

*Dr. Danielsen:* Good morning. Welcome to the panel discussion on programmatic accreditation sponsored by the ATSU Center for the Future of the Health Professions. My name is Randy Danielsen, director of the center. A transcript from today's panel discussion will be published in our first e-newsletter sometime the first of the year.

Let me introduce our panelists. **Jeffrey Morgan, DO, MA, FACOI**, is dean of the School of Osteopathic Medicine in Arizona, an associate professor of internal medicine, representing osteopathic medical education.

**Robert Trombly, DDS, JD**, is dean of the Arizona School of Dentistry & Oral Health, representing dental education.

**Albert Simon, DHSC, MEd, PA-C**, is professor and chair of the department of physician assistant studies in the Arizona School of Health Sciences, representing physician assistant education.

**Lori M. Bordenave, PT, DPT, PhD**, is director of the Doctor of Physical Therapy program and associate professor in the Arizona School of Health Science, representing physical therapy education.

**Mary-Kathrine Smith McNatt, DrPH, MPH, MCHES, CPH, COI**, is department chair and associate professor of the master of public health program within the College of Graduate Health Studies, representing public health education.

**Eric L. Sauers, PhD, ATC, FNATA**, is a tenured professor and chair of the department of interdisciplinary health sciences in the Arizona School of Health Sciences. Dr. Sauers also holds a joint appointment as a research professor in the School of Osteopathic Medicine in Arizona, today, representing athletic training education.

**Jyothi Gupta, PhD, OTR/L, FAOTA**, is a tenured professor and chair of the department of occupational therapy in the Arizona School of Health Sciences, representing occupational therapy education.

**Tabitha Parent-Buck, AuD**, is a tenured professor and the founding chair of the department of audiology in the Arizona School of Health Sciences, representing audiology education.

Our moderator today is **Norman Gevitz, PhD**, who is a professor of history and sociology of medicine, department of family

medicine, preventative medicine, and community health and senior vice president of academic affairs A.T. Still University (ATSU). With that, Dr. Gevitz, I will turn it over to you.

*Dr. Gevitz:*

Accreditation is an evaluative process by an external body to determine if applicable standards are met by specific programs. The purpose of health education accreditation in the United States is to protect the public health and safety and to serve the public interest. If we look at the history of accreditation, briefly, we see six stages that report. The first is the development of regional accrediting bodies in the 1880s.

The second of health professions education accreditation beginning early in the 1900s with both the American Osteopathic Association and the American Medical Association (AMA) doing on-site inspections and ratings of their respective medical and osteopathic schools. The third is the AMA collaboration with what was called, at the time, Allied Health Education Occupations that developed in the 1930s. The fourth is the United States Department of Education (USDE) from 1956 overseeing higher education approval of colleges in order to receive money under the Veterans' Readjustment Act.

The fifth occurred in 1965 where Congress enacted a Higher Education Act so that the USDE formally regulates accreditation in the United States and the authority to distribute Title IV funds, which, of course, is big leverage that the federal government has. Sixth, in the 1960s, some of what were called allied health professions severed their connection with the American Medical Association to develop their own professional accrediting bodies. Today, at the table, that physical therapy, occupational therapy, PA studies, AT or athletic training, audiology, have their own programmatic accreditation system. Now, in one sense, it seems that programmatic accreditation is a dry subject; however, right now, accreditation is in the news.

In July 2018, the Trump administration proposed a regulatory overhaul of accreditation by introducing a wide-ranging rulemaking session, which they're going to schedule later this summer which will be announced and may have a dramatic effect in terms of how education or accreditation, in fact, is carried out in the future.

Diane Eauer Jones, the Department of USDE principal deputy undersecretary, said, "The administration's goal is to reduce compliance requirements for accreditors, freeing them up to focus

on education equality while more clearly defining the college oversight roles of these agencies, state governments, and federal regulators. The broader plan from Education Secretary Betsy DeVos to ‘rethink higher education’ is a stark contrast to the Obama Administration’s approach, which made a signature policy of tougher scrutiny of accreditors, often sighting oversight failures involving low-performing, for-profit colleges.”

We are at the cusp of change, very possibly. I think it’s an important time that we look at where accreditation in the health professions is now and what is likely to be the future. My first question for all of you is the present: Has your programmatic accreditors significantly changed its standards or processes in the last several years? If so, how? Dr. Morgan, you’re involved with a health profession that, clearly, has gone through an accreditation overhaul. What do you see as the salient features of these changes, both structural and in terms of process?

*Dr. Morgan:*

Let me first say that, in regards to my role in the accreditation process as the dean of the medical school, it is my responsibility to assure that the school, of course, meets all the standards but to also defend our stand that we have met any accreditation related standards by going before the commissioners at our accrediting body to make statements that defense. ATSU-SOMA is accredited by the Commission on Osteopathic College Accreditation, or the COCA, who is itself-recognized by the United States Department of Education, to accredit all osteopathic medical schools in the U.S. Presently, there are 34 colleges of osteopathic medicine, providing instruction at 51 sites throughout the U.S. in 32 states. They are training 20 percent of tomorrow’s physicians. The osteopathic medical students represent about 20 percent of physicians to be practicing in the U.S., with somewhere in the 29,000 range of enrolled students right now. As an accrediting body, the COCA is under the scrutiny of the United States Department of Education who recognizes COCA to accredit us.

The United States Department of Education performed an audit of our accrediting body, and in 2015-16, recognized that their standards had too much subjectivity to them. As a result, the USDE wanted greater objectivity in the way that site visitors were assessing and evaluating the colleges. They basically put the COCA on probation. They said that the COCA had to address those perceived weaknesses in the eyes of the Department of Education.

The COCA's response to that was to scrap the then nine standards that we had to comply with and to rewrite them; and their product was 12 standards, each with a number of elements within them. The elements are either core or non-core elements, and the new rules were that you had to meet every core element within a given standard or you failed the entire standard. Current accreditation by the COCA is that you can fail a standard and still be accredited, but your timeframe of accreditation is restricted, and the review process is more onerous.

The highest level you can now get is a ten-year accreditation, which is new for the COCA. It has, historically, only been a seven-year accreditation cycle, but the new process is that you can achieve a ten-year accreditation if you meet all of the standards, to include the core and non-core elements within each of the standards. Then, you have a ten-year cycle. If you miss two elements, it's a seven-year accreditation. If you miss three to five elements, it's a four-year accreditation cycle. Anything beyond that, and then you're on a one-year cycle or non-accreditation.

There's a tiered system now for accreditation. The answer is, yes, they completely revised and revamped the process. They kept a number of the standards similar, but provided greater objectivity in terms of how we could meet those standards, the types of demonstrable outcomes that we could show that said, "We're fulfilling these particular standards." I will add that one of the standard revisions was in graduate medical education (GME) placement, and I'll talk about this a little more when we talk about some of the perceived challenges. The COCA tied our accreditation to meeting 100 percent placement in graduate medical education if we were going to expand our class or start a new school. Schools that are status quo, meaning they are getting reaccredited with the same number of student seats, wouldn't really have any challenges there, but, if you want to grow your class, if you want to start a new school, you have to show the COCA that you can accommodate 100 percent of those students in graduate.

*Dr. Gevitz:*

Okay, so one of the changes, apparently, is that it was typical, in accreditation, that the school or program wishing to be accredited presents an argument, and, in the new system that COCA has adopted, necessarily, there is no narrative. It is basically the production of materials. Did you find that this was rather difficult or anxiety-producing? Because, usually, you present a case as to why you should be accredited. In COCA's new standards, you don't have to do that.

*Dr. Morgan:*

What Dr. Gevitz is saying is that, historically, we would provide a document that said, "Here's all the evidence that you've asked for in a narrative form." With the new process, it's all online. Everything was uploaded to a website for the COCA to review. As it turns out, the site visitors that come to the school to evaluate us don't necessarily read the uploaded materials. There's another team doing that, and they (the site visit team) come in prepared to assess us, presumably based on the new standards. Our experience was that they came in asking us for all the stuff that we usually would have put in a narrative but didn't have readily available because that wasn't the new process.

The timeframe was in our favor because we were preparing for reaccreditation and had prepared the document that we usually would have submitted - the narrative, and had all the information that they wanted. They were in a learning process. SOMA was the first school that the COCA evaluated under the new standards, and so it was a learning process for them as well. It did impact us, but we were prepared because we had that old standard and narrative prepared and ready to give them as they asked.

*Dr. Gevitz:*

Dr. Gupta, you had the occupational therapy program, and what is unusual now is that you had two entry-level programs so that occupational therapy is a program that is shifting gradually from a masters level entry program to a doctoral-level entry program. Your accreditors have to accredit, at least for almost the next ten years, these two different types of programs. What is your experience in terms of the accrediting body, in terms of its standards and processes changing over the last few years, and how are you, in fact, addressing that?

*Dr. Gupta:*

My experience with accreditation is from ACOTE, which is the Accreditation Council of Occupational Therapy Education, up until now, has been, as a faculty member, submitting materials for my courses, and that was at the master's level. At this point in time, as the program director, I am taking our new entry-level doctorate program through accreditation. I also have experience with the accrediting body during my election as chair to the Commission on Education for occupational therapy (COE) for the American Association of Occupational Therapy.

Having said this, I must point out that ACOTE, which is our accrediting body, is overseen by CHEA, which is the Council of Higher Education Council. A lot of what was mentioned for the osteopathic medical education, is paralleled in the occupational therapy world in terms of getting rid of the subjectivity and having

more objective measurable programmatic outcomes for our students, moving from paper submissions where we used to FedEx 10, 20 boxes of documents to having to input short narrative and artifacts to an online portal.

We also have two accreditors who review the materials and two other accreditors coming on the site visit. It seems like each accrediting body relates to the accreditation of other health professions at large. What I have seen as a change is that when occupational therapy moved into being dual entry point—it has been a contentious issue. In the late 1980s, occupational therapy transitioned from baccalaureate degree to a master's degree. Then, about 15 years ago, some of the programs wanted to have accreditation standards for an entry-level clinical doctoral degree. We have had post-professional clinical doctorate that is not accredited by ACOTE. However, the entry-level clinical doctorate is relatively recent.

When ACOTE put forth the standards for the entry-level clinical doctorate, CHEA and the Higher Learning Commission (HLC), sent it back basically saying that the standards were not sufficiently different from the master's and it was "degree creep." The standards that I'm taking my program through right now shows some difference in the sense that I have to adjust it and show, very clearly, that my entry-level clinical doctorate students are, in some sense, getting competencies beyond the entry level, although it's an entry-level degree.

To speak to that, they have certain standards that only get addressed in the doctorate degree and not the masters. I must point out that, because it's an entry-level degree, I would say, approximately 80 percent of the standards are the same in terms of entry-level competencies including clinical education. There is no difference in the standards. The entry-level doctorate graduates take the same board exam as the masters. There's no difference in that. However, we are accountable for some advanced outcomes for the doctorate students.

*Dr. Gevitz:*

Do you think you'll be able to demonstrate those outcomes as a point of difference from your master's level students?

*Dr. Gupta:*

Yes. The way I have done that is we have common classes for the master's and the doctorate students where the doctorate students have the same standards, or if the standard is only marginally different. They (ACOTE) have done that by using a higher level of Bloom's Taxonomy. If this is the case, the masters are taught to the higher level. I have a whole section of the curriculum that is only

for doctoral students, and this is the way in which the advanced competencies are demonstrated primarily in two areas.

One is in the area of scholarship and application of evidence into practice, and the other area in which the doctoral students are different from the master's students is in that they have to come up with a innovative capstone project. For most students, this takes place primarily in the community because of the population-based, community-based care advanced standards that is much more stringent for the doctoral students than the master's students. I have designed the curriculum to address those advanced competencies such that I'm able to offer both entry-level degrees to address the needs of the market.

*Dr. Gevitz:*

Dr. Parent-Buck, audiology, has originated some innovative programs. While your residential program is small, your online program has accounted for, perhaps, as many as 30 percent, is it, of all AuD degrees through this online program, and, now, you're reaching out internationally. Although those two programs are not subject to programmatic accreditation, can you tell us what changes have occurred within the accredited AuD program over the last five years and where you are right now?

*Dr. Parent-Buck:*

Of course. With audiology accreditation, our accrediting body is the Council on Academic Accreditation in Audiology and Speech-Language Pathology, called CAA. It does go back to our history and roots of being tied to undergraduate speech-language pathology programs and growing out of that as a profession, but there are programs that are accredited just for audiology and programs that are accredited just for speech-pathology, then some that are accredited for both.

My background with accreditation really came from being the person to come to ATSU and establish our AuD program from scratch, which we had to go through a higher learning commission, change, add on the first entirely online doctoral degree with A.T. Still University and then to go through programmatic accreditation as we built the residential program here. Our residential program has been accredited from the time of our—before our first graduating class of students in 2006. The standards have changed, over time, with our accrediting body. It took a while for the accrediting body to catch up with our transition from a master's level being the entry to the practice through the doctoral degree.

I think we've successfully made that change in the accrediting body and the programs. The accrediting body does routinely

update the standards. Our latest standards were implemented in 2017. Set prior to that was from 2008. Over that nine-year span, we had a consistent set of standards, but there were occasional revisions that were slipped in that just didn't meet the level of throwing out all the standards and starting over but adding some changes to tighten up things for clarity or to expand on something.

The most significant change in this last set for 2017 was actually addition, which may have come down from the accrediting body's approval through CHEA and the Department of Education, to focus on some general attributes of professions, which is interesting going with what ATSU is focusing on with our core professional attributes. When I read one set of documents versus the other, I'm like, "They must've talked to each other somewhere along the lines," because the profession practice were added in 2017 were accountability, integrity, effective communication skills, clinical reasoning, and collaborative practice.

It sort of mimics our CPA. Although the accrediting body is trying to make things tighter with objective evaluations, they put in things in these competencies that are somewhat hard to evaluate objectively. They're subjective characteristics or traits that, now, we have to prove our students are meeting those standards. That does place some difficulty on programs to demonstrate that and find concrete evidence.

The other big emphasis was more emphasis on having majority of academic content taught by faculty who hold a PhD. or EdD degree rather than a clinical doctor, like the AuD degree. That also poses some difficulties throughout the profession because of our shortage of, and we may talk about that a little bit more a little later also.

*Dr. Gevitz:*

Thank you. Dr. Bordenave, you represent a profession that has gone from the master's degree to the doctoral level degree and, perhaps, parallels or has gone through the process, which, right now, Dr. Gupta and occupational therapy is going through, the switch from the master's degree to the doctoral degree. Now, apparently, this has transpired prior to five years, but if you could talk about the changes that occurred in physical therapy accreditation over the years.

*Dr. Bordenave:*

Sure. My background in accreditation emerges from multiple roles. I was actually here as a faculty member during our initial accreditation, so I was part of that process back in 1999 and also was a faculty member for a number of years. During our last

accreditation cycle, I was actually the director—long title, but I oversaw our admissions process and our student disciplinary process. I was responsible for developing a lot of the materials that were provided for our accreditation relative to those two processes. Now, as the director, I will be responsible for the accreditation in a more holistic way, looking at all of those pieces.

We've always looked at accreditation and the development of the documents here at ATSU in our program as being something that's a collaborative process, and everyone participates. I think that's made it easier in some ways. Sometimes it makes it more difficult as well. It's interesting to hear the change from the type of documentation that's necessary. Ours is also all online, sort of what Dr. Morgan was talking about. We have to provide both the narrative as well as samples of documentation for that, and that online transition is one of the many transitions.

The transition from the masters to the doctorate was a lengthy process. For quite a few years, the accrediting agency, the Commission Accrediting Physical Therapy Education, or CAPTE for short—everyone has a little, short name for their accrediting body. CAPTE was accrediting those types of programs both at the master's and at the doctoral level. Back in, I believe it was, 2010, they stopped accrediting master's level programs and transitioned to only accrediting doctoral programs at that point. It really hasn't been that long since we made that transition.

Just recently, they've updated all of our accreditation standards and evaluative criteria. That was back in late 2015, early 2016. Our new accreditation cycle here will be based upon those new standards when, previously, it was based on the old standards. The most significant changes in those criteria currently are related to interprofessional education (IPE)—which I know is something that's come up for some of the other programs—and the need to have doctorly prepared faculty beyond entry-level doctorate. There're actually prescriptive criteria for what percentage of your faculty must be doctorly prepared with a terminal doctoral degree. Also, we, as a collective faculty, must assure—that's the actual word that they use in the evaluative criteria—that our students are prepared to enter clinical practice prior to sending them out on their terminal clinical experiences.

This is a new criterion or something new that we really have to demonstrate how we're making those assurances to our clinical sites that they're prepared for moving on to the clinical

experiences. That's something that I think we've been exploring here is to how we're going to make those assurances.

I think it's a response to some of the other accrediting bodies overseeing CAPTE, as well as part of the need to create some standardization across clinical practice relative to clinical excellence and those kinds of things and reduce the variability in practice, which is something that, in physical therapy, we've been looking at. I think this is one of those places where we really sought to create some more equity, I guess or make our programs more equal in that way.

*Dr. Gevitz:* Very good. Dr. Simon, physician assistant program has moved from baccalaureate to a master's level. Now, to unveil an innovative post-professional master—excuse me, doctor of science medicine degree program. What changes are occurring or have occurred in terms of the physician assistant program with respect to the residential program accreditation standards and processes?

*Dr. Simon:* I think it's fair to say that our profession is struggling with several issues, even our name. I've been involved with the accreditation from one side or the other for some time. I have served as both accreditation site visitor and team chair for our accreditation agency in the past.

I've provided consultative services for probably about 25 different programs over the years in terms of assisting them in gaining initial accredited or getting out of accreditation trouble. I was also president of our National Physician Assistant Program Association in 1991-92, which was the year that we made the transition from having the AMA sponsor our accreditation, to another outside body. I participated in that transition. From that experience, I view the changes we have seen in physician assistant accreditation over the last six to eight years as the most significant. First, I think we've seen more of an influence from the Department of Education. More and more, we've heard our accreditation agency saying, "We now have to do this because of a United States Department of Education mandate."

I think we've seen our accreditation standards become more prescriptive than they previously were. We also have noticed that more frequent updates are issued. There was a period of time when we would go for long periods without seeing any changes in accreditation. Now, frequently, we are notified of, a clarification or an update to a particular standard that we need to pay attention to.

I have also seen a considerable increase in cost, too, to the accreditation process, which is probably not uncommon among health professions accreditation. Recently, the language changed from being specific about programs being accredited at the master's level to, say, at the graduate level. I think, surreptitiously, the door has been opened for, someday, a program to offer *an* entry-level doctorate, although the professions on record as to say they are against that *as an entry-level degree*. We have also, like several of the other professions, gone to ten-year accreditation cycles.

One of the most significant changes I've seen *and I am not spinning this as* necessarily as positive or negative, but, in my day, as a team visitor, we were instructed on identifying deficiency for example on a clinical rotation, that would have been cited as one deficiency in the way the program was meeting that standard on that one rotation. Let's say the program offered eight different rotations. Under today's policies that would be cited as eight different citations. Frequently, programs come out with a much longer list of citations to address. We have seen quite a few changes.

*Dr. Gevitz:*

Dr. Trombly, dentistry.

*Dr. Trombly:*

In dentistry, our accrediting body is the Commission on Dental Accreditation (CODA). We're still connected to the American Dental Association, historically. If you go back to, I think, '75 and before, it was a council within the American Dental Association. That was the accrediting body that we moved it out as a separate commission. That commission consists of 30 people from various specialties—allied health. It sounds like a medical side.

CODA has responsibility for dental, all the allied dental—the dental assisting, dental lab techs, the dental hygiene, as well as all the specialty programs. They are looking at, I think, over 1,400 different programs that they accredit at varying levels. There are 67 dental schools right now, which may or may not have advanced training programs. Under the commission, there are new committees for some of the specialties. My background is that I have been on the institutional side in some way, shape, or form since the late '80s.

Our process is an 18-month self-study. It is the recommended, and we still developed narratives. I wish we did not, but we still do. The commission is still associated with the American Dental Association regarding the operating budget. One of our issues is

that it is not funded at an appropriate level, at least from my perspective, so the staffing, our ability to move forward with technology. We are still binding up the big spiral-bound notebooks and shipping them off, along with a little flash drive, but that is about as far as we have gotten technology wise.

*Dr. Trombly:*

Again, I think that is just purely budget and resource-driven. Our standards have gone, over the years, from being very prescriptive to being more flexible, and I don't think we got quite to nine broad standards as it sounds like COCA did. We came from hundreds of standards and very prescriptive to, right now, we're at 50 some standards are what we have. I've been involved in leading self-studies at existing institutions, typically, the self-study team clinic portion and so forth.

I've chaired the self-study committees at new schools and existing schools and also been site visitor and also served on review committees—the pre-doctoral review committee. I've had a lot of experience from a lot of different angles. As we go into the next year, I'll now be one of the site visitor chairs. Typically, there's a multidisciplinary team, as, probably, most of you have. The most recent set of standards kicked in—and they're really what we're working with right now—around 2010. The American Dental Education Association had done a project to develop a model set of core competencies for general dentists. That turned into a lengthy discussion, at the commission level, regarding rethinking the standards, and there was a fair number of new standards added at that point, other existing standards modified.

They were approved in 2010. They were implemented over three years, and we've been, more or less, functioning with that group since 2013. That consists of 62 must statements. We have standards that have the graduate or the institution must. They're often accompanied—about half of them have some intent statement, which has should types of things, and then some of those include, also, examples of evidence they might have.

They also publish a self-study guide that talks about, in more depth, the types of supporting documents that you should be developing, binding, and shipping off to them and stacking up into the change is similar to some of the things that I've heard from the other disciplines. They included, also, an introduction, which wasn't necessarily a standard, but the introduction talked about the core principles of dental education.

There were 11 different areas that they described, each with a paragraph or so—critical thinking, self-directed learning, developing a humanistic environment, evidence-based dentistry, assessment, etc. Then, within the standards, the types of things that we saw developed and put into the new standards were some were institutional level. The institution should develop a humanistic learning environment. Some of them were professional, both at the institutional level and at the graduate level, the competency level.

At the institutional level, they wanted to see evidence of how the dental school was interacting with the other higher education in other healthcare disciplines. They wanted to see that our graduates were competent in communicating and collaborating with other healthcare providers. We had things like evidence-based dentistry come in more prominently at that point, a few things that were more related to some of the changes and what was happening out in practice, like placement of implants became something that the general dentist was expected to do as opposed to a specialist—cultural competence, self-assessment, application biomedical sciences into inpatient care delivery, and some things related to faculty development, and as well as the research programs. Since then, every couple of years, there's been a tweak or a modification or a new standard. Coming out of the recent opioid crisis, now, that one of the standards was revised to include to make sure that it was precise that your graduates have to prescribe and consider substance abuse and so forth. Those are the types of things that we've seen change over the last several years.

Our process is prolonged. Our commission meets twice a year. They will typically have a couple of years for public comment on a new standard, and then that'll be followed, typically, by an approval along with a one or a two-year implementation, so it may not get to the three or four years, so we don't see a lot of change happen very rapidly in the CODA world.

*Dr. Gevitz:* Dr. Sauers, you've been intimately involved with athletic training accreditation. What changes have you seen over the last number of years?

*Dr. Sauers:* Yeah, we've seen quite a few changes. Just a little bit, my role, I've been responsible for chairing three programmatic self-studies in athletic training education here at ATSU. I've served the last six years as a commissioner for the CAATE, which is the Commission on Accreditation of Athletic Training Education. It's an independent body responsible for professional accrediting programs, post-professional degree programs, and residency training programs.

Before my time with the CAATE, I chaired the national committee that wrote the post-professional degree accreditation standards, and we developed the first set of residency standards, and then we moved that all over to the CAATE so that all the accreditation was housed under one accrediting body. Last weekend, I took over as president-elect of that group, so I'll serve one year in that term and then three long years as the president of that commission.

I've been involved in regional accreditation activities as well, chairing our focused site visit steering committee here at ATSU several years ago. The most significant changes, for us, have been the move from entry-level baccalaureate to entry-level master's, so similar to the other changes described, only at a lower level. Interestingly, unlike what physician assistant described, where they open the door for entry-level doctoral, our commission, against my recommendation, has actually individually capped it and said, "We will not accredit an entry-level program at the doctoral level," which I have argued is an overreach of our authority because, if a program meets our minimal standards and they offer a higher degree, I don't think we have any specific authority to prohibit that. Should somebody challenge it, I think we would lose, but I lost the vote in the board room.

That is our current state of things. We've been moving more from process-oriented accreditation to outcomes-oriented assessment. Specifically, the biggest thing that we did was implement a bright line standard related to our pass rate for our national certification exam, which was controversial. When we did it, we got a lot of blowback from programs. We had programs that had longstanding accreditation but the abysmal performance of their graduates on the national certification exam.

In a minimum period, we drove radical improvement on that measure. You could argue the validity of that measure or whether or not the improvement on that measure means improved educational outcomes, but I think it made a positive difference in our profession. It led to the illumination of many programs who didn't have the resources to meet that standard.

It's never comfortable when you implement standards changes that lead to program closures. In almost all cases, those programs voluntarily withdrew their accreditation as they saw the process nationally playing out and seeing that it was inevitable that their accreditation was going to be withdrawn. Concerning our—we are recognized by the Council for Higher Education Accreditation

(CHEA) as well, like the others. That boded very well for us in our CHEA review, that they saw that we had meaningful standards, we're holding programs accountable, and it was leading to change.

We've also had lots of changes just relative to what the expectations are regarding the competencies of an athletic trainer. Often, that has been driven predominantly by our physician partners. We have three physicians who are commissioners on our board, and they've been some of the most vocal advocates for us expanding what it is we do because they see us needing to do more to help meet their patient care needs.

That's been an exciting tension where programs are saying, "We can't possibly do more," but we've got stakeholders wanting us to be able to create a professional that can do more. We also have an online accreditation system where you do uploads. An interesting thing that we found when we went to that—we still require a narrative and then upload. We don't require a narrative for every standard, but one thing we realized—and it took us a long time to realize it—was, in that electronic transition, we somehow lost the ability that programs used to have to tell their story, which was we started our program at this institution in this year. This is why we did it. This is who has been here over time, and this is what our place is. We just realized it got too mechanical, and that inability to tell your story mattered negatively. We have revamped that.

The other thing that we lost, not only telling the story but telling the story of the self-studied process. It became, did you upload everything, as opposed to describing, what was your—I've heard anywhere from a year to 18 months. What was the self-study process you went through? Like, we convened a committee. We started to have meetings. This group did this. This group did that. We lost that in the process as well. The technology is excellent, but sometimes you lose, I think, essential elements, so we've been trying to find a way to work back and get those historical pieces in.

*Dr. Gevitz:*

Good. Dr. Smith, you're in the unique role of heading a program that is subject to accreditation but is online. What has been your experience, and how have things changed? I think you've gone just for initial accreditation and received that.

*Dr. Smith McNatt:*

Yeah, so we have seen quite a few changes these past few years. We had our initial accreditation from fall 2014 to early spring 2015, and we're going to be up for our five-year follow-up soon. Then this past couple years CEPH has changed everything on us. CEPH is the Council on Education for Public Health and is our

accrediting body. They changed things so before schools and programs developed their competencies to where now all schools use pre-determined/ pre-developed CEPH competencies, so after we went through our initial accreditation, this past year we had to go back and re-do all our competencies and re-align all our objectives to new competencies. This was done in order to create standardization among CEPH schools and programs.

We, in the process, once we received our accreditation, have now had to go back and use their competencies and redo all of our competencies this past year. In that process, we went from doing everything, the old-fashioned way, kind of like somebody else described with the full print it out, mail it in the binders format, to the online format. We now have to report everything online using their standardized Excel spreadsheets. These spreadsheets that they developed are not very user-friendly. Even our data analyst has a hard time understanding them.

Dr. Smith McNatt: They are a mess, and they make no sense from the old school where we had to print everything out and mail it in, I think, in five FedEx boxes. Aside from the competencies that CEPH gives us to implement we do choose five areas that we feel represent our program what we write an additional competency on.

Now, we have five written on our own and then 22 of theirs in four areas that are prewritten, and we have all of those mapped out to assessments and individual objectives. It has been changed quite a bit. Our mapping is pretty in-depth, and it's down to each objective in assignment areas. We do that online already, so that was not a real issue, but their spreadsheets, as I said, are hard to use and work with. They don't allow us much room for anything and minimal narrative, although, they do want a little bit of narrative.

*Dr. Gevitz:* Good. Thank you.

*Dr. Gevitz:* Each accrediting body expects programs to educate their students and have specific competencies. Briefly, can you talk about, in general, the type of competencies expected and how you assess them? Dr. Morgan?

*Dr. Morgan:* The COCA indeed has listed just seven core competencies that they want to see all AOA-accredited COMs have their students achieve, and they parallel the competencies that the Accreditation Council for Graduate Medical Education (ACGME) accrediting body wants of all allopathic medical schools with the addition of

one more that's focused on osteopathic medicine. The competencies are an osteopathic philosophy and manipulative medicine, medical knowledge, patient care, interpersonal communication skills, professionalism, practice-based learning improvement, and system-based practices.

These are not different. They have not changed over the past several years. When we went through our self-study, we recognized that the COCA wanted us to be addressing these competencies, and we integrated them into all of the syllabi back in 2014. All of the courses carry these as a core element of each particular course with a caveat that you may not be able to address every one of them, but we want you to be aware of them, focus on them, and try and achieve them. By way of example, in the clinical years of our students' training, again, each of these seven competencies is part of the syllabi. Students are required to log their experiences, and we have core faculty that looks at every log of every student rotation and looks to see if they're achieving any or all of these competencies in those rotations.

*Dr. Gevitz:* Medicine and osteopathic medicine are different, perhaps than any other field here because you don't produce a finished product. Your graduates do not immediately go out to practice. They go out for internships and residencies or graduate medical education, generally. When you talk about practice management, what kind of progress do they expect you to make, and how do you document that?

*Dr. Morgan:* These are the core competencies that the accrediting body says we must have our students achieve to produce a product if you will—to produce a student capable of being eligible for and enter into graduate medical education. We also are training them to achieve core professional attributes and competencies that are identified by EPAs—

*Dr. Gevitz:* CPAs?

*Dr. Morgan:* No, EPAs, entrustable professional activities. These are the things that we're also incorporating into our training so that students are eligible candidates and desirable in the eyes of the GME world.

*Dr. Gevitz:* Dr. Gupta, do you see any comparison regarding what the competencies that are expected of your graduates with, let's say, osteopathic medicine?

*Dr. Gupta:* I think there's a lot of commonalities, in patient-centered care, cultural competency, evidence-based practice, but our accrediting body doesn't pull out and say, "Every OT graduate has to meet X number of competencies." They're buried within the various standards. We look towards our clinical rotation and—classroom and clinical being an extension of the others, so we prepare them to implement those competencies when they are out on their rotations. It's much vaguer. It's not as prescriptive as what you are alluding to.

*Dr. Gevitz:* Okay. Dr. Parent-Buck?

*Dr. Parent-Buck:* With respect to audiology accreditation, through the CAA, the student standards for outcomes is probably our most prescriptive area and the most tedious thing for us to deal with, although they have large overarching standard areas that are those professional practice attributes, then they have the foundations and scientific foundations and identification areas like meeting patients, an evaluation area and a treatment area.

Underneath each of those standards, they go down to the minutia of students must do the screening in tinnitus. Students must provide direct rehabilitation in vestibular disorders. It's hard to track that and to have the equity across all students, across all programs to say that every graduate came up with, what is the minimum bar in this do not have them like 45 pages long of these individual standards under each area of practice.

That is one of our biggest challenges in meeting those and documenting them. From the classroom, we know we teach it. From the laboratory, we have them practice it. Do their clinical hours in every one of those areas out in a rotation? Maybe, maybe not. That's our most tedious area is the outcomes—

*Dr. Gevitz:* It's easy for you to document in the classroom, but, as far as clinical experience is concerned, do students have to log in? Do they have to say that they have had that experience?

*Dr. Parent-Buck:* Fifteen minutes. They logged over 1,800 hours. Our students get over about 2,500 hours logged down to 15-minute chunks with CPT codes of, were they doing tinnitus treatment or screening or therapy? Was it an adult or a child? Was it normal or abnormal? Our logging process is probably taking more time than teaching the class.

*Dr. Gevitz:* If we're talking about prescriptive, when I first got here, the first programmatic accreditation report that I oversaw was physical therapy, and it was just page after page of what is taught. Do you teach this? Do you have, if you will, a learning objective attached to this? You'd go, "Yes," and then you'd put in the course. Does that still take place? Does that—

*Dr. Bordenave:* That still takes place. That used to be the five C's. They're now the seven D's.

*Dr. Gevitz:* Can you explain that?

*Dr. Bordenave:* Sure.

*Dr. Bordenave:* You know, the seven D's. The evaluative criteria is 7D. It's seven, and it starts 7A, but 7D is where—you were mentioning that. It basically lists all of the competencies relative to clinical practice that are to be taught in a particular program, and we have to provide evidence of objectives matching that particular competency, and, then also, is there assessment related to that? What does that assessment look like? It is prescriptive, but it's not quite as prescriptive as audiology in that we don't have to document a particular number of hours or that every student has certain periods met in particular areas.

*Dr. Gevitz:* Yours is particularly didactic. It's the didactic teaching where—because that's what I noticed about it.

*Dr. Bordenave:* Well, it is, but that's part of the difference, or one of the changes is this idea of what the significant outcome is related to entry-level clinical performance. Yes, we have to demonstrate those competencies within the didactic, but then the end product, of course—it's different from medical education, that our students leave here and can go directly into practice. That entry-level clinical performance is defined by a tool called the clinical performance instrument that evaluates those clinical skills in a much broader way than what the seven D's—the evaluative criteria do.

*Dr. Gevitz:* Dr. Simon.

*Dr. Simon:* The PA profession adopted the allopathic competencies. Those would be the six that Dr. Morgan had mentioned. We don't do the manipulation, so we have six. We had a meeting called the four orgs meeting where the competencies were adopted.

When you adopt those—and our accreditation doesn't necessarily require us to adopt those, but they say, "Whatever you adopt, you have to show us how you're meeting that," and they judge if it's reasonable. One of the things that they want to know is, "Okay, these were designed for residents. How have you modified the competencies to be appropriate for PA students? In addition to documenting all the educational things we do, objectives, goals, outcomes and such, during the clinical year, we have the students log cases, which the faculty scrutinizes to determine if the students have met the list of minimum competencies they have to achieve.

Through the course of the year, on their various clinical rotations, the student's preceptors certify competency on specific procedures. They get signed off by the preceptor and then documented on their evaluation form. We monitor to make sure by the time they graduate, that they will then have that set of competencies signed off to document outcomes.

*Dr. Gevitz:* Yes and competencies!

*Dr. Gevitz:* As far as competency is concerned, I know that, in both dental schools, that a great deal of attention is to make sure that you've set levels for certain things that students are supposed to do to become proficient at, and that seems to be a big part of the accreditation process.

*Dr. Trombly:* Yeah. We have 28 competencies, half of which are all lumped in as a subset of clinical skills. We're kind of in between. We have these remnants of what used to be very prescriptive standards and what used to be clinic requirements, and you do so many of these and so many of those. Dentists like to count things, and we're very procedure based, and we get reimbursed by the procedure. Timing and stealth really—even though everything is outcomes-based and competency-based, the site visitors come in with their version of, "Oh, well, how could you learn to do that if you haven't done it X number of times?"

Each program will typically set some level of minimal experience in order to demonstrate the competencies, as well as have some summative assessments that are independent. Some of the controversies that we have right now concerning from one school to the next is, are there certain things that you can assess that don't involve patients, that you can do it through an objective structured clinical exam (OSCE), from simulation, or does it have to be patient-based? Right now, the commission has not addressed that—or the review committees—and we don't have as much

training as we should with our site visitors. They're all told to leave their biases at the door, etc., etc., but they will often come with their expectations of that.

Whether it's patient assessment or doing particular skills in restorative dentistry or replacing missing teeth, which are the level of our standards as well as the critical thinking, self-assessment, evidence-based, and those types of things, we have a whole slew of ways that we assess these different areas, and it can range.

Ultimately, the way the standards are written, again, if we get into the whether something's patient-based or simulation, it's a matter of when the site visit team comes, can you talk to them and explain why you think that's the appropriate way to do it? Depending on how well you do or don't make that argument could result, in our world, as a recommendation is what it is often.

*Dr. Gevitz:* Is it the school, for example, that sets the number of procedures as opposed to the accrediting body—

*Dr. Trombly:* Yes.

*Dr. Gevitz:* - and that they assess you or your ability to meet that number?

*Dr. Trombly:* Yes. Once you set it—and, in theory, you could set it to be one, or you could set it to be 100. You have to be then able to argue why one is an appropriate level as opposed to some other multiple. Yeah, you set it yourself. We do get into—we spend a lot of time with our electronic patient record and other things as to how to track what students are doing.

We have a lot of our faculty time devoted to our preceptors off-site or our faculty on site determining, what kind of experiences has each one of your students had, and have they achieved competency? Most of the schools set relatively low levels of minimal experiences and have shifted, over the years, to focus more on the independent competency assessment, direct faculty observation, or some combination of simulation and patient care experience that determines that a student is competent.

*Dr. Gevitz:* Dr. Sauers?

*Dr. Sauers:* Regarding our content, we now have foundational knowledge, but it must be taught concerning statistics design, path of physiology, biomechanics, healthcare delivery—those kinds of things. We do have core competencies that are the first Institute of Medicine

(IOM) core competencies. Patient-centered care, interdisciplinary, evidence-based practice (EBP), quality improvement (QI), informatics, and then we added in professionalism out of the ACGME core competencies.

Then we have the patient or client care, prevention, health promotion, wellness, and healthcare administration. Out of the 94 accreditation standards that we have, 40 of them are curricular content, so 12 sounds like—

*Dr. Sauers:*

Over the rainbow place that I can't imagine being. This is a radical reduction over the last iteration, which I think was 154 total standards, was much more down to every single thing, very much check-off-based. At some point, you've got to go to your preceptor and get every single one of those things checked off. We have moved way away from that. As a result, a bunch of the things that others have alluded to regarding consistently and, how do you assess if enough is enough, or can you do that—did you have to learn that on a real patient? Could that have been done with simulation? Those issues are just starting to emerge.

The employers are, more than they have in the past, making—but we don't think new graduates are ready to practice. It's hard to discern how much of that is also related to generational things. There's a significant element of that mixed in there. In our world, employers often want a new product to go out and be completely independent, autonomous, have no supervision whatsoever, have no on the job mentoring at all. It's just really unrealistic, whether you're in healthcare or any enterprise, to expect a brand-new product—I guess we could use that term—to go be independent on their own.

We're looking at some ways, down the road, where we might use something like the ACGME milestones as a way of looking at clinical behaviors and have those be more observed in a systematic way but not necessarily going straight to check off of all competencies. Maybe, when we talk about future directions, I'll talk about that more.

*Dr. Gevitz:*

Before I turn to Dr. Smith, since all of you run clinical programs, how many of you are using standardized patients or simulations, or OSCEs, as ways to measure or to determine whether students have achieved competencies? Dr. Steinman.

*Dr. Simon*

We have some reasonably extensive schedule of both OSCE, simulations. We have something called the situation where we

come up with clinical scenarios and have students working in teams to work through, usually, a more crisis type of situation—cardiac arrest, pulmonary edema—those type of things.

The OSCEs, we have them interact with standardized patients to go through and work through a patient visit, and then we have what we call station-based OSCEs where it's not focused on one patient, but they have ten different stations, each with a different skill they have to demonstrate—prescribing, interpreting, an X-ray, maybe doing an ultrasound procedure. It varies.

*Dr. Gevitz:* Okay. Dr. Parent-Buck?

*Dr. Parent-Buck:* This is one of the things that has been beneficial for, I think, audiology moving into a university like ATSU. When we came here and built an audiology program amongst other healthcare programs, it was unique for the profession of audiology. We used to be housed in schools of education, speech-language pathology master's programs. We learned a lot from watching the other programs like PA and medicine and dentistry and seeing so much of the simulation or OSCEs—it took me a while to learn what OSCE stood for.

We have implemented using more. I'd say, standardized patients or subjects in our comprehensive exams and our labs. We want to use that more, but I've heard, around the table here, this parallel accreditation, that we need to make sure that those either hours or experiences to show the competency is validated and accepted by the accrediting bodies so that it can take the place of some of the other tedious things that we're doing to make it valuable.

Also, we have to deal with the cost of running a standardized or certified patient. It's something we've learned from you all, and we'd like to add more of, but we need our accreditation bodies to make sure that they don't hold that against us.

*Dr. Gevitz:* These tools are not necessarily what the accrediting body expects. You have to convince the accrediting body of its utility. I see you nodding your head, Dr. Gupta.

*Dr. Gupta:* Yes, yes, yes.

*Dr. Gevitz:* Why is that?

*Dr. Gupta:* It's not an expectation, especially in OT, and not at the master's level. We, as a program, because we have joined practice classes between the doctoral and the master's students, I'm moving

towards using more of the standardized patients, but budgetary constraints are an issue. It's not required by accreditors; however, they want us to have some competency evaluation performed before the doctoral students go on what they call their doctoral experiential component.

They're not prescriptive. They're so about it that there are—you can use any number of things, and I have chosen, because of deficiency, to use an exam that is conducted by our board exam people. It's called the OT examination, and they accepted that. Or I could mark things on my curriculum. They'll accept that, and they even go to a professional portfolio.

I think this is a problem with the profession. If they so much so that anything across a broad continuum, that you have quantitatively measured in versus a portfolio that the student puts together, anything goes. This was a challenge.

*Dr. Gevitz:* Dr. Bordenave.

*Dr. Bordenave:* Yeah, I was going say that this push and change in our accreditation criteria to assure that students are prepared, we've been given pretty broad range also to demonstrate that competency from simulated patients to standardized patients—or simulation to standardized patients. In our program, we've chosen to use standardized patients in a comprehensive, practical experience for the students at two points in the curriculum. I know that there's substantial use of OSCEs and standardized patients, and that's all been accepted by the accrediting body as meeting those standards then.

*Dr. Gevitz:* Let me turn back to Dr. Smith because I wanted to cover, apparently, the assessment piece here. Your program does not have a designed standard clinical component, per se. Are the competencies that you seek to measure, then, more didactic than not, and how do you measure?

*Dr. Smith McNatt:* As I previously stated, we use the competencies that CEPH assigns us plus five additional that we write that represent our program that align with the mission, vision, and values of the department and the university. We measure our competencies to individual assessments in the courses, and we measure them very specifically because we have to make sure that competencies are—we measure them to Bloom's Taxonomy, and we have to make sure that competencies are met before they actually start the practicum, and then we make sure that specific competencies are met a certain

number of times. For example, if they're—in the mission, vision, and values of the university, we make sure that they've met a certain number of times more than individual core competencies because we try to target those more and make those our harder hit competency areas.

*Dr. Gevitz:* Thank you.

*Dr. Gevitz:* Turning to an issue I think that you're all interested in, I'm going to ask the question, how does programmatic accreditation encourage or discourage educational innovation? The first angry person can speak.

*Dr. Morgan:*

I'll kick this off with, actually, what I think is a very positive note. There's no anger in this. The COCA came in and inspected SOMA for our seven-year reaccreditation cycle in January, and they awarded us, in May, accreditation, with Exceptional Outcomes, the highest accreditation status you can get, a 10-year reaccreditation cycle. I think that that speaks to their recognition of the innovation that our school brings to the table concerning medical education.

We're training medical students like no other medical schools in the U.S. right now, and they accepted that, and they hold it out as exceptional, in their eyes. That encourages, I think, innovation. The challenge is that—well, let me back up and say another positive about the COCA's accreditation process. The rewriting of their standards became less prescriptive. Really, they said, "Here are the outcomes we want you to show that you've achieved. Get there how you can." I think that encourages innovation.

*Dr. Gevitz:* Okay. Well, we can see one positive voice.

*Dr. Trombly:* I would agree. I think it cuts both ways. In our case, I think our standards are broad enough. They have moved away from being very prescriptive. Again, I think the standardization of training of the site visitors and such could improve that. Again, I think this school—ASDOH is an excellent example of it was a very different model when it was developed, and it had all the offsite learning that was happening, which was extremely unusual, if not unique, within dental education.

I think, if I have my facts correct, we got an extra site visit to look at that because it was so different specifically. It was accepted, and it wasn't an issue for them. I think, in our case, we have the flexibility within the standards to be able to do things. The institution's got to be able to tell its story, though, and make the arguments for us.

*Dr. Gevitz:* I think ASDOH was a predicate for MOSDOH, and it was challenging, at first, for MOSDOH to get the go-ahead to start the dental school because the model was so radical, but it was based upon the ASDOH model, except it went further—

*Dr. Trombly:* It went a little bit more, yeah.

*Dr. Gevitz:* - in two ways concerning the amount of education that would be provided in community health centers and, second, that it would be two campuses, mainly, or two sites, which was unusual for dental education. It does seem that accreditation standards, at least in some cases, can provide at least leeway to do something different. A challenge often arises concerning competency-based education, but that may not be the responsibility of the accrediting body but more of the U.S. Department of Education regarding—

*Dr. Trombly:* Something I was going to mention is I also think the peer site visitors and the self-study process, that sounds like most of the programs are using, is also, I think, a way to help develop innovation as well. I think, reflecting—and as Eric said—you could lose that, I suppose, in the reporting part of it if you don't have the opportunity within your narrative, but I think that helps you tell that story and explain why you innovate.

As well as, when you do have the peer site visitors come in, there's a lot of exchange of ideas that happens within that process. Yeah, there can be biases and baggage that come along with it depending on how, but I've learned a ton, as a site visitor, from going to different programs. I know, from interacting with them after the site visit, they felt they learned a lot from the site visit, too.

*Dr. Gevitz:* Dr. Simon.

*Dr. Simon:* I agree with Dr. Morgan. I think that one of the ways that accreditation promotes innovation is by example. Yale University, for example, just started the mainly first online PA program. By accrediting that program, the accreditors said, "Here, this'll work. This is one way you can build standards." Even though in some

ways, our accreditation standards are more prescriptive than they used to be, there still are many that are relatively broadly written.

For example, a standard may say that you have to teach math. They don't say that you have to have a math course. You only have to provide math education to meet your outcomes. We just decided to go away from using cadaver prosections recently. We felt there was a better way to teach the clinically relevant *when our accreditors return we will have to demonstrate that what we are doing now works as well or better than the anatomy experience we had previously.*

I think, as program directors, it's our responsibility to make sure we meet the minimum. I think a trap that you fall in as a program director is to chase those standards. I think we formulate what's the best way to provide this educational experience for the students, and then try and fit that into the standards rather than chasing them.

*Dr. Gevitz:*

Dr. Gupta?

*Dr. Gupta:*

Our accreditation body claims that they don't want to stifle innovation, which is why they are not prescriptive, but that's a double-edged sword. Then what happens is, how are you making sure that the product's coming out of the programs have some minimum level of competencies? They also say that, for accreditation, meet the lowest bar. You don't have to aspire for best practice. It's left to individual programs to develop a unique curriculum.

For example, I recently had a mock visit consultant come in. She was saying that what she has seen in our curriculum is the—and the review team also noted—solid science foundation, which is very unusual for the OT program. As a person leading the department, I have a lot of influence on how I steer the curriculum and what we focus on. The innovation is there, but I worry about the product coming out. Is there some consistency? If they're putting out cookies, are they all cookies? Are they turning more into cakes? Do you know what I mean?

*Dr. Gevitz:*

Dr. Parent-Buck.

*Sr. Parent-Buck:*

I would somewhat agree with that when I thought about this question. Our accrediting body is somewhat. I would say, neutral on innovation. They neither encourage it nor discourage it. Looking at the standard, being that minimum what is necessary, it

is up to the individual programs and those people leading the programs and the faculty who contribute to the programs to decide how much burden they are willing to take on to promote that innovation themselves because they can do the status quo.

We have over 75 programs in audiology, which amazes me when I hear these other disciplines, which are much larger than audiology, having fewer programs than we do. We have over 75 programs and only 14,000 or 15,000 practicing audiologists. I think that is one of our significant challenges. The accrediting body is not willing to take some of those steps to raise a bar that might force a program to close because that's frowned upon. We keep accrediting new programs, and we do not need them.

If you want to be innovative as a program, you have to take on that burden to answer additional questions. You, maybe, have additional site visits or even get a ding and have to prove then and justify yourself why this is meeting a standard and how it is different than what the status quo is. The burden is on the program to undertake that and do the extra justification and arguments to prove their innovation is valid.

*Dr. Gevitz:*

Okay. Dr. Sauers?

*Dr. Sauers:*

I wrote the same thing down, that our accreditor neither encourages it nor discourages it. Unfortunately, we've focused exclusively on minimal assurance standards, and we don't have any aspirational standards right now, which is something that I hope to change in the future because, without a set of aspirational standards, everybody just keeps chasing the start and just getting to—we demonstrated the minimum, we demonstrated the minimum, and there's no accreditation impetus to go beyond that.

I think, maybe, the open pathways process of the regional accreditors is a concept that, when they were starting that, they were very much describing that regarding you have to identify some way to improve. Even if you fail at that, it is okay, but do something. Pick something to try to get better. That always resonated with me that we need to do that at our programmatic level because most programs will not do anything you do not tell them to do, unfortunately.

I think ATSU is the exception, in many cases, to the rule, and we have schools and programs trying to really innovate and go beyond. Many programs are just chasing, what's the minimum I have to do? If you do not have accreditation standards that are

aspirational, that force them to think about how not just to be minimally competent but how to improve themselves in some specific way, that they might not. I'm hoping that we move in that direction in the future.

*Dr. Parent-Buck:* I could add in on that. The one thing that our accrediting body, I think, did do to try to focus on that or fill the gap was to emphasize each program having a healthy, solid strategic plan and following that strategic plan and showing analysis of data, maybe a quality improvement type of initiative, and closing the loop, but I don't know that that was sufficient. I think that was their tactic to say, "How do we know that you care about your quality and what you're doing? Let's make sure you all have a five-year strategic plan and that you're following it." That could be still to meet the minimum standards.

*Dr. Morgan:* I'd like to add to that and to echo what Tabitha just said. As long as we have some rational providers what we are doing the mission, the vision of the institution and they have put out metrics concerning what our programmatic evaluation, which is based on our strategic plan, which is based on the institutional strategic plan, I think they are okay with innovation.

*Dr. Gevitz:* Anybody else wants to speak on this subject?

*Dr. Bordenave:* I would say, in PT accreditation, I don't necessarily know that they encourage it, but they certainly don't discourage it. I'm not sure that they're necessarily neutral, but they're probably more towards the encourage. Even though we do have all of those criteria that we must demonstrate competency or that we address in our curriculum, we don't have to address it in a particular way, and they are minimum criteria.

I think that that's been a big issue in physical therapy education as well, so broader than just accreditation. To that end, there have recently been several publications that had come out to explore best practices in physical therapy education to encourage programs to move beyond the minimum standards set forth by accreditation.

*Dr. Trombly:* Yeah, I agree. A couple things—

*Dr. Gevitz:* Dr. Trombly.

*Dr. Trombly:* - to build off of what Eric mentioned, Commission on Dental Accreditation (CODA) used to have commendation, and then they eliminated that from the write-up, so it's either unique or not. You

can still have the recommendations and suggestions, and you get the suggestions, which don't fall into a reporting type of thing. The cyclical nature, I think, of how the process works, also—we're on a seven-year cycle.

Typically, you get to the point to where you start your self-study right at the start. You got some opportunity there to maybe even use the standards, if they are written well, to leverage a little bit of change internally, and then you get into the shutdown phase. We don't wanna try anything because we're too close to the site visit, and we don't wanna—and then you get into the year or two after the site visit where everyone's putting so much effort into doing it, they don't wanna talk about anything right now, and then you're left with this couple of years' window that you can innovate.

The standards themselves allow it, but I think if there'd be a way to come up with continual monitoring of the program where information is just sent in, if you will, and monitored as opposed to these big boluses of a ten-year or a seven-year, that it is an all-hands-on-deck thing.

*Dr. Gevitz:* Sounds like a man burdened with an excessive amount of paperwork, I suppose. Dr. Trombly, do you not do annual reports to your accrediting body?

*Dr. Trombly:* No. We only have—well, there are some reports that go into the American Dental Association that include some of the information that then get syphoned off into CODA, but it's not—and, if you had a recommendation, you'd have reporting requirements that may be—for the most part, there are some surveys that happen. Or, if you have a change, if you want to propose a change in enrollment or some change in certain things, you have to report that.

*Dr. Bordenave:* Yeah, so we have substantive change, apparently, that that kind of report—but we also have an annual report, and, every year, the accrediting body decides, "Well, we want to know X about programs, or we want to explore this about programs." The annual report has a particular focus every year that then they collect additional data from the programs.

*Dr. Trombly:* Again, the surveys that go to the American Dental Association that are for dental education, they do funnel back to the review committees, but they are not utilized. Having sat on the other side, they are not utilized to either say, "things are going okay," and they

do not lower all the resources you need at that significant site visit coming up.

*Dr. Smith McNatt:* I would have to say CEPH encourages educational innovation. They are continually encouraging outside collaboration, hands-on education, interactive education, new methods, interactive learning, and so forth, they encourage experiential learning, and have workshops and committees meet on innovations in pedagogy to work towards learning the best way to educate adult students.

*Dr. Gevitz:* We are a Center for the Future of the Health Professions, and so the last formal question that I have to pose to you is, what do you think is going be the future of your health profession's accreditation system and processes? What's going happen over the next five years? Dr. Simon?

*Dr. Simon:* I think in the PA profession that the accreditation process has matured. The accreditation agency has had to respond to meet the demands of the vast increase in the number of PA programs that we have, and it changed, as an organization, in that regard.

*Dr. Gevitz:* What is the-is it five years in order for a new program to start?

*Dr. Simon:* It is a little less, but it is still many years once you enter in the accreditation process queue. The process has changed. For example, we used to submit our self-study in with the rest of the accreditation documents. Now, you have to send it in two years beforehand to an outside reviewer who gives you feedback so that it can be amended before the actual site visit.

Secondly, our profession is now going through a big discussion about a concept we call optimal team practice, which indeed may change the way that we have to educate individuals because they may come out with significantly more responsibilities as an entry-level provider. I agree with what Eric said before, many times, our graduates are expected to go out and jump right in, and they are put in situations where, I think, it is unsafe. That's a concern, and the accreditation standards would likely need to be revised to provide more guidance for the increased educational demands that would need to be met.

Third, the accreditation folks are slowly responding to the changes brought on with distance education. A lot more programs are interested in doing things much differently than they have traditionally done. I gave the example of the Yale PA Program cited earlier accreditation processes will have to deal with new

paradigms of educational practice. They may also have to respond to in the PA world to different degree requirements. I still predict that, in the not too distant future, the PA profession is going to begin to gravitate toward the entry-level doctorate. That also will present a challenge and a need to change the accreditation standards.

*Dr. Gevitz:* Dr. Bordenave?

*Dr. Bordenave:* I think there are probably three big things that are related to accreditation that are challenges for the profession. As I mentioned, having faculty who are doctorally prepared at the terminal degree level, the requirement, currently as it stands in the accreditation criteria, is that 50 percent of your faculty have to be trained at that level.

That's a big challenge in PT. Some programs are having difficulty meeting that. They might be pulling in basic science faculty to help them meet those criteria. I think that that's gonna continue to present a challenge for us in having adequate faculty to teach in physical therapy programs. Then we have the challenge that we have a lot of programs, too. I was surprised when Dr. Morgan was saying how many programs there are. We have over 200 physical therapy programs and more and more being developed.

Some of the data suggest that there's going to be increased demand for physical therapy programs, but the data is not necessarily very reliable. We're not really very clear on how many physical therapists we're going to need into the future, so then, how do we decide how many programs are enough? Is the accrediting body going to allow market forces to drive that, which is necessarily what they are doing currently, really, or are they going to make the standards more stringent in order to control that in some ways?

Then I think the last piece is about those assurances that we have to make for entry-level practice in the criteria. A lot of programs, including our own here, are using integrated clinical experiences during the didactic portion of the curriculum before their full-time clinical experiences, where student practice in the clinical environment. Our students go out four hours a week to do that. We've taken what's a demand on our clinical sites to take students for these terminal clinical experiences, and now, added another clinical experience. So, take more students—typically unpaid in physical therapy education, to provide those assurances.

Then how can we provide those integrated clinical experiences for our students without increasing the demand on our clinical sites who are already facing increased demand for their time relative to the number of new programs, increase in class size—all those kind of things? I think those are the big ones that are going to impact us.

*Dr. Trombly:* Same. I think we are in touch on more of the point in that that goes back to the old issue, are any of our professions or accrediting bodies working collectively with the government to have a plan for healthcare.

*Dr. Gevitz:* Dr. Parent-Buck?

*Dr. Parent-Buck:* Audiology has similar issue, as we echo things around the table that that PhD shortage or issue for AuD program, and the fact that we have instead a shortage in the profession—we have few audiologists compared to the need that we haven't been able to keep up with and actually have more audiologists retiring than are graduating. We can't meet that need if programs can't fill their faculty seats and if the accrediting bodies restrict that. It's going be innovative in our complexity of what our faculty degrees are for a program that's clinically based.

I think there are methods for having AuD clinical educated faculty teaching clinical parts to the program, and it's still a viable and quality program. We also have a problem with the number of programs and the number of graduates we need. Audiology has always thought that, with the least known health profession, no undergraduate student jumps up and says, "Oh, I want to be an audiologist," when you ask them what healthcare profession they want to join. If we're going to fill the seats with the students, we need to increase the applicant pool to be able to do that. That's one of our challenges.

The evolution of some AuD programs becoming three-year programs versus four-year programs is a challenge for the four-year programs as well as for the accrediting body to decide how they're going to handle the differences and the approval of a three-year program versus a four-year program, and the equity of the student experience and the clinical experience.

*Dr. Gevitz:* Dr. Gupta.

*Dr. Gupta:* Many similar challenges; faculty capacities continue to be one with the accrediting body requiring more what they call a doctoral faculty and not being very prescriptive in terms of how many

percent—30 percent having doctorally prepared faculty, so doctorally doesn't necessarily mean a PhD or a because they actually went with 30 percent having academic doctoral degrees, and then there was a pushback from the community, and so that continues to be a challenge as a program director and a chair because the expectations for scholarship has gone up.

My question is, so why do they need to be trained in order to do the scholarship and the research, which, in a way, is a—the degree is a proxy for that, but they don't come out of this. They also believe in market forces determining because programs are just mushrooming all over the country when we have a shortage of faculty. I think OT is the number two fastest growing profession and a need given the demographics of the population. A lot of for-profit entities are coming up.

The third challenge is we have a gazillion standards. The last time I counted, it's at big categories, but many standards, for each of which we have to have evidence of how we teach and produce artifacts of how we assess our students. Then what happens is you are completing the programs that, maybe, are doing the minimal standard, so you are offering the same degree with far fewer credits than if you want to have a dynamic curriculum to meet the entry-level competencies programs like mine are competing against.

Finally, as a profession, we are not in a good place right now because, as we are talking today, our professional association and our accrediting body fighting with each other, one accusing the other of overreach because the accrediting body wants to mandate an entry-level doctorate for OTs by 2027, and they said they refuse to accredit any master's program come 2026.

Then they also accredit the occupational therapy assistant program, and they wanted to mandate baccalaureate entry level, but, given that 90 percent are housed in community colleges, they are threatened by a lawsuit. Now, they have said two points of entry for OT assistants, so waiting to see where the future unfolds. I think we, at A.T. Still, are okay because I have two programs.

*Dr. Gevitz:*

Dr. Bordenave?

*Dr. Bordenave:*

Yeah, can I say something to what Jyothi was talking to relative to the program director? Also, physical therapy education, finding program directors—the number of jobs posted for that particular role is, I think—at one point, there were 50 positions posted for

program directors. I think the challenge is being that the accreditation standards and meeting those demands are so significant and takes so much of a program director's time that a lot of people are like, "I do not want to do that." I think that that is a massive challenge in our professional programs.

*Dr. Gevitz:* Well, just a note regarding Dr. Simon, Dr. Bordenave, and Dr. Gupta, we are talking about accreditations standards that have been set to have a certain percentage of academically trained PhDs or doctoral-level faculty in the program, and, yet, all of you were fast-growing professions.

It seems that the accrediting body is setting standards which limits your growth because they are not providing you with a mechanism by which you can train or which the profession can train those many doctorates. Therefore, there's a real limitation regarding what you could do—expand in your size, mainly if there is a need—because of the accreditation standards. Am I wrong on that?

*Dr. Bordenave:* I think that, in physical therapy, the intention was good, right?

*Dr. Gevitz:* Yeah.

*Dr. Bordenave:* Because of intent—

*Dr. Gevitz:* We know where good intention.

*Dr. Bordenave:?* Yeah, we do. The intention was that there isn't an adequate amount of research and high-quality research in physical therapy. Since academic institutions' role are to advance the profession, through research, let's make that as a requirement so that we can improve that in the *profession* overall. Unfortunately, it is a double-edged sword, as everything is.

*Dr. Gevitz:* Dr. Morgan.

*Dr. Morgan:* The COCA's charge is focused on undergraduate medical education. I think one of the most significant risks or challenges they face has to do with graduate medical education and the agreed-upon the merger of two accrediting bodies that accredited allopathic and osteopathic residencies. In 2020, there will only be one accrediting body, a combination of the two existing bodies, hopefully. The elephant in the room for the COCA is, will this trend—if it's a trend—will this process influence undergraduate medical education accreditation in a similar way? Is there a need to have two accrediting agencies for medicine?

*Dr. Gevitz:* Dr. Smith, where is CEPH going, do you think, regarding accreditation standards and processes? You noted that there was flexibility, but there was prescriptive behavior, as well, as part of the accrediting body. Where do you see it going?

*Dr. Smith McNatt:* We like the uniformity that CEPH is working towards in the sense that they have implemented these competencies with certain workplace variables and certain topical areas, but, underneath those competencies, they have broadened the methods in which they could be met. They have increased the push toward experiential learning across the board and are encouraging schools and program to collaborate so that students get actual hands-on experience in school and not just textbook education. With the practicum, they no longer have an hour requirement on it, but rather students now have to meet specific competencies to pass it.

CEPH also wants to see our students involved in research and service hours, which, for our full-time faculty, due to budget cuts, has been a heavy load times. CEPH is requiring a lot more hands-on interprofessional experiences and is looking more now at IPE and the service work. They're trying to get the students to be more workplace-ready, when they come out, through the way the new competencies were written. They're going into more of the IPE workplace-ready as opposed to just academic-ready, which is a good thing.

They are working with CPH, which is the Certification in Public Health, and Association of Schools & Programs of Public Health (ASPPH) to do so. They're trending more towards that sector of it as opposed to just straight academia in the long haul. They're very much into the whole experiential learning as opposed to just straight book and academic learning, and that's where I think they will continue to move toward in the future.

*Dr. Gevitz:* Thank you. Dr. Sauers.

*Dr. Sauers:* I just put on my accreditor hat concerning the issue of, should the accrediting body be allowed to restrict the number of programs to keep it competitive? I think that is a dangerous place for accrediting bodies to go because you have to have accreditation standards. If a program meets them, they meet them. Then people say, "We'll make more rigorous standards," but the idea is minimal competence to prepare an entry-level person. I think it's funny to listen to some of the numbers. Athletic training only has 50,000 credentialed members. We have 405 accredited entry-level

programs. Our accreditation process is a vast enterprise. It is time-consuming. We have a considerable number of relatively small programs, so the average graduating class of an entry-level program is only 14 students. You can compare that to—there's many programs but sparse resources for each program.

I think what's going happen, over time, as we make our accreditation standards more and more rigorous is we'll have a shrinking of the total number of programs, and we'll have fewer bigger programs, hopefully, with more resources. You can't say that as an expected goal of—because you can't set out to do that, but you can set out to make more rigorous accreditation standards, but that becomes a byproduct of—we've tried to do that what we've been accused of selectively targeting small programs at small institutions because we have accreditation standards that require more resources.

It hits them the hardest, and so then they make claims that you're going after them. We've got some of the same things coming down the pike. Our new accreditation standards focus much more on faculty expertise and scholarly productivity, so there are many questions around that. We have introduced immersive clinicals where—there was a complaint that graduates did not understand what the day in, day out life of a practitioner looked like because they were always straddling class in the morning and then clinicals in the afternoon.

Now, they have to do immersive, where they spend unfettered amounts of time, like most of the other health professions. They're not concurrently attending didactic classes doing their clinicals. I alluded to earlier we want to introduce some quality advancement accreditation standards, and then we are looking at a way to take that milestones concept from the ACGME, and we're reworking those to describe the clinical practice not just across the continuum of a residency but across the continuum of the profession.

Instead of five levels for a resident, five levels for the profession, we would then try to set accreditation standards where a level three would be the standard you need to take somebody to in a professional program. A level four would be what they would get to at the completion of a residency, and then a level five would be an aspirational, across your career, as you want to become an expert, you might only have a—nobody's gonna try to be a level five anything, but to show somebody this isn't the finish line. There's more out there. I think that's an exciting project that I've been workin' on that I hope we're able to do because it shows the

educators and the learners the progression across the whole spectrum.

*Dr. Gevitz:* Dr. Trombly.

*Dr. Trombly:* Yeah. From the commission's perspective, they did a white paper, I think, it was in 2014, give or take, about needing to move forward with separating from the association, and I think that's one of the that would benefit.

I think the commission's perspective is that their role is not to determine workforce needs or be a national hub for how many programs there should or shouldn't be or enrollment but to make the determination, does the program meet the standards? I think the perception or the reality, depending on how you look at it, is that the association might be more interested in the workforce and controlling how many—I think there's a lot of—the external environment, right now, in dentistry is very dynamic. It is all areas. We've got delivery system changes. We have got the scope of practice potential changes. Cost of education, it continues to rise. All these things are areas that the standards can get in the way of or be neutral to or support where things are going to go. Again, it is not just separation from the association, but it is also making sure that the commission itself can work more effectively, have a budget to be able to support these types of things.

Many schools, ours included—I would love to have a specific competency-based curriculum where our students could progress through in something less than four years, but there's a standard that says the program has to be four years. Again, the standards can get in the way of innovation as much as they can try to create that more global world. Our commission has been playing around with and looking at how to accredit international programs. Again, they do not have the resources to do that. It's when you look at it, but we have to—that's part of the world we live in right now.

*Dr. Simon:* I think there is a balance with accreditation that between elevating credentials and ability to access education and produce frontline providers. As we move more and more toward higher academic credentials and, therefore, theoretically, making education more expensive, that may impact access to a PA (and other) educational programs. I think we have to be sensitive to the impacts that these changes may evoke.

*Dr. Gevitz:* I have never seen you so. Are we getting into a debate?

*Dr. Gevitz:*

I will close it at that point because, again, I want to tell you that there's going to be minimal editing concerning what you all did today, that you did a masterful job. I am amazed and impressed by all of you regarding your depth of knowledge and how you prepared for the session today.

I will tell you—but do not repeat it outside of this classroom—that I have never felt more honored to be at ATSU than what I experienced today by all of you concerning this session. You are experts in your area. You are knowledgeable. You prepared. You showed up. I'm just grateful for your participation. This was an excellent session, in my estimation. When it comes out in the narrative, we may all disagree. I think that, for premier, and I meant that concerning a beginning, that this is supposed to be our first collective effort. I thought you just did magnificently regarding how you discussed all of the questions, and I want to thank all of you.