Accreditation Standards Adopted

By Peter Koehneke, MS, ATC

following a three-year process, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) adopted the revised athletic training accreditation Standards and Guidelines in April 2001. There were numerous opportunities for input by accredited and candidacy programs as well as by individuals over this period. The Standards are in effect for all programs submitting a self-study to the Joint Review Committee on Educational Programs in Athletic Training (JRC-AT) in June or September of 2002. All currently accredited programs must demonstrate compliance at the time of their site-visit in 2002 and beyond. Regardless, all programs must be in compliance by 2005.

Several highlights of the Standards have incorporated NATA Education Council initiatives and recommendations. The first is the adoption of the 1999 Athletic Training Educational Competencies that include the clinical proficiencies. The adoption of the Competencies also incorporates the use of Approved Clinical Instructors (ACI) and the elimination of the "hours" requirement for clinical instruction.

The ACI approach requires students to be assigned to a specific individual who guides them through that portion of the educational process. During this time, the ACI will be responsible for the instruction and evaluation of the clinical proficiencies. This is then transferred to the field experience when a student is deemed competent to apply that skill to the individual involved in physical activity. The learning-over-time continuum protects the safety of the individual being administered to, the institution and the clinical instructor supervising the student.

As each clinical proficiency must be formally instructed in a classroom environment, formally evaluated as part of a formal class or laboratory, and further evaluated during the clinical and field experience, every student will have demonstrated competence in each of the proficiencies. This will provide prospective employers, lobbyists and legislators with a clear definition of the capabilities of an entry-level curriculum graduate and certified athletic trainer.

The single route to NATABOC certification in 2004 will allow legislative issues to become uniform relative to educational standards and skill capabilities. The need for "hour" documentation remains an issue for some state practice acts, and programs must remain aware of their specific state requirements. Programs may also elect to retain some form of "hour" requirement for their clinical courses. However, the educational emphasis is on the acquisition and demonstration of competence in the areas of psychomotor skills related to the clinical proficiencies for accreditation.

During the course of Standards development for the 1991 edition, the JRC-AT was locked into the then-Commission on Accreditation of Allied Health Education, or CAHEA, accreditation Standards template. The JRC-AT was very limited in the language and substance of the Standards.

The CAAHEP template has allowed the JRC-AT the opportunity to greater define the Standards and to remove areas of concern and dysfunction from the previous edition. One of these areas is that of the formation of consortia to offer athletic training education. The concept fit well for many of the two-year institution participating in CAHEA at the time. However, there were no four-year institutions involved.

As attempts were made by several institutions to do this, the JRC-AT watched the development closely. Upon thorough consideration, and based upon the administrative and quality control issues cited, the language to allow consortia was removed from the revised Standards. This does not mean that institutions cannot share resources such as classes. This has been done for many years by some programs. What it does

imply is that each institution of a consortia must demonstrate compliance with the Standards and be considered for accreditation, not the consortia.

While there are advantages to this – such as each institution having its own graduates – there are disadvantages as well, such as competition for enrolling students and the resources required for each institution.

The personnel required for an accredited program have been identified and their roles clarified. While a clinical coordinator is not required, it is apparent that the days of the program director being the individual to coordinate the academic program, the clinical education portion and be extensively involved in athletics has passed. Tenure requirements of the faculty position are another burden on the program director and other faculty not faced by most clinical instructors. The number of adverse tenure decisions has been rising as much effort by the program director is put into the academic program, thus decreasing his/her time for scholarly productivity to meet tenure requirements. The tracking of the competencies and clinical proficiencies will further compound these time demands.

The progression of the profession has been established with the requirement that all athletic training education programs be established as a major course of study. While this area has been discussed in length over the past three years and in fact since the 1980s, it is a strong statement to institutions to recognize the profession as an equal in allied health. It does not eliminate the opportunity for students to pursue teacher education and in many instances makes it easier with the inclusion of electives that were not previously available. This does mean that all institutions will embrace the major concept due to institutional philosophy. This is a decision that each institution must make relative to every program it offers. Some areas and majors are rejected while others are adopted. Athletic training education is part of this normal evaluation process and is not a "fit" with all institutions, as has been seen previously.

The field experience component of the Standards has been broadened to allow more flexibility for programs to develop experiences unique to their institutions. The traditional experience has been retained, and all students must complete a traditional experience as a minimum of one-half of their field experience.

The other one-half of the experience may be completed in the traditional setting or may be completed in other settings such as an industrial, clinical or community-based health care settings. This does not remove the identity of the individual as an athletic training student; rather, it may expose other health care providers to the uniqueness of the profession and how the athletic trainer fits into a broader based scope of health care practice.

The student must complete the competencies and clinical proficiencies and therefore the knowledge base remains consistent in the profession, with field experiences strengthening diversity among graduates. This is currently done within the realm of the American College of Sports Medicine, American Red Cross, American Heart Association, National Strength and Conditioning Association and others as students are provided with these certification opportunities. The opportunities will allow students to experience practice settings that will complement graduate school or career choices.

Program outcomes will also be a focus of the revised Standards. Currently programs are asked to provide outcomes on the effectiveness of their students relative to course evaluation, NATABOC certification examination score results and placement. The revised Standards are requiring programs to evaluate their outcomes relative to the above and also based upon the program goals and objectives. Vision and mission statements cannot be left idle until the next accreditation visit. To put it in simplistic terms, program officials must constantly assess what they are doing and how well they're doing it. The learning-over-time concept will assist with this, as will graduating students, alumni and employer follow-up. Both student and instructor will assess the field experience components, as opposed to getting feedback only from the instructor, as happens in many current cases. Outcome assessment is a challenge to all programs but is not a new concept as all institutions are required to perform this for regional or national accreditation as well.

Other Education Council initiatives that have strengthened the resources for programs to comply with the Standards include: technical standards examples for entry into the educational program, course syllabi requirements and examples, sample affiliated site agreements, program policies and procedure manual outlines, web-based resources, and on-going dialog and development in several other areas. Programs should visit the Education Council website at least monthly for new information.

The question that is raised by some educators is "When will this all stop?"

Education reform has been an evolving process with two- and three-year processes or longer. Input from various communities of interest has been obtained in a timely manner and will continue to be obtained. When will this all stop?

Never.

Technology, educational materials and instructional tools, as well as changes within the scope of practice mandate that education changes keep pace. Athletic training education has entered the 21st century in a catch-up phase. While change remains uncertain, if it were not uncomfortable, it would most likely not be progressive.

On behalf of all educators, I wish to thank the current and former certified athletic trainer and physician members of the JRC-AT and Education Council for their work and foresight on the accreditation Standards and educational reform. Relative to educational issues, it would be wise to heed the quote by Heraclitus that "There is nothing permanent except change." **nn**

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