Dynamic Chiropractic

EDUCATION & SEMINARS

Transparency and Accountability: Q&A With the CCE

Editorial Staff

Every profession needs an organization dedicated to upholding the quality and integrity of its degree programs and educational institutions. In the case of the chiropractic profession, that organization is the Council on Chiropractic Education, of course, incorporated as an autonomous national organization in 1971.

But the past 40-plus years have not been without turmoil for the CCE, particularly in the past several years, as some members of the profession have questioned the council's revision of its *Standards* and the organization's overall governance structure.

In this exclusive interview with *Dynamic Chiropractic*, the CCE clarifies its ongoing governance reform process while discussing, among other topics, the CCE *Standards* and how trends in health care are shaping the face of chiropractic education.

So, why the need for governance reform? The CCE is responsible to the U.S. Department of Education (USDOE) criteria and federal codes of law, regulation and sub-regulatory guidance operating under the Higher Education Act. The Higher Education Act is periodically amended, and the CCE must be responsive to those changes and continually adapt to new criteria. That process in and of itself promulgates regular review and reflection on the practices, policies and bylaws of the CCE.

Such reviews are the responses appropriate to actions mandated by changes in federal law that apply to accrediting agencies commissioned by the USDOE. The CCE also believes that the agency benefits from periodic comprehensive review of its structures, practices and policies. The current iteration of that process was assigned to the Governance Review Task Force (GRTF) and the Administrative Review Task Force (ARTF).

These task forces have been charged with gathering information about the CCE's current norms and reviewing them against best practices, perceived strengths and weaknesses, and needs of the agency going forward for the near to intermediate future. The task forces are truly focused on quality improvement.

As a part of that process, these task forces have received and considered input from stakeholders and other interested parties – especially those that are critical of the CCE and its practices, policies and bylaws. Feedback obtained through meetings with constituency groups assists the council in identifying needs and priorities for improvement.

The council recognizes that no shortage of strong feelings and opinions have been expressed in recent years. Those expressions have been thoughtfully and thoroughly vetted through review and consideration, along with all the other inputs to the process. The outcome is that some are able to be incorporated into the mix, while others are not.

How is the CCE progressing toward governance reform? What specific changes are in the works

and what has been discussed? Throughout 2012-2014, the leadership of the CCE held multiple public forums on governance, gathering information and input from a diverse array of stakeholders. One example of this outreach occurred in March 2014, where CCE leaders held frank and open discussions with representatives from each of the accredited Doctor of Chiropractic degree programs, as well as holding a similar forum with representatives from the Summit Steering Committee. The council chair gathered and directed all inputs and recommendations to the Governance Review Task Force.

The GRTF was charged to study the CCE's organizational structure and function, and recommend changes that could reduce costs, better assure compliance with the CCE *Standards* and improve how the CCE interacts with its multiple constituencies in meeting its mission. The GRTF analyzed its findings through multiple lenses, including compliance with USDOE regulations, best practices in accreditation, cost effectiveness, value to the programs and institutions accredited through CCE, and likelihood of creating improved outcomes from the programs and institutions seeking recognition through the CCE. The council met in July 2014 and considered the input, as well as recommendations from the GRTF.

At this meeting, the council accepted a recommendation from the GRTF to begin to reduce the size of the council. This was based on the factors already mentioned and the recognition that many specialty accrediting agencies have less than the 24 seats on the CCE. The council decided to begin the process by eliminating two (2) vacant seats in Category 4 in the upcoming election in working toward this goal; the seats in question were seats being vacated by two (2) councilors who had no eligibility remaining.

The immediate effect of this change will decrease the seats available for the council to vote on in upcoming election cycles from 17 to 15. The council will continue to review the need for upcoming open seats in future years for possible reduction in size of the council through attrition.

In addition, the council changed its process in the upcoming election to place *all* qualified nominees for open seats in Categories 2, 3 & 4 on the ballot for consideration in their respective categories. Under past practices, the Council Development Committee would select a slate of 2-4 candidates for consideration from the list of eligible candidates for a position. Placing all eligible candidates on the ballot was implemented for the programmatic elections in 2013.

The council believes it has created improved transparency in the election process. Making this change required the council to suspend a portion of one of its policies (CCE Policy 29, Item 3, paragraphs 3 and 4) on council voting in the 2015 election cycle only for Categories 2-4. The council chair also directed the Bylaws, Standards and Policies Committee (BSPC) to review Policy 29, specifically item 3, paragraphs 3 & 4, to submit a proposed policy revision in the fall of 2014 for review / approval by the council at the January 2015 meeting to ratify a permanent change to this policy.

Also, the council adopted the GRTF recommendation to review the CCE Bylaws, Article VI, to preclude councilors who have served three (3) 3-year terms to be eligible to return to the council. This is intended to maximize diversity across programmatic, practicing DC, and public representation. To complete this plan, the BSPC will review the CCE Bylaws, Article VI, in preparation for submission of a proposed bylaw revision in the fall of 2014 for review / approval by the council at the January 2015 meeting.

The ARTF was charged with reviewing CCE staff structure, roles and relationships between the officers, staff and council members in order to determine where improvements could be made to enhance efficiency, clarity, focus and effectiveness within and between all the groups. This process

incorporated reviews of job descriptions, staff and CCE officers' self-report of their duties and activities, best practices in volunteer council relations and responsibilities, and a variety of other internal workings of the CCE.

The ARTF report to the council included a series of recommendations, including realignment of senior officer roles and responsibilities to improve communication and efficiency, clarification of the staff roles in the wake of redesign of the officers' roles, and improvements in the clarity and focus of councilors' activities to improve the council's efficiency, focus and effectiveness. This included a recommendation to adopt a "Partnership Model" between the council and agency staff. Those recommendations were adopted by the council at its July 2014 meeting.

What does chiropractic education look like now and moving forward compared to 20 (or even 10) years ago; and how does the CCE plan on upholding those standards across all chiropractic programs? Health care has consistently been increasing focus on accountability by practitioners for their actions and outcomes in practice. State regulatory bodies, national boards, legislative bodies (at state and federal levels) and patients have all demanded better health care practices, to ensure that patients enjoy optimal cost, quality and access to needed health care services.

Chiropractic practice has responded to that shift accordingly, as has chiropractic education accreditation. Not surprisingly, the greatest change over this period of history within higher education accreditation has been increasing accountability for demonstrating intended student learning through robust assessment programs.

The CCE *Standards* have evolved significantly in that direction, specifically in the 2012 *Standards*, where the expectations for programs moved from a focus on quantity of procedures as a basis for demonstrating competency (i.e., perform 30 X-ray study interpretations in order to qualify for graduation) to demonstrating mastery in the performance of complex clinical behaviors (Meta-Competencies).

The CCE Meta-Competencies have been written as outcome statements to be measured by the Doctor of Chiropractic programs – measurements that they get to determine and then implement, analyze and benchmark. The emphasis has changed from simply *counting* clinical encounters (i.e., number of adjustments and lab interpretations) to *measuring* the learning that takes place in those encounters.

How can chiropractic education better prepare the DC to practice in an integrative health care environment while still maintaining the individuality / uniqueness of their profession? The CCE does not dictate or establish chiropractic program curricula, as the council values educational freedom and institutional autonomy. Each institution creates and offers a curriculum of its own accord that supports and fulfills its unique educational mission, philosophies and programmatic goals. Whether a program chooses to focus on graduating solo practitioners or practitioners who practice in an integrative health care environment or some point between, the *Standards* encourage that self-determinism.

The *Standards* are constructed in a way that supports a program's expression of its intent in this regard while still meeting the *Standards*. Also, as a part of its previously mentioned continuous quality improvement focus, the *Standards* are reviewed regularly. The review process is codified in CCE policy and relies on inputs from diverse audiences to evolve and ensure program *Standards* that reflect a level of consensus by the broadest number of stakeholder groups.

The CCE accepts that revising a document as large and expansive in its effect as the CCE *Standards* is bound to result in some who are dissatisfied with the final product. Realistically, 100

percent agreement on all aspects and content of such a substantial document is unlikely. This is particularly true given that CCE's *Standards* review process includes invited representatives from multiple chiropractic educational programs that embrace diverse missions; regulatory representatives from states with diverse scope-of-practice laws; private practitioners with diverse practice philosophies and patient care methodologies; and individuals with diverse higher-education / accreditation experiences.

Public review and third-party commentary soliciting proposed language changes and reactions to draft proposals cast an even broader net for opinions and trends in contemporary practice that impact the relevance of quality educational standards and clinical competency.

Despite the complexity and occasional disagreement, the exchange of diverse ideas and opinions is healthy and welcome. It is within this cauldron of consensus that modifications of the *Standards* are considered. The scrutiny and critique of any recommended change is not easy, yet it is necessary. In the end, this process does effectively ensure that input to the *Standards* is balanced and the outcome represents a well-vetted and informed product.

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