

Frequently Asked Questions

Section 4: Curriculum

Guidance for CoARC-accredited programs, sponsoring institutions, healthcare employers, and consortium partners

Based on the CoARC 2027 Entry into Practice Standards and the supplied apprenticeship planning documents

Commission on Accreditation for Respiratory Care

Effective date of cited Standards: January 1, 2027

Purpose. This FAQ explains common implementation questions related to Section 4. It should be read together with the Standards, Interpretive Guidelines, Evidence of Compliance, and applicable CoARC policies and procedures.

At a glance

- Standards 4.01–4.02 — Foundational and Professional Content
- Standard 4.02 — Use of Simulation
- Standards 4.03–4.07 — Core Competencies
- Standard 4.08 — Curriculum Review and Revision
- Standard 4.09 — Equivalency
- Standard 4.10 — Management of Learning Experiences

Standards 4.01–4.02 — Foundational and Professional Content

1. Which general-education areas are required?

Oral and written communication, social and behavioral sciences, and biomedical and natural sciences. The content must be appropriate to the degree level and intentionally support program goals and respiratory care competencies.

2. Must each required content area be a separate course?

No. The Standards do not require a separate course for every content area, but all expected learning outcomes must be present in the curriculum and course syllabi and be assessed appropriately.

3. What practice settings and populations must the professional curriculum address?

Students must be prepared for acute, post-acute, ambulatory, and emerging settings and for neonatal, pediatric, adult, and geriatric patients, with exposure to emergent, acute, chronic, rehabilitative, and patient/family education experiences.

4. How should didactic, laboratory, simulation, and clinical education relate to one another?

They must be horizontally and vertically integrated and progressively sequenced so knowledge, skills, behaviors, responsibility, independence, and clinical complexity develop toward entry-to-practice competence.

5. What additional content is required at the bachelor's level?

Professional content beyond associate-level preparation in at least one area: leadership, education, research, or expanded clinical skills, aligned with published baccalaureate goals and competencies.

6. What additional content is required at the master's level?

Advanced content in purposeful evidence-based practice, applied research, education, and future professional leadership, with higher-order analysis, evidence synthesis, improvement initiatives, and competencies distinct from entry and baccalaureate levels.

7. What information must a professional-course syllabus contain?

At minimum: course name and description, instructor-of-record name and credentials, goals or rationale, assessment methods, grading criteria, topic outline aligned with objectives, and measurable learning outcomes that guide and assess competency acquisition.

Standard 4.02 — Use of Simulation

8. How much required clinical time may simulation replace?

No more than 25% of program-required clinical clock hours and associated clinical competency evaluation.



9. How is simulation substitution calculated?

One hour of simulation may count as two clinical hours for substitution purposes.

10. What components must a clinical-substitution simulation include?

Pre-briefing, the structured simulation activity, theory-based debriefing, and evaluation, supported by evidence-based quality-assurance processes and appropriately prepared faculty.

11. May the same simulation hours count as both clinical and laboratory hours?

No. Simulation used as a substitute for clinical experience may not also be counted as laboratory time.

12. Do all students in a synchronous simulation receive the same credit?

Students participating synchronously should receive equivalent credit, even if they assume different roles during the experience.

Standards 4.03–4.07 — Core Competencies

13. What are the five core competency areas?

Evidence-based diagnostic and therapeutic procedures; information literacy and care planning; critical thinking and problem-solving; ethical decision-making and professionalism; and interprofessional teamwork and communication.

14. How should procedural proficiency be documented?

Use a faculty- and Advisory Committee-approved list of required procedures plus laboratory, simulation, and clinical evaluation tools showing each student's safe and effective performance before graduation.

15. What does information literacy require?

Graduates must be able to find, critically evaluate, apply, and communicate credible information to develop respiratory care plans. Expectations increase at bachelor's and master's levels.

16. What does critical thinking include?

Timely, evidence-informed judgment that integrates patient needs, available resources, social context, and changing clinical information to prioritize and adapt care.

17. How must ethics and professionalism be taught and assessed?

Through structured content and experiences in classroom, laboratory, simulation, and clinical settings, with documentation of ethical reasoning, integrity, accountability, confidentiality, informed consent, professional conduct, and intellectual honesty.

18. What must interprofessional preparation include?

Team roles and scopes of practice, patient-centered communication, shared decision-making, accountability, conflict resolution, health disparities, social determinants of health, bias, cultural responsiveness, and structured opportunities to collaborate with other professions.

19. How do degree-level expectations differ for the core competencies?

All graduates meet entry-to-practice RRT expectations. Bachelor's graduates demonstrate additional proficiency in defined leadership, education, research, or expanded clinical areas; master's graduates demonstrate advanced integration and application of evidence-based practice, research, education, and leadership.

Standard 4.08 — Curriculum Review and Revision

20. What must the written curriculum management plan include?

A curriculum map showing where content and competencies are introduced, reinforced, and assessed; course-effectiveness evaluation; a mechanism for coordinating instruction; and an annual review process with stakeholder input.

21. Who should contribute to the annual curriculum review?

Faculty, students, administration, the Advisory Committee, and other appropriate stakeholders. The review should analyze assessment data, stakeholder feedback, program outcomes, and NBRC examination performance.

22. How often must curriculum content be compared with national specifications?

At least annually for alignment with entry-to-practice competencies and the current NBRC job analysis and examination content outline, with a comprehensive review following revisions to those specifications.

23. What documentation supports curriculum review?

The management plan, curriculum map, CoARC Content Outline Comparison Form, course- and program-level analyses, RCS data, written approval and revision policies, meeting minutes, action plans, and follow-up evidence.

Standard 4.09 — Equivalency

24. Does equitable mean identical?

No. It means educationally equivalent in substance, quality, opportunity, performance standards, and expected outcomes. Format, delivery method, or assessment approach may differ if disparities are not created.

25. What experiences must be comparable within a cohort?

Course content and access to materials, didactic instruction, laboratory and simulation resources, and clinical experiences—including their volume, breadth, depth, and complexity—must provide comparable opportunities to achieve required competencies.

26. How should evaluation equivalency be demonstrated?

Assessments across locations or formats must measure the same competencies and use comparable performance standards. Programs should compare outcomes and clinical-course evaluations and act on meaningful differences.

Standard 4.10 — Management of Learning Experiences

27. Which instructional sites require written agreements?

All external institutions, organizations, or facilities providing laboratory, simulation, or clinical practice experiences. Separate agreements are not required for locations operated by the sponsor or consortium.

28. Who is responsible for selecting and evaluating sites and preceptors?

The program and its Key Personnel. Policies must describe initial selection, approval, periodic evaluation, qualified supervision, and compatibility with expected competencies.

29. May students locate potential clinical sites or preceptors?

They may suggest them, but must not be required to identify sites, recruit instructors, or determine which competencies will be mastered at each site. Every suggestion must undergo the program's formal approval and equivalency review.

30. May responsibility for securing clinical experiences be delegated to students?

No. Securing, approving, coordinating, and evaluating laboratory, simulation, and clinical experiences remains the sponsor/consortium Key Personnel's responsibility.

Reference

Primary source: CoARC 2027 Accreditation Standards for Entry into Respiratory Care Professional Practice, Section 4 — Curriculum, approved March 2026. Current CoARC policies, procedures, forms, thresholds, and deadlines should also be consulted when applicable.