Response to the AARC's request for comparing the current accreditation Standards to the competencies outlined in Conference II

March 24th, 2012

Dear President Stewart,

On behalf of the Commission on Accreditation for Respiratory Care (CoARC), the following constitutes the CoARC Board of Commission's input and comments regarding the initial results of the AARC 2015 and Beyond GAP analysis and relative implications for CoARC's Accreditation Standards as per your request. In order to provide the context for this response, it is necessary for us to provide some background information on the establishment and purpose of the Accreditation Standards.

BACKGROUND

CoARC accredits first-professional respiratory care degree programs at the Associate, Baccalaureate, and Master's Degree level in the United States and internationally. The CoARC also accredits first-professional respiratory care degree programs offering certificates in polysomnography. CoARC Policy 12.02 (p. 53) defines a *First-Professional Degree Program* as "an educational program designed to provide students who possess no prior competence in respiratory care, with the knowledge and clinical skills required to function competently as a registry-eligible respiratory therapist. Conferral of the first-professional degree requires completion of a program that meets all of the following criteria: completion of the academic prerequisites to become a registry-eligible respiratory therapist; requires at least two years of college-level study upon completion of the program; and is awarded after a period of study such that the total registered time to the degree, including both pre-professional and professional study, is equivalent to the acceptable level required of an associate's degree." CoARC currently does not provide accreditation services for degree advancement programs (defined by CoARC Policy 12.03 as "an educational program designed especially to meet the needs of the practicing respiratory therapist who, having already completed an accredited respiratory care program with an earned first professional degree is returning to school to obtain an advanced degree.")

The CoARC and its collaborating organizations (the American Association for Respiratory Care, the American College of Chest Physicians, the American Society of Anesthesiologists, and the American Thoracic Society) cooperate to establish, maintain, and promote educational standards of quality to prepare individuals for respiratory care practice, and to provide recognition for postsecondary educational programs that meet the minimum requirements outlined in the *Accreditation Standards for the Profession of Respiratory Care* (the "*Standards*"). The *Standards* are used for the development, evaluation, and self-analysis of respiratory care programs. They provide the explicit framework for which accredited programs are expected to demonstrate competency in achieving their programmatic goals within the context of their institutional missions. The *Standards* ensure that all programs prepare students at a competency level consistent with the national credentialing examination for registered

respiratory therapists. This level of preparation better equips graduates to begin practice with the professional competencies needed to work effectively in partnership with other healthcare providers.

The *Standards* place a greater emphasis on the desired foundation and practice, the manner in which programs must assess student achievement of competencies, and the importance of the development of the student as a health care professional. Further, the *Standards* focus on the development of core and professional knowledge, skills, attitudes, and values, as well as sound and reasoned judgment and the highest level of ethical behavior. The *Standards* reflect an appropriate balance between the processes to be followed and outcomes to be achieved. Such a balance allows the CoARC to assist programs in meeting high quality accreditation standards and in complying with policies while respecting the institution's mission, governance, innovative efforts, and prerogative to set its priorities.

CoARC describes academic quality in terms of goals and outcomes. Goals are defined by CoARC as the "aims of the programs that are consistent with the institutional and program missions and reflect the values and priorities of the program" (*Standards, p.9*). Specifically, in *Standard 3.01*, CoARC requires that each program must have the following goal defining minimum expectations: "To prepare graduates with demonstrated competence in the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains of respiratory care practice as performed by registered respiratory therapists (RRTs)." For programs offering the polysomnography option, the program must have the following additional goal defining minimum expectations: "To prepare sleep disorder specialists with demonstrated competence in the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains of polysomnography practice as performed by sleep disorder specialists" (*Standards, p.19*). In *Standard 3.02*, CoARC further requires that "program goals must form the basis for program planning, implementation and evaluation. Program goals with measurable outcomes are to be reviewed annually by program personnel to ensure compatibility with the mission of the sponsoring educational institution" (*Standards, p.19*).

CoARC defines program outcomes as "performance indicators that reflect the extent to which the goals of the program are achieved and by which program effectiveness is documented. Examples include but are not limited to: program completion rates, job placement rates, certification pass rates, and program satisfaction" (*Standards, p.10*). Outcomes measures used by CoARC reflect metrics of program effectiveness and student achievement. CoARC uses an outcomes-centered approach to its accreditation review process. This approach focuses on a specific set of outcomes which include the following: a) Graduate performance on the national credentialing examination for entry into practice; b) Programmatic retention/attrition; c) Graduate satisfaction with program; d) Employer satisfaction with program; and e) Job placement. The CoARC routinely monitors the program's outcomes results in relation to the thresholds via an Annual Report of Current Status (RCS). CoARC provides definitions of these criteria in its *Interpretive Guidelines* (p.23), in its *Accreditation Policies & Procedures* (p. 38), and on its website (www.coarc.com/15.html).

RESPONSE RELATED TO DOCUMENT TITLED, "GAP ANALYSIS FOR 2015"

Recommendation 1: *That the AARC request CoARC to change by 7/1/12 accreditation standard 1.01 to read as follows:*

1.01 The sponsoring institution must be a post-secondary academic institution accredited by a regional or national accrediting agency that is recognized by the U.S. Department of Education (USDE) and must be authorized under applicable law or other acceptable authority to award graduates of the program a baccalaureate or graduate degree at the completion of the program.

Programs accredited prior to 2013 that do not currently offer a baccalaureate or graduate degree must transition to conferring a baccalaureate or graduate degree, which should be awarded by the sponsoring institution, upon all RT students who matriculate into the program after 2020.

Violates Attribute 1: Maintain an adequate respiratory therapist workforce throughout the transition.

Violates Attribute 2: Address unintended consequences such as respiratory therapist shortages.

- **GAP - Will need determination of workforce needs and areas of need.**
- **GAP – Will need to determine locations of schools in comparison to the workforce needs and shortages.**
- **GAP – Will need to identify process to which AS can become BS for future.**

Violates Attribute 3: Require multiple options and flexibility in educating both students and the existing workforce (e.g. affiliation agreements, internships, special skills workshops, continuing education, etc.).

- **GAP – Will need a determination if there is enough geographically located to replace current AS programs, consider a stretch to 2020 or make a determination that the content of the AS programs must change to meet the demands of the emerging needs.**

- **The past transition place to all associate programs took 7 years so this must be considered if there is a transition to the BS level.**

- Information needed:

1. Current vacancy rate by regions of the country.
2. Determine if shortages will actually occur. Create a list of schools and options for schools.
3. Create practical time line.
4. Identify any and all commitments needed.

CoARC's Response:

The CoARC Board concludes that the recommendation above, if enacted, would result in a significant overall reduction of respiratory therapy enrollments and graduates.

As of December 31, 2011, there were a total of 444 respiratory care programs and satellites. Of these, 384 (87%) offer the Associate degree upon graduation. Fifty-seven percent (255) of these associate-degree granting programs are sponsored by community or junior colleges, many of which are prohibited by state laws to award baccalaureate degrees. These programs would be required to enter into a collaborative arrangement with a 4-year institution (e.g., transfer and articulation agreement or consortium) in order to remain in compliance with the proposed accreditation standard as it is currently worded. Even though the Community College Baccalaureate Association (www.accbd.org) identifies approximately 17 states with the ability for community colleges to award a baccalaureate degree, none of the 255 respiratory care programs sponsored by community colleges currently award the baccalaureate degree.

Programs offering only associate degrees accounted for 86.1% of the total number of programs submitting annual reports in 2011. There were 10,421 new students enrolled in 2010; of this total, 9,404 (90.2%) were enrolled in Associate degree programs, of whom 54% (5,605) were enrolled in community or junior colleges. In addition, there were 7,732 graduates in 2010; of this total, 6,919 (89.5%) graduated from Associate degree programs, with 53.6% (4,143) graduating from community or junior colleges. Keep in mind that these are total graduates and include those who do not earn a credential and obtain employment[1].

To assist the AARC in obtaining additional information identified in this recommendation, CoARC provides the following link that maps the distribution of current programs by geographic location and includes degree, institutional type, institutional control, 2010 enrollments, 2010 graduation rates, 2008-10 attrition rates, job placement, and CRT credentialing success:

http://batchgeo.com/map/0dfb6b86d50fd6c47073479eb121e009

CoARC can provide this data, upon request, in spreadsheet format. Please note that workforce demand is indirectly evaluated vis-à-vis job placement rates and all values, except CRT credentialing success are self-reported by the programs. Job placement rates include those graduates working part time and per diem, which could reflect underemployment or lack of available full time positions. CRT credentialing success numbers are cross-verified with NBRC Annual School Summary reports.

[1] Commission on Accreditation for Respiratory Care. (2012). *2011 Report on Respiratory Care Education*. pp. 7, 18, 26. Retrieved from http://www.coarc.com.

Recommendation 2: *That the AARC recommends to the NBRC on July 1, 2011, that the CRT examination be retired after 2014. That the AARC recommends to the NBRC on July 1, 2011 that the multiple choice examination components (CRT and RRT written) for the RRT should be combined after 2014.*

CoARC's Response:

The CoARC Board has no comments regarding the merits of this recommendation. However, as a point of information, should such a combination of exam requirements come to fruition, CoARC will revise its Evidence of Compliance requirements that refer to the NBRC content exam matrix to ensure consistency. All 100-level (CRT-only) programs have ceased admitting students and are on track to voluntarily withdraw by the December 31, 2012 deadline. With the establishment of the revised Standards in June 2010, all programs are required, as per Standard 3.01, to "prepare graduates with demonstrated competence in the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains of respiratory care practice as performed by registered respiratory therapists (RRTs)."

Recommendation 3: *That the AARC establish on July1, 2011, a commission to assist state regulatory boards transition to a RRT requirement for licensure as a respiratory therapist.*

CoARC's Response:

The CoARC Board has no comments regarding the merits of this recommendation. However, as a point of information, CoARC respects the overarching mission, goals and policies of the sponsoring institution of the respiratory care program and respects the state and local laws governing both the institution and the respiratory care program seeking and maintaining accreditation. When, in the process of accreditation, a conflict exists between CoARC Standards and/or specifications with state and/or local laws that govern the respiratory care program and/or the sponsoring institution/consortium, state and/or local laws will usually take precedence over CoARC Standards. When such a conflict is identified, the program and sponsoring institution/consortium will be asked to provide both an explanation of the conflict and appropriate documentation that the conflict exists. The CoARC Board will review the documentation prior to waiving the Standard(s) and/or Evidence of Compliance in question. If, in the judgment of the CoARC, the state and/or local law(s) constrain the ability of the program and the sponsoring institution/consortium to offer a program which adequately prepares graduates to seek the RRT credential and future employment, CoARC reserves the right to not waive the Standard(s) and/or Evidence of Compliance in question.

Recommendation 4: *That the AARC Executive Office request that the AARC Board of Directors ask the appropriate existing sections to develop standards to assess competency of RTs in the workforce relative to job assignments of the RT. Standards should address the variety of work sites that employ RTs. Standards should address RT knowledge, skills and attributes relative to the tasks being evaluated.*

CoARC's Response:

The CoARC Board has no comments regarding the merits of this recommendation. However, for clarification, the CoARC Board supports differentiating between the competencies expected of a new graduate entering the workforce, the competencies of an experienced practitioner, and the advanced competencies.

Recommendation 5: *The AARC encourage clinical department educators and state affiliates continuing education venues use clinical simulation as a major tactic for increasing competency levels for the current workforce.*

CoARC's Response:

The CoARC Board has no comments regarding the merits of this recommendation. However, as a point of information, CoARC does not address the relationship of high-fidelity patient simulation to clinical patient hours or the ability to substitute the former for the latter. CoARC encourages the use of patient simulation as an adjunct to clinical training, but simulation cannot replace patient contact.

CoARC conducted a recent survey that included questions regarding the use of human patient simulation in the school setting. Attached are the results of the survey.

Recommendation 6*: That the AARC, in cooperation with CoARC, consider development of consortia and cooperative models for associate degree programs that wish to align with bachelor degree granting institutions for the award of the Bachelor's degree.*

CoARC's Response:

CoARC's Standards also allow for flexibility in program structure. *Standard 1.02 (p.12)* allows more than one institution (e.g., consortium) to be involved in the provision of academic and clinical education. Affiliate agreements between consortium members typically specify whose policies govern and document student access to educational resources. Although the responsibilities of the consortium and of each member must be clearly documented in a formal affiliation agreement or memorandum of understanding, which delineates instruction, supervision of students, resources, reporting, governance and lines of authority, CoARC does not limit or direct how those responsibilities are shared. CoARC currently accredits 23 consortiums with the typical structure of the consortium involving the partnership of a higher education institution and a medical center. *CoARC provides* a sample consortium agreement on its website (www.coarc.com/33.html). This sample is intended to provide an example of provisions related to the *Accreditation Standards for the Profession of Respiratory Care*. It does not in any way represent the legal language that may be required or desired between the consortium members.

Recommendation 7: *That the AARC provide budgetary resources to assist associate degree programs with the transition to baccalaureate level respiratory therapist education.*

CoARC's Response:

The CoARC Board has no comments regarding the merits of this recommendation.

Recommendation 8*: That the AARC BOD explores development and promotion of career ladder educational options for the members of the existing workforce to obtain advanced competencies and the baccalaureate degree.*

CoARC's Response:

The CoARC Board supports the development and continued growth of Baccalaureate completion programs for AS-RT graduates and Master's degree programs for BS-RT graduates.

CONCLUDING REMARKS

While the overall goal of Conference 3 was to determine what changes in the profession are necessary to position respiratory therapists to fulfill the roles and responsibilities identified in Conference 1 and to ensure that future and practicing respiratory therapists in 2015 and beyond acquire the competencies identified in Conference 2, there did not appear to be any discussion regarding which competencies identified by the communities of interest are considered essential for the new graduate versus those considered essential for continued competence in the workforce. CoARC believes that identifying any such differences is critical for CoARC and the programs it accredits to effectively develop future competencies needed for entry into the profession. In order to effectively address the issue, CoARC must either clearly specify the student learning outcomes we require programs to address, or must require programs to do so. Given the important nature of this issue, perhaps an updated survey is warranted that asks whether the competencies should be expected upon graduation (i.e., entry into the profession), should be expected after a defined period of professional practice, or should be considered an advanced competency. Once the competencies for entry into the profession have been defined and approved, one of the crucial questions which CoARC will address will be how to measure these competencies and what evidence would be considered acceptable to ensure that program graduates have attained the levels of competence needed for effective professional practice.

As mentioned previously, CoARC already requires programs to provide evidence of student learning outcomes (i.e., competencies) as an integral part of its standards and processes for review. These student learning outcomes encompass the integration of a specialized set of knowledge, skills, and abilities that students have attained at the completion of their professional program and that are required for entry into the profession. Specifically, CoARC Standard 4.01 requires that programs *"prepare students to meet the recognized competencies for registered respiratory therapists identified in these Standards."* Documentation of competencies encompassing knowledge, technical proficiency, and behaviors expected of program graduates as well as evaluation mechanisms designed to monitor knowledge, performance, and behavior are the minimal evidence of compliance associated with this Standard. Programs may select the types of learning activities and assessments that will indicate compliance with recognized competencies. To prepare competent respiratory therapists, the curriculum should be the framework for a deliberate and systematic educational process in the affective, psychomotor, and cognitive domains. It is intended to develop new proficiencies with an application in mind, and is presented with attention to needs, objectives, activities, and a defined method of evaluation. The curriculum should include supervised pre-clinical (didactic and laboratory) and clinical activities, as well as documentation of progress towards achieving competency.

Further, Standard 4.02 requires programs to *"define and list the competencies it requires for graduation. The program must employ student evaluation methods that measure all defined program competencies. These competencies and evaluation methods must be written and communicated to the enrolled students."* Evaluation mechanisms designed to monitor knowledge, performance, and behaviors as well as published materials demonstrating communication of competencies to students are

the minimal evidence of compliance associated with this *Standard*. The educational competencies for the respiratory care education program should include the preparation of graduates who possess the knowledge, skills and values to practice respiratory care. The evaluation methods used in the program should include process and end-product assessments of student performance (e.g., competency checklists), as well as a variety of objective testing measures. These mechanisms will provide student performance data related to measuring defined program competencies throughout the program for the students, faculty and college administration. The program should provide evidence that each student is made aware of (i.e., written acknowledgment) the competencies required for completion of the program.

Please note that CoARC will be undergoing a *Standards* revision process this year. CoARC will provide adequate opportunity for broad comment from its communities of interest[2] prior to adoption of proposed changes to the *Standards*. CoARC will continue its outcomes-centered approach to the accreditation review process. Furthermore, revisions to the 2010 Accreditation Standards will likely reflect an increased emphasis on student learning outcomes that focus on the competencies and attainment levels reached by students upon completion of the program.

The competency statements identified in Conference 2 as they are currently phrased do not allow us the opportunity to conduct a crosswalk with our Standards. We recommend looking at the NBRC response and crosswalk with the NBRC matrix. The matrix is validated and our Standards refer to the NBRC matrix.

On behalf of the Board of Commissioners, we appreciate the opportunity to provide our response to your request for comments and feedback. Should you need additional information or clarification of the information provided in our response, please contact me or our Executive Director, Tom Smalling, PhD, RRT, FAARC, at tom@coarc.com.

Respectfully,

S. P. Mikles

Stephen P. Mikles, EdS, RRT, FAARC
President

[2] Communities of interest include all the bodies within the CoARC organizational structure; related bodies or organizations (the AARC, the ACCP, the ASA, the ATS, the ASAHP, the NN2, and the NBRC; RT educational program representatives (CEOs, deans, program directors, medical directors, site visitors, and advisory committee members); respiratory therapy educators; practitioners; consumers; employers; regulators (licensure boards, state higher education commissions); recognition bodies (Council for Higher Education Accreditation); accreditors (regional, national, and specialized accreditors); the accrediting membership organization (Association of Specialized and Professional Accreditors); students; and the public at large. CoARC reviews the data collected (validity, ease of interpretation, potential issues, positives and negatives regarding drafts of the revised *Standards*) from all evaluation instruments and feedback from communities of interest.