hospitals have used it so far
The Talent Acquisition Team supports both sides

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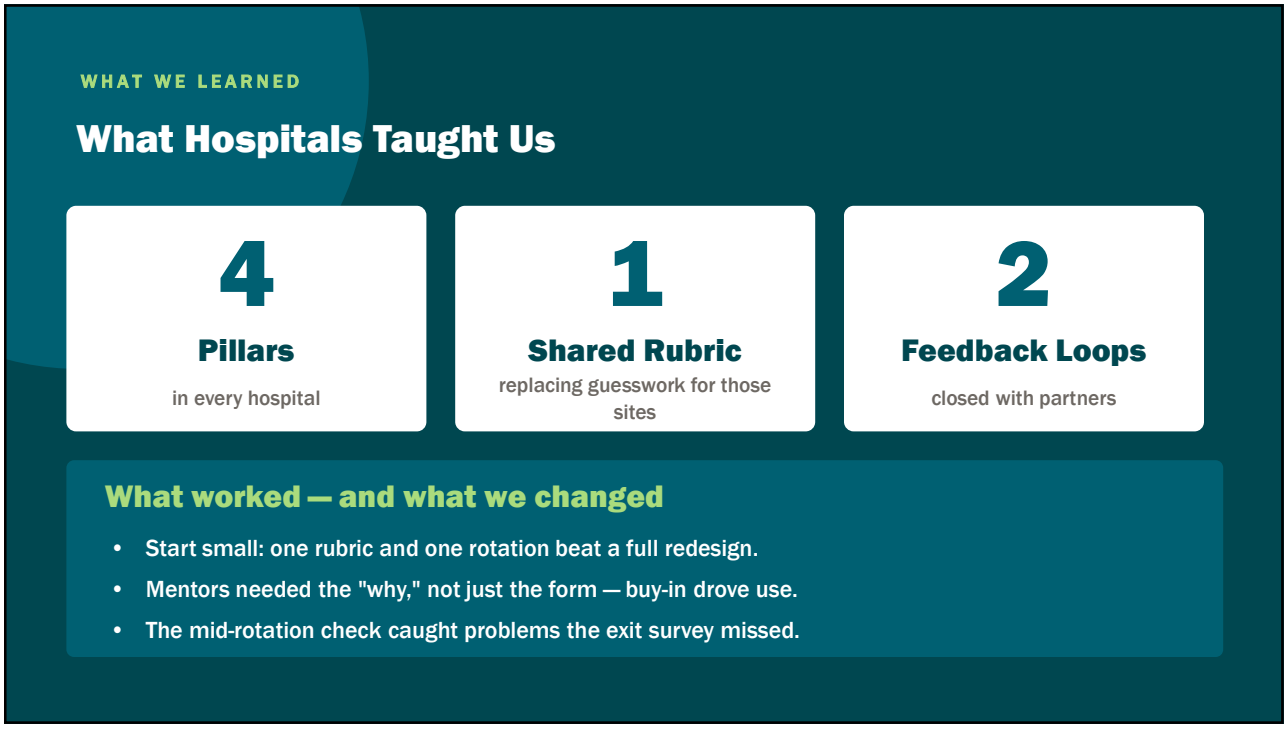
WHAT WE LEARNED
What Hospitals Taught Us
4
Pillars
in every hospital
1
Shared Rubric
replacing guesswork for those sites
2
Feedback Loops
closed with partners
What worked — and what we changed
Start small: one rubric and one rotation beat a full redesign.
Mentors needed the "why," not just the form — buy-in drove use.
The mid-rotation check caught problems the exit survey missed.

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THE CASE, RESOLVED

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Maya's Monday, Rebuilt

BEFORE

- Checklist no one reads
- A week of "just watch"
- Mentor guessing at her level
- Program never hears how it went

AFTER

- Shared rubric her mentor knows
- Day one has real targets
- Entrustment is explicit, not assumed
- Her feedback loops back to faculty

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OBJECTIVE 3 IN YOUR HANDS

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The Toolkit

Shared competency rubric
Adapt to your skills list this week

Rotation & objectives map
One block, fully structured

Mid-rotation feedback form
Five questions, both directions

Partnership agreement
A one-page starting template

Mentor-matching worksheet
Match by teaching strength

Communication protocol
Who talks to whom, and when

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MORE RESOURCES

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Instructor Resources for Site Partnerships

Two more adaptable guides — one for evaluating and maintaining a site, one to hand directly to your partner.

Site Partnership Guide

- What to evaluate in a potential clinical site
- Agreement essentials and learning expectations to establish first
- How to maintain the partnership over time

Info-Sharing Checklist

- Program overview and student learning expectations
- Supervision, scope of practice, and evaluation timelines
- Communication, support, and administrative essentials

Interested in partnering with an Ethos or NVA hospital? Let us know using the QR code at the end.

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TAKE THIS WITH YOU

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Your Take-Home Toolkit

Everything the four pillars promised, in two documents — one page to act on Monday, one packet to build from.

Start Here

- One page — the 90-day roadmap, phase by phase
- Each phase mapped to the template it calls for
- All six templates with a "reach for it when" trigger

The Pilot Toolkit

- Fifteen pages — all six templates at full depth
- A worked example and adaptation notes on each
- Shared-language primer, expanded roadmap, references

Both are print-ready PDFs — same QR code as the closing slide.

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SIXTY SECONDS

Write down one clinic you will call

- A lapsed site
- An alumni contact
- A referral partner
- The one you avoid

Do not say it out loud. Write the name, and a date this month.

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START MONDAY, NOT SOMEDAY

A 90-Day Roadmap

1	Weeks 1–2	**Pick one partner** — Choose a single willing clinic and one rotation to pilot.
2	Weeks 3–4	**Align the language** — Map your skills list to their day-one expectations together.
3	Weeks 5–8	**Run the pilot** — Place one student with a matched mentor and shared rubric.
4	Weeks 9–12	**Close the loop** — Run the mid-point check, gather feedback, adjust, and scale.

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ONE YEAR LATER

A year later, Dana didn't wait for our email. She called the program first.

Nothing about her hospital changed — not her capacity, not her budget. What changed is that she stopped being a placement site and became a partner.

Clarity
One rotation, one rubric, one named mentor.

Influence
Her mid-rotation note changed a skills lab.

Recognition
Maya's graduation letter is on her wall.

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REMEMBER THIS

If you take one thing home

- **A placement is not a partnership**
  Structure is what turns a site into a true educational partner.
- **Shared language beats good intentions**
  A common definition of "ready" is the load-bearing pillar.
- **Feedback must flow both ways**
  The classroom can only improve if the clinic talks back.
- **Start with one, not everything**
  One rubric, one rotation, one partner — then scale.

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THE RESEARCH BEHIND THIS

94 competencies. 18 domains. One shared language.

Published in JAVMA, June 2026 — a workforce-informed, academically validated competency framework for credentialed veterinary technicians.

FULL FRAMEWORK, SATURDAY

Building the Bridge: How Competency-Based Education Creates a Shared Path from Classroom to Clinic

Scan for the published JAVMA framework

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Build the bridge — one partnership at a time.

Thank you.

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