INDIANA STATE UNIVERSITY

LEGAL SERVICES
TERRE HAUTE, IN 47809
812-237-4141

February 7, 2024

Ms. Sue Loughlin
Tribune-Star
2700 Poplar Street, Ste 37A
Terre Haute, IN 47803

Re: Request for Public Records submitted February 5, 2024

Dear Ms. Loughlin,

Indiana State University ("ISU") is in receipt of your public records request submitted on February 5, 2024, for the following:

The Tribune-Star is requesting an October 2023 communication to Indiana State University from the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). regarding its probation accreditation status for the physician assistant program.

We also are requesting ISU's Feb. 1 response to this communication.

Attached please find:

- Notice of Adverse Action
- Citations
- ISU's response

If you have any additional questions, please contact our office via email ISU-GeneralCounsel@indstate.edu.

Sincerely,

Mary Koenig
Legal Project Manager
Indiana State University

Accreditation Review Commission on Education for the Physician Assistant, Inc.

October 25, 2023

3325 Paddocks Parkway, Suite 345
Suwanee, GA 30024
Phone: 770-476-1224
Fax: 470-253-8271
Email: sharonluke@arc-pa.org

Deborah J. Curtis, PhD
President
Office of the President
Parsons Hall 208
Indiana State University
200 North 7th Street
Terre Haute, IN 47809
President@indstate.edu

Re: Notice of Adverse Action

Dear Dr. Curtis:

This letter will serve as formal notice that the Accreditation Review Commission on Education for the Physician Assistant, Inc. ("ARC-PA" or the "commission") has determined to place **Indiana State University Physician Assistant Program** ("PA Program" or the "program") on **Accreditation-Probation** status. As explained in more detail below, the commission has also determined that the program is **not to matriculate the cohort of students scheduled for January 2024 or any other time until it is informed by the commission to do so**. The basis for these decisions was the information contained in the program application and all appendices submitted to the ARC-PA, the report of the site visit team, the program's response to the site visit team's observations, and the program's accreditation history.

As defined in the ARC-PA Policies, probation accreditation is a temporary accreditation status initially of not less than two years. However, that period may be extended by the ARC-PA for up to an additional two years if the ARC-PA finds that the program is making substantial progress toward meeting all applicable standards but requires additional time to come into full compliance. Probation accreditation status is granted, at the sole discretion of the ARC-PA, when a program holding an accreditation status of Accreditation - Provisional or Accreditation - Continued does not, in the judgment of the ARC-PA, meet the *Standards* or when the capability of the program to provide an acceptable educational experience for its students is threatened. Once placed on probation, a program that fails to comply with accreditation requirements in a timely manner, as specified by the ARC-PA, may be scheduled for a focused site visit and is subject to having its accreditation withdrawn.

The PA Program did not demonstrate compliance with several standards, as explained in further detail in the enclosed Citations document. In particular, the PA Program failed to demonstrate the following at the time of the site visit:

- Sufficient principal faculty to meet the academic needs of enrolled students and manage the administrative responsibilities consistent with the complexity of the program.
- Consistently defined and published *learning outcomes* and *instructional objectives* in measurable terms for each didactic and clinical course that would guide student acquisition of required *competencies*.
- Sponsoring institutional support of the program faculty in program assessment and compliance with the ARC-PA accreditation *Standards* and policies.
- Completion of ARC-PA required documents.
- Program director's sufficient knowledge and responsibility toward implementing a robust self-study process, demonstrating effective leadership, and submitting documents as required by the ARC-PA.
- Policies and procedures that are defined, published, consistently applied, and made readily available to prospective and matriculated students to include technical standards, granting advanced placement and deceleration.
- Evidence of supervised clinical practice experience evaluation of student performance that aligned with the program's *learning outcomes* and *instructional objectives* and allowed for the identification of any student deficiencies in a *timely* manner.
- A process for initial and ongoing evaluation of clinical sites.

During its review of the program, the ARC-PA noted **thirty-three (33)** areas of noncompliance with the *Standards*, as described in further detail in the enclosed Citations document. The Citations document includes information on reports due to the ARC-PA. If an appeal is not initiated, the program should respond to the citations as directed in the document. If an appeal is initiated, the program will receive a revised or affirmed Citations document at the end of the appeal process with information regarding reports due to the ARC-PA.

A focused probation site visit will need to occur in advance of the **September 2025** commission meeting. This visit will evaluate the PA Program and institutional progress in addressing specific citations identified during the course of the most recent commission review of the PA Program. The ARC-PA retains the right to meet with faculty and students or pursue other issues that may surface during the course of the visit related to the *Standards*. The enclosed Citations document contains details about requirements for the focused visit as well as required reports. Additional information will be conveyed to the PA Program in writing prior to the visit.

Please note that the program is approved to accept up to **30** students per class.

A program with the status of Accreditation-Probation is not eligible to request an increase in the maximum entering class size or expansion to a distant campus until it returns to an accreditation status of Accreditation-Continued. Further, it must maintain the status of Accreditation-Continued for five consecutive years before the ARC-PA will consider a request for an increase in maximum entering class size or expansion to a distant campus.

If the program wishes to appeal the ARC-PA's decision, it must send a written Notice of Appeal to me within ten (10) calendar days after the date of this letter. If a Notice of Appeal is not received, this decision is final and not subject to appeal. A copy of the relevant portion of ARC-PA's policy related to appeals procedures is attached for your information.

The appeals fee can be paid via check mailed to the ARC-PA at 3325 Paddocks Parkway, Suite 345, Suwanee GA or by ACH Direct Deposit to Renasant Bank, Routing # 084201294, Account # 8015270022.

If an appeal is initiated: the listing of the program on the ARC-PA website will continue to reflect the pre-adverse action accreditation status of the program, pending outcome of the appeal. The program should create its own appeal documentation as described in the attached Appeals Procedure document.

If an appeal is not initiated or if, upon appeal, the ARC-PA affirms its decision to place the program on Accreditation-Probation: the program must notify students and applicants of its probation status and update the accreditation status on its website, using the language provided below, within two business days. Additionally, a detailed description of the process used to notify students and applicants of the probation status must be emailed to accreditationservices@arc-pa.org within 14 calendar days. The program listing on the ARC-PA website will be revised to reflect the program's probationary status.

To communicate the program's accreditation status in all printed and electronic media, the program and institution must replace any previous wording with the following statement **exactly** as it is written:

> At its **September 2023** meeting, the Accreditation Review Commission on Education for the Physician Assistant, Inc. (ARC-PA) placed the **Indiana State University Physician Assistant Program** sponsored by **Indiana State University** on **Accreditation-Probation** status until its next review in **September 2025**.
>
> Probation accreditation is a temporary accreditation status initially of not less than two years. However, that period may be extended by the ARC-PA for up to an additional two years if the ARC-PA finds that the program is making substantial progress toward meeting all applicable standards but requires additional time to come into full compliance. Probation accreditation status is granted, at the sole discretion of the ARC-PA, when a program holding an accreditation status of Accreditation - Provisional or Accreditation - Continued does not, in the judgment of the ARC-PA, meet the *Standards* or when the capability of the program to provide an acceptable educational experience for its students is threatened.
>
> Once placed on probation, a program that fails to comply with accreditation requirements in a timely manner, as specified by the ARC-PA, may be scheduled for a focused site visit and is subject to having its accreditation withdrawn.
>
> Specific questions regarding the Program and its plans should be directed to the Program Director and/or the appropriate institutional official(s).
>
> The program's accreditation history can be viewed on the ARC-PA website at **https://www.arc-pa.org/accreditation-history-indiana-state-university/**.

As a reminder, any program with a PANCE pass rate percentage of 85% or less must submit an analysis of its PANCE performance to the ARC-PA within six months of providing this data within the Program Management Portal or by July 1 the year following that cohort's completion, whichever is sooner. The form for reporting PANCE results is available at http://www.arc-pa.org/resources/program-change-forms/. Additionally, 5th edition standard A3.12c states that programs must post the most current annual NCCPA PANCE Exam Performance Summary Report Last 5 Years no later than April 1 each year.

Effective August 1, 2023, programs with a student attrition rate of 10.9% or greater must submit a Student Attrition Required Report within 6 months of the cohort's completion. The Student Attrition Required Report is available at the link above.

Please refer to the ARC-PA website, www.arc-pa.org, for the current *Standards*, an accreditation manual and other helpful information.

If you have questions or concerns, do not hesitate to contact us.

Sincerely,

Sharon Luke, EdD, PA-C
Executive Director

c: John Pommier, PhD, CTRS, Department Chair, John.Pommier@indstate.edu
Douglas Scott Stevens, PA-C, Program Director, Douglas.Stevens@indstate.edu
Jack Bierig, JD; Legal Counsel, ARC-PA

10.8 Accreditation Actions Subject to Appeal and Appeal Procedures

The following adverse actions by the ARC-PA are subject to appeal pursuant to the ARC-PA's Appeal Procedures.

- refusal to consider a program for initial provisional accreditation
- assignment of probationary status
- withholding of accreditation
- withdrawal of accreditation

Any appeal must be based upon the time and the circumstances that triggered the ARC-PA adverse action (e.g., a reaccreditation commission review, provisional application, required report, etc.) and shall be based solely on the information contained in the documents upon which the decision was based. Descriptions of program changes made since that time will not be considered.

Programs receiving an adverse action are notified in writing of their right to appeal at the time of their accreditation status notification.

Appeal Procedure
Note: *In extenuating circumstances, the chair of the ARC-PA may adjust these procedures to insure a fair and impartial review*.

Appeals Fee

Reconsideration	Appeal before an Independent
$5,000*	Appeals Panel $12,500 *

(In addition to other expenses as detailed
In the Appeals Procedure)
*Accreditation Fees: http://www.arc-pa.org/about/accreditation-fees/

Accreditation Fees are to be mailed to:
Accreditation Review Commission on Education for the Physician Assistant
Attn. Accreditation Services
3325 Paddocks Parkway, Suite 345
Suwanee, GA 30024

Accreditation Status, Public Release

If the ARC-PA is requested or required to provide information to a third party regarding the accreditation status of a PA program that is pursuing the appeal process, the ARC-PA shall advise those inquiring that the program's accreditation status remains as it was prior to the appeal.

A. Notice of Appeal

If a PA program wishes to appeal the ARC-PA's adverse action, a written request for appeal must be received from the program by ARC-PA within ten (10) calendar days from the date of the written letter containing notice of the accreditation decision. The written Notice of Appeal along with payment of the Reconsideration Fee, which must include all documentation in support of the appeal, must be received by the ARC-PA Executive Director within twenty (20) calendar days from the date of the written request for appeal.

At a minimum, the Notice of Appeal is to include:

- A statement of the accreditation decision to be reviewed;
- A description of the modification or reversal sought by the program;
- A complete and concise description of any inaccurate, incomplete or erroneous fact(s), or incorrect interpretation of the ***Standards***, on which the Program believes the decision was based;
- Pertinent detailed supporting documentation, and
- Any other relevant information the program wishes to have reviewed.

The Notice of Appeal must be no more than two hundred (200) pages total, using standard twelve (12) point font (Times New Roman or Calibri) and one (1) inch margins.

The program is to submit its written request for appeal and Notice of Appeal **electronically as an attachment to** accreditationservices@arc-pa.org.

If a written request for appeal is not received by the ARC-PA within ten (10) calendar days from the date of the letter notifying the institution and program of the adverse action, the initial adverse action by the ARC-PA shall constitute final action by the ARC-PA, effective immediately.

B. Reconsideration Panel

All Notices of Appeal are initially referred to a Reconsideration Panel consisting of three members to include two PA educators with ARC-PA experience and/or past commissioners. The panel will also include a public member*. The ARC-PA will develop a pool of 15-20 panelists per year for a term of two years with the potential to renew upon approval by the Executive Committee. Conflict of interest considerations would apply so panelists may not have any connection to the program being considered. A member of the Reconsideration Panel cannot have a conflict of interest with the program being considered, e.g., served as a consultant to the program.

No person shall be included on the Reconsideration Panel if they:

- participated in the site visit that triggered the adverse action;
- was assigned to review recent site visit findings, required reports or other ARC-PA findings regarding that PA program on behalf of the ARC-PA; or
- has a conflict of interest as determined under the ARC-PA Conflict of Interest Guidelines.

The Reconsideration Panel will be provided with the following materials, which shall constitute the Review Record:

- a complete file of all documents concerning the program that were available to the ARC-PA and upon which the ARC-PA relied in making the decision that is the subject of the appeal;

- a copy of the Letter of Accreditation notifying the institution/program of the adverse action; and
- the Notice of Appeal.

The Reconsideration Panel members will consider the materials independently before discussing the program during an in-person meeting or via telecommunication. The Reconsideration Panel members may consult with ARC- PA staff regarding ARC-PA policy issues during the course of its review.

C. Deliberation of the Reconsideration Panel

In developing its decision, the Reconsideration Panel will give consideration to the Notice of Appeal, the particular facts or ***Standards*** at issue, as well as the existing ARC-PA policies. The Reconsideration Panel shall determine whether the ARC-PA's action is supported by the evidence, and whether the action was taken in accordance with the ARC-PA's policies and procedures.

D. Reconsideration Decision and Report

The Reconsideration Panel shall make one of the following decisions:

- Affirm the initial adverse action; or
- Modify or reverse the initial adverse action.

The Reconsideration Panel shall forward a written report of its decision, and the reasons therefore, to the ARC-PA Executive Director. The program will be notified of the Reconsideration Panel decision by the ARC-PA Executive Director.

If the adverse action being reconsidered is related to probation or refusal to consider a program for accreditation, the decision of the Reconsideration Panel is final and the appeal process is complete. The program may not request a Formal Appeal hearing by the ARC-PA.

If the program remains dissatisfied with a decision relating to withdrawal of accreditation or withholding of accreditation, it may request a Formal Appeal hearing before the ARC-PA. The ARC-PA must receive a request for a Formal Appeal Hearing, in writing, within **ten (10) calendar days** from the date of the letter notifying the institution and program of the Review Panel decision.

The Appeal Process Graphic is also available to provide programs a summary and easy reference of the ARC-PA's appeal procedures.

Accreditation Review Commission on Education for the Physician Assistant, Inc.

Indiana State University Physician Assistant Program

Citations

A succinct narrative response as detailed in the Required Report description must be included below each citation on this document in the response field provided. Follow the guidelines for responding to citations described in the Accreditation Manual - http://www.arc-pa.org/accreditation-manual/. Supplemental documents must be included as needed to complete a response and/or to provide verification of compliance. Please note their inclusion in the narrative and append them to the report as appendix 1, 2, 3, etc. Return this document in its current Word format; i.e., do NOT convert to a pdf document. Be sure to "save" the document before submitting.

The response is due no later than **as detailed below**.

The program should submit its report by uploading it as a Report Due document type from the program's portal page. From the portal Program Dashboard, click on Manage Program Documents in the Action Center or click the Documents icon, which looks like several sheets of paper, in the dashboard's upper-right corner. For help with uploading a document, click on "(i) How to Upload" in the upper right corner. If the report consists of multiple documents, put all documents in a zip file and upload the zip file.

The ARC-PA will review and consider the reports and any accompanying materials either by an expedited review process or at its next regularly scheduled meeting, as determined by the ARC-PA, in March, June, or September. Unless otherwise stated, the Commission will review reports as follows: Reports due on or before **October 1** are considered for the March meeting. Reports due on or before **February 1** are considered for the June meeting. Reports due on or before **May 15** are considered for the September meeting.

Citations

As you read the information below, please keep in mind the following: the ARC-PA defines "findings" as explanations that may accompany a citation. In addition, there may be "comments." Their purpose is to clarify the issue of noncompliance, but not to specify how a problem may be resolved.

Based on information contained in the program application and all appendices submitted to the ARC-PA, the report of the site visit team, the program's response to the site visit team's observations, and the program's accreditation history, the program failed to demonstrate compliance with the following standards:

1. **Standard** A1.02a The sponsoring institution is responsible for:

   a) supporting the planning by *program faculty* of curriculum design, course selection, and program assessment,

Findings: The sponsoring institution did not demonstrate responsibility for supporting program faculty in program assessment.

Comments: The commission added this citation. At the site visit, institutional officials verified that they had reviewed the application and self-study report (SSR) prior to submission. However, there were multiple areas omitted and incomplete within the submitted documentation of the SSR. Examples include but were not limited to missing areas of assessment in Appendix 14B and omission of the collection and analysis of data from faculty and staff. Refer to the following citations for further details: C1.01a, C1.02c.i, and C1.03.

Required Report: Provide a succinct narrative response indicating how the institution demonstrates its responsibility to support the program faculty in application and documentation of program assessment and assure compliance with this standard in the future. The program is also required to submit a modified self-study report (mSSR) as part of its accreditation probation application. See Citations #27-29.

Click here to enter program response

2. **Standard** A1.02c The sponsoring institution is responsible for:

   c) ensuring effective program leadership,

Findings: The sponsoring institution did not ensure the program director provided effective program leadership.

Comments: The commission added this citation. There was no evidence at the time of the site visit that the institution was taking steps to support the program director to ensure effective leadership as evidenced by the number and broad nature of citations in this document. In the application, the program described its process for annual evaluation and self-assessment of the program director which included the program's assessment plan, data from faculty peer evaluations, student advising feedback, student course evaluations, and staff evaluations. However, at the site visit, the institution did not provide evidence of data or analysis related to the evaluation of the program director's leadership.

Required Report: Provide a succinct narrative response indicating how the institution plans to resolve the citation and assure compliance with this *Standard* in the future. The institution is also expected to demonstrate its responsibility for complying with this *Standard* at the subsequent accreditation probation visit.

Click here to enter program response

3. **Standard** A1.02d The sponsoring institution is responsible for:

   d) complying with ARC-PA accreditation *Standards* and policies,

Findings: The sponsoring institution did not demonstrate responsibility for complying with ARC-PA accreditation *Standards* and policies as indicated by the quality of the self-study report submitted and the lack of evidence of compliance with the *Standards*.

Comments: There was a lack of evidence that the sponsoring institution supported the program in complying with the ARC-PA *Standards*. The sponsoring institution is expected to demonstrate responsible intervention and oversight. As evidenced by the number and broad nature of citations, the sponsoring institution did not support the program in compliance with ARC-PA accreditation *Standards.*

In its response, the program stated that the university recognizes, supports, and accepts responsibility for compliance with the *Standards*. The narrative explained that the program director was responsible for compliance and expected to function as the accreditation expert under the direction of the Department Chair of Applied Medicine and Rehabilitation, the university's Assessment Coordinator, and the Dean of the College of Health and Human Services (CHHS). The Dean of the College of Health and Human Services stated that the Dean's Office reviews and provides feedback on all accreditation reports and self-studies, including the PA program. However, the institutional support that may have been provided to the program was insufficient to demonstrate compliance with the accreditation Standards.

Required Report: Provide a succinct narrative response indicating how the institution plans to resolve the citation and assure compliance with this *Standard* in the future.

Click here to enter program response

4. **Standard** A1.07 The sponsoring institution *must* provide the program with the human resources, including *sufficient* faculty, *administrative* and technical staff, necessary to operate the educational program, comply with the *Standards*, and fulfill obligations to matriculating and enrolled students.

   Findings: The sponsoring institution did not provide the program with sufficient faculty to operate the program.

   Comments: The sponsoring institution did not provide the program with sufficient human resources to operate the program and fulfill obligations to matriculating and enrolled students. Institutional officials stated support for the program through providing funds for instructional faculty where needed or providing principal faculty with supplementary pay for working extra; however, the program director did not verify the program had sufficient principal faculty in its current situation. At the time of the site visit, the program director was carrying a 15-semester hr. annual teaching load in addition to assigned administrative duties. In addition, a principal faculty member was on administrative leave with no timeframe to return to the program.

   In its response, the program stated that collaboration with the department chair ensured the program had sufficient academic and administrative personnel to fulfill obligations to enrolled and prospective students. The narrative discussed that the provost provided oversight of accreditation compliance concerning the sufficiency and effectiveness of personnel through the dean and collection and analysis of data from the PA students, faculty, and staff. The program

did not provide a clear rationale as to how it determined sufficiency of faculty to fulfill obligations to matriculating and prospective students.

Required Report: Provide a succinct narrative below indicating how the sponsoring institution has provided sufficient faculty to operate the educational program, comply with the *Standards*, and fulfill obligations to matriculating and enrolled students.

Click here to enter program response

***STANDARDS* CLARIFICATION**

The commission made clarifying changes to the *Standards,* 5th edition, at its March and September 2023 meetings. This included changes to A1.11a-d. The latest version of the *Standards* is available on the ARC-PA website.

In response to citations received following accreditation reviews, programs will address standards A1.11a-d as they are currently clarified.

Previous version:

Standard A1.11 The sponsoring institution *must* demonstrate its commitment to student, faculty and staff *diversity,* and *inclusion* by:

a) supporting the program in defining its goal(s) for *diversity,* and *inclusion*,
b) supporting the program in implementing recruitment strategies,
c) supporting the program in implementing retention strategies, and
d) making available, resources which promote *diversity,* and *inclusion*.

9.2023 Clarified Standard:

Standard A1.11 The sponsoring institution *must,* in a manner consistent with its own mission and applicable laws demonstrate a commitment to student, faculty and staff *diversity, equity,* and *inclusion* by:

a) supporting the program in having a documented action plan for *diversity, equity* and *inclusion*,
b) supporting the program in implementing recruitment strategies,
c) supporting the program in implementing retention strategies, and
d) making available, resources which promote *diversity, equity* and *inclusion*.

The March 2023 clarification includes the addition of the term “equity” to the stem of the standard and to sub standards a and d and the inclusion of a definition of equity in the Standards glossary. Diversity affords appreciation for the many ways people differ. Inclusion provides a sense of belonging through active engagement. Equity allows for the allocation of personalized support and resources required for success. The September 2023 clarification adjusts the requirement for substandard A1.11a. The program does not need to have identified "goals," but the institution must support the program in documenting an action plan that addresses diversity, equity, and inclusion for all 3 groups: students, faculty, and staff. This could be one plan that addresses all three groups or three different plans (or some combination). The same concept applies to sub standards A1.11b and A1.11c for recruitment and retention strategies. Strategies must address all three groups (students, faculty, and staff).

5. **Standard** A1.11a The sponsoring institution *must* demonstrate its commitment to student, faculty and staff *diversity, equity,* and *inclusion* by:

    a) supporting the program in defining its goal(s) for *diversity, equity* and *inclusion,*

    Findings: The sponsoring institution did not demonstrate its commitment to supporting the program in defining its goals for faculty and staff diversity, equity, and inclusion.

    Comments: At the site visit, institutional officials verified they were aware of the ARC-PA *Standards* but could not describe program-defined goals toward diversity, equity, and inclusion. Institutional officials stated it would support program goals related to diversity, equity, and inclusion but had not required the program to put these goals in place. In addition, the program did not articulate why it had not implemented goals for diversity, equity, and inclusion.

    In its response, the program stated that the sponsoring institution supports the program goals for diversity, equity, and inclusion because it agreed with the core values of the university. The response also reiterated that the provost stated programs were not required nor prohibited from establishing DEI goals.

    Required Report: The ARC-PA reminds the program that the commission made clarifying changes to Standard A1.11a, 5th edition, at its September 2023 meeting as described above. This required report addresses the clarified A1.11a Standard.

    Provide a succinct narrative below indicating how the institution has demonstrated its support of the program in developing a written action plan for diversity, equity, and inclusion of students, faculty, and staff.

    Append the program action plan for diversity, equity, and inclusion that addresses students, faculty, and staff.

Click here to enter program response

6. **Standard** A2.01 All *program faculty must* possess the educational and experiential qualifications to perform their assigned duties.

    Findings: All program faculty did not possess the educational qualifications to perform assigned duties.

    Comments: All program principal faculty did not possess the required educational and experiential qualifications to perform their assigned duties as described in the principal faculty job description. The job descriptions, in the application's appendix 4 and reviewed at the time of the site visit, listed the educational qualifications for the clinical coordinator (Edmondson) as a master's degree, current NCCPA certification, and Indiana PA Licensure. In the application and at the time of the site visit, the clinical coordinator (Edmondson) was an advanced practice nurse and did not meet the principal faculty qualifications on the program's job description. The program stated it determined Edmondson was qualified based on the equivalency of her

education to that of a PA and was licensed and certified, and had the skills needed by the program. However, the program did not provide documentation of how it determined she was qualified to perform her assigned duties.

In its response, the program acknowledged the error of providing the wrong job description for the clinical coordinator and attached the job description that was used for the job posting. The posting showed the qualifications were a master's degree and health care experience with education preferred in allied health, business, communications, administration, or marketing. In addition, the program provided the ad for the clinical coordinator position which did include qualifications for the position, but these qualifications were not reflected in the job description which was not included in the response. The program did not provide evidence of how Edmondson met the education qualifications provided in the ad.

Required Report: Append the job description for the clinical coordinator that includes the educational and experiential qualifications required to perform their assigned duties and the current CV for the clinical coordinator.

Click here to enter program response

7. **Standard** A2.03 *Principal faculty must* be *sufficient* in number to meet the academic needs of enrolled students and manage the administrative responsibilities consistent with the complexity of the program.

Findings: The program did not have sufficient principal faculty to meet the academic and administrative needs of the program.

Comments: Principal faculty were not sufficient in number to meet the academic needs of enrolled students and manage the administrative responsibilities consistent with the complexity of the program. In the application, the program stated it utilized six full-time faculty members. However, this included the program director, who by ARC-PA definition is not considered principal faculty. The program director stated that the principal faculty was sufficient in number except when any principal faculty were on leave. During the site visit, one principal faculty (1.0 FTE) was on administrative leave. There was no timeframe given for when that principal faculty member would return to work. The program director and institutional officials stated that the work was covered by the remaining principal faculty, program director, and instructional faculty. Although the program director stated that this individual was "doing some work at home", the conditions of the leave prevented this individual from completing a significant portion of their job duties.

In its response, the program stated that the program director was not included in the calculation for student-to-faculty ratios. The narrative stated that at the time of the site visit the program consisted of the program director and four principal faculty with one principal faculty on administrative leave. The program also stated the faculty member on administrative leave "was a new situation and therefore was not included in the initial application." The narrative explained that the principal faculty on administrative leave was still working on lecture preparation and admissions review. The program also noted that the program director and three didactic faculty taught most of the curriculum. Despite these assurances, the program had

insufficient faculty at the time of the site visit as defined by its own calculation for faculty sufficiency.

Required Report: Provide a succinct narrative below indicating how the institution will resolve the citation and assure compliance with this *standard* in the future. Provide evidence that principal faculty as defined by ARC-PA are sufficient to meet the academic needs of enrolled students and manage the administrative responsibilities consistent with the complexity of the program.

Click here to enter program response

8. **Standard** A2.09d The program director *must* be knowledgeable about and responsible for:

   d) continuous programmatic review and *analysis,*

Findings: The program director did not demonstrate knowledge of the program's continuous review and analysis.

Comments: The program director was not knowledgeable about and responsible for continuous programmatic review and analysis. The program director did not demonstrate the requisite knowledge of continuous programmatic review and analysis as noted by the provision of the self-study report (SSR) that did not accurately and succinctly document the process and results of ongoing program self-assessment. Despite feedback provided by the ARC-PA in the March 2017 mSSR, the most recently submitted SSR failed to provide consistent evidence of the program's process of analysis, reaching conclusions including identifying strengths and areas needing improvement. The analysis was not consistent within the submitted SSR and was not clearly articulated at the time of the site visit, specifically in relation to the identification of program strengths. In addition, the program did not articulate the reason(s) for incomplete or missing data for multiple aspects of the program, which was inconsistent with the described program's self-assessment plan.

In its response, the program referred to the assessment calendar that was provided on-site and appended with the response. At the site visit, the narrative explained that the program was asked for exit survey results from the cohort of 2023 at which time the program stated that it analyzed this data in June (per the assessment calendar). The analysis was not available at the time of the site visit.

Required Report: Provide a succinct narrative response below indicating how the program and institution will resolve the citation and assure compliance with this *standard* in the future.

Click here to enter program response

9. **Standard** A2.09g The program director *must* be knowledgeable about and responsible for:

   g) completion of ARC-PA required documents,

Findings: The program director was not knowledgeable about and responsible for the completion of ARC-PA required documents.

Comments: The program application was submitted with multiple incomplete and inaccurate documents (see Citation #33 (E1.03) below for further details). Upon contact by ARC-PA staff, the program did provide the correct documentation apart from the NCCPA PANCE Exam Performance Summary Report Last 5 Years which was submitted on the second attempt.

The site visit team commented that it was necessary to repeatedly request additional information including items identified in the Application of Record List of Documents that must be readily available for site visitors at the time of the site visit. In addition, the Program Data Sheet in Appendix 1a was inaccurate, the program website was missing items such as technical standards and admissions preferences, and course syllabi were disorganized and incomplete.

In the program's response, the program responded by saying that the Indiana State University PA program does not require technical standards, therefore there was nothing posted on the website. The program also noted that it utilized university-provided syllabi templates, which were provided in Appendix 17 and contained "learning objectives" in each syllabus. The program's response did not address the program director's lack of responsibility in completing documents to demonstrate compliance with ARC-PA accreditation standards.

Required Report: Provide a succinct narrative indicating how the program and institution will resolve the citation and assure future compliance.

Click here to enter program response

10. **Standard** A2.09h The program director *must* be knowledgeable about and responsible for:

    h) adherence to the *Standards* and ARC-PA policies.

Findings: The program director did not demonstrate responsibility for adherence to the *Standards* and ARC-PA policies.

Comments: At the time of the site visit, the program director did not demonstrate understanding and responsibility to adhere to the *Standards.* This was evidenced by the number and broad nature of areas of non-compliance with the *Standards* found at the site visit.

The program did not respond to the observation.

Required Report: Provide a succinct narrative indicating how the program and institution will resolve the citation and assure future compliance.

Click here to enter program response

11. **Standard** A3.12b The program *must* define, publish and make *readily available* to enrolled and *prospective students* general program information to include:

b) evidence of its *effectiveness* in meeting its goals,

Findings: The program did not define evidence of its effectiveness in meeting its goals.

Comments: The commission added this citation. The program published five goals on its website https://www.indstate.edu/health/program/pa/info#goal but did not provide evidence of its effectiveness in meeting all these goals. The program did not provide any benchmarks to allow the prospective students to understand the program's effectiveness in meeting any of its goals. In addition, the data provided on the website was from the Class of 2020 and was not updated to include the program's most recent outcomes.

Required Report: Provide a brief, succinct narrative clarifying the current program goals. Submit evidence that all program goals have a defined benchmark in which to measure effectiveness and are accurately defined, published, and made readily available to enrolled and prospective students on the program's website. Provide the URL where this information is published on the website along with updated data that demonstrates effectiveness in meeting its goals.

Click here to enter program response

12. **Standard** A3.12g The program *must* define, publish and make *readily available* to enrolled and *prospective students* general program information to include:

g) program required *competencies* for entry level practice, consistent with the competencies as defined by the PA profession,

Findings: The program did not define, publish or make readily available to enrolled and prospective students the program required competencies for entry level practice.

Comments: At the time of the site visit, the terms 'goals', 'competencies', and 'objectives' were used variably and inconsistently in documents such as the PA Student Handbook, Clinical Phase Manual, evaluation rubrics and Appendix 9. In Appendix 9, the program provided the "Physician Assistant Program Defined Competencies/Goals and Student Learning Outcomes Curriculum Map which was a table of the program's goals and how those goals were accomplished through each of the courses. This document did not include any of the program required competencies for entry-level practice. On the website in the Clinical Phase Manual (https://www.indstate.edu/health/program/pa/physician-assistant-clinical-phase-manual), p. 2 was a list of "Competencies: Clinical Year Competencies and Rotation Requirements" which were specific to the clinical curriculum and different than the goals included in Appendix 9. In addition, on p. 31 of the Clinical Phase Manual was another set of physician assistant competencies which were different than both the information in Appendix 9 and p. 2 of the Clinical Phase Manual. The multiple references to competencies with different items listed did not provide a clear identification of the program's defined competencies for entry level practice.

In addition, the summative evaluation rubric listed competencies that were related to each part of the exam and were consistent with those as defined by the PA profession but not the same competencies listed in the Clinical Phase Manual.

At the site visit, faculty explained the correct program competencies were those listed on pages 1 and 31 of the Clinical Phase Manual. The students stated that they were aware of the competencies needed for successful completion of each rotation, post-clinical phase, and graduation.

In its response, the program stated that meeting clinical competencies was required for students to advance to the summative semester. The program further stated that the summative evaluation competencies differed from clinical competencies as the summative evaluation does not occur in the clinical phase. However, the program did not publish and make readily available to enrolled and prospective students its program-required competencies as defined by the ARC-PA.

Required Report: Provide a succinct narrative that includes evidence that the program defines, publishes and makes readily available to enrolled and prospective students the program required *competencies* for entry level practice. Provide the URL(s) to the information if published online (including page number if within a document[s]) or append a copy of the information provided to prospective and enrolled students.

Click here to enter program response

13. **Standard** A3.13c The program *must* define, publish, consistently apply and make *readily available* to *prospective students,* policies and procedures to include:

    c) practices for awarding or granting *advanced placement,*

Findings: The program did not define, publish and make readily available to prospective students its policies and procedures for awarding or granting advanced placement.

Comments: In the application and reviewed at the site visit, the program website https://www.indstate.edu/health/program/pa/pa-admission-criteria stated that "Advanced placement credits may be accepted for prerequisite courses at the discretion of the PAC." The program did not include any other statement regarding advanced placement that would be available to prospective students. The program director stated that advanced placement was not offered for program courses; however, the website did not include any information about whether the program awarded or granted advanced placement.

The program did not respond to the observation.

Required Report: Provide the policies and procedures concerning awarding and granting advanced placement. Identify how these policies and procedures will be made readily available to prospective students. Provide the URL to the policy (and page number if on an online document).

Click here to enter program response

14. **Standard** A3.13e The program *must* define, publish, consistently apply and make *readily available* to *prospective students,* policies and procedures to include:

    e) any required *technical standards* for enrollment.

    Findings: The program did not define, publish, and make readily available to prospective students its policies and procedures for any required technical standards for enrollment.

    Comments: The program did not define, publish, and make readily available to prospective students its policies related to any required technical standards. Although the program stated that it did not require technical standards, there was no evidence that this information was readily available to prospective PA students.

    Required Report: Provide the policies and procedures concerning any required technical standards. Identify how these policies and procedures will be made readily available to prospective students. Provide the URL to the policy (and page number if on an online document).

Click here to enter program response

15. **Standard** A3.14 The program *must* make student admission decisions in accordance with clearly defined and *published* practices of the institution and program.

    Findings: The program did not provide evidence that it made admission decisions in accordance with published practices.

    Comments: The admission rubrics provided by the program in the application appendix 6 (app 6C-"Interview Tool ISU PA" and "Stud Screen App") and reviewed on-site did not include the preference for applicants interested in rural health medicine and veterans (active duty and reservists). On the website, the program stated that health care experience was highly recommended, but the FAQ website https://www.indstate.edu/health/program/pa/pa-faq, stated that "applications lacking hours in these areas will still be considered until further notice." The rubric in Appendix 6c for Stud Screen App showed points awarded by the number of health care hours completed.

    At the site visit, the program director and principal faculty explained that points for rural health interest were awarded in the personal statement of the file review rubric. The principal faculty and program director noted there was an additional guide used by faculty that specified how to use the rubric scaling in more specific terms. However, the additional guide for the admissions file reviewers was not provided at the time of the site visit despite repeated requests by the site visit team.

    In its response, the program stated the admissions rubric was provided to the site visit team and appended to its response. However, the program only appended the interview tool rubric and

did not provide the guide nor information related to points for interest in rural health medicine or veteran status.

Required Report: Provide a brief narrative that describes how the program makes admission decisions in accordance with the published practices of the institution and program.

Provide a weblink URL to the program's published admission criteria.

Append the admission rubric(s) used by the program to screen and select candidates for admission and the admissions guide used by faculty in reviewing files.

Click here to enter program response

16. **Standard** A3.15c The program *must* define, publish, consistently apply and make *readily available* to students upon admission:

    c) policies and procedures for *remediation* and *deceleration,*

Findings: The program did not define, publish, or make readily available its policy and procedure for deceleration.

Comments: In the application of record and at the time of the site visit, the program did not define, publish, or make readily available its policy and procedure for deceleration. At the time of the site visit, the PA Student Handbook p. 18, included a heading of "Goals of Remediation/Deceleration and Guidelines for Remediation/Deceleration." In the policy, the program described the process for remediation, but did not show evidence of a policy for deceleration. The program director also provided a link to the ISU Policy Library but there was no evidence of a policy for deceleration provided in the ISU Policy Library.

The program did not respond to the observation.

Required Report: Provide evidence that the program clearly defines, publishes, and makes *readily available* to students upon admission, policies, and procedures for deceleration**.** Provide the URL to the information if published online (including page number if within a document or append a copy of the information provided to students upon admission that includes policies and procedures for deceleration.

Click here to enter program response

***STANDARDS* CLARIFICATION**

The commission made some clarifying changes to the *Standards,* 5th edition, at its September 2022 meeting. This included changes to B1.03 and B3.01. The latest version of the *Standards* is available on the ARC-PA website.

In response to citations received following accreditation reviews, programs will address standards B1.03 and B3.01 as they are currently clarified.

Previous version:
Standard B1.03 For each didactic and clinical course (including *required* and *elective rotations*), the program *must* define and publish *learning outcomes* and *instructional objectives,* in measurable terms that can be assessed, and that guide student acquisition of required *competencies.*

9.2022 Clarified Standard:
Standard B1.03 For each didactic and clinical course (including *required* and *elective* rotations), the program *must* define and *publish* for students the following detailed information in syllabi or appendix to the syllabi:

a) course name,
b) course description,
c) faculty instructor of record,
d) course goal/rationale,
e) *learning outcomes* and *instructional objectives*, in measurable terms that can be assessed, that guide student acquisition of required *competencies*,
f) outline of topics to be covered that align with *learning outcomes* and *instructional objectives*,
g) methods of student assessment/evaluation, and
h) plan for grading.

For every didactic and clinical course (including required and elective rotations), students must be informed of the items listed within the sub standards. The word 'syllabus' is purposefully not defined in the ARC-PA glossary. The Commission expects this information to be defined and published for students in a written or electronic document. The Commission recognizes that some institutions may have restrictions in place for syllabus development. If there are institutional restrictions on what is included in the program's course syllabi, programs are expected to include the information as an addendum to the course syllabus.

17. **Standard** B1.03d For each didactic and clinical course (including *required* and *elective rotations*), the program *must* define and *publish* for students the following detailed information in syllabi or appendix to the syllabi:

d) course goal/rationale,

Findings: The program did not consistently define and publish for each didactic and clinical course detailed information in syllabi to include course goal/rationale.

Comments: Course information, provided in the application Appendix 17 and reviewed at the time of the site visit, did not include a detailed course goal/rationale in any of the program's didactic and clinical courses.

In the application and at the time of the site visit, there were no course goals listed for the didactic courses. The PASS 643 Clinical Skills did include a heading labeled course goals, but the items listed reflected instructional objectives. Clinical year syllabi were inconsistent with listing the course goals which reflected rotation expectations and were not present in all clinical year syllabi. For example, the rotation goals included for the General Surgery rotation stated:

- Each condition will be seen at least once.

- Each skill will be performed at least once.
- 60% of the population will be adults (60 patient encounters).
- 1/3 of encounters must be pre-op, 1/3 intra-op, and 1/3 post-op, with a minimum of 100 patient encounters.

In addition, goals were not defined and published in the course syllabi for PASS 655 PASS 671, PASS 674, PASS 677, PASS 678, PASS 679, PASS 680.

In response to the observation, the program stated the goals/rationale were in progress for the program at the time of the site visit.

Required Report: Provide the course goal/rationale for each didactic and clinical course (including required and elective rotations). Do not provide the whole syllabus, but an excerpt of the course goal/rationale with each syllabus.

Click here to enter program response

18. **Standard** B1.03e For each didactic and clinical course (including *required* and *elective rotations*), the program *must* define and *publish* for students the following detailed information in syllabi or appendix to the syllabi:

    e) *learning outcomes* and *instructional objectives*, in measurable terms that can be assessed, that guide student acquisition of required *competencies*,

Findings: The program did not consistently define and publish learning outcomes and instructional objectives in measurable terms for each clinical course that would guide student acquisition of required competencies.

Comments: Course syllabi submitted in the application of record (Appendix 17) and reviewed at the site visit did not include detailed information that each course offered in the didactic and clinical curriculum included learning outcomes and instructional objectives. The program provided its learning outcomes with multiple titles such as, “learning objectives”, “course outcomes”, etc.
For example:

- PASS 687 Physician Assistant Practice Transition and PASS 686 Clinical Management III: There were “learning goals” that took the student to the PAEA blueprint website.
- PASS 624 Pharmacotherapeutics I, PASS 628 General Surgery, PASS 643 Clinical Skills, and PASS 687 PA Practice Transition: No learning outcomes were present.
- PASS 624 & PASS 634 Pharmacotherapeutics I & II had one instructional objective tied to a list of topics that did not guide the learner.
- No instructional objectives were present in PASS 626 Clinical Management I, PASS 624 Pharmacotherapeutic I, and PASS 634 Pharmacotherapeutics II.

When present, the learning outcomes and instructional objectives were poorly written, not measurable, and did not guide student acquisition of *competencies*. “Learning Objectives” were the same for SCPEs and did not guide students toward acquisition of competencies specific for

each course. For example, "students will be able to demonstrate for the clinical conditions listed below, the ability to:

- Describe the clinical presentation (signs and symptoms).
- Select appropriate diagnostic studies (lab, radiology, special studies).
- Formulate a comprehensive differential diagnosis.
- Develop a competent management plan for patients presenting with acute and chronic conditions.
- Demonstrate an understanding of pharmacotherapeutics, first line and second line, commonly and effectively used.
- Describe appropriate patient education/follow-up instructions.

Each course syllabus contained a list of conditions and skills to which students were expected to be "exposed to" or perform but did not include statements to guide student acquisition of skills.

In the clinical year, the program did not define any learning outcomes for professional behavior and interpersonal skills in any of the clinical rotation syllabi. No instructional objectives were present in all of the clinical rotations. "Skills" identified on p. 3 of the syllabi were not identified as learning outcomes or instructional objectives. In these cases, it was a list of exposures to conditions and skills to be performed.

In its response, as evidence of compliance the program referenced the same six "learning objectives" across all rotations that faculty identified as the learning outcomes. None of the learning objectives included detailed information necessary to guide student acquisition of required competencies for each rotation.

Required Report: Provide both the didactic and clinical syllabi with learning outcomes and instructional objectives that are measurable and can guide student acquisition of the competencies. Provide only the excerpt of each course syllabus for these sections.

Click here to enter program response

19. **Standard** B3.03a *Supervised clinical practice experiences must* enable all students to meet the program's *learning outcomes*:

    a) for preventive, emergent, acute, and chronic patient encounters,

Findings: The program did not provide evidence that it had defined supervised clinical practice experience learning outcomes for preventive, emergent, acute, and chronic patient encounters.

Comments: Standards B3.03a-e require that the program clearly define, for students and preceptors, the expected learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning and problem-solving abilities) that must be achieved by each student.

The program did not provide evidence that it had defined its learning outcomes for preventive, emergent, acute, and chronic patient encounters. The Director of Clinical Education stated the learning outcomes were in the form of the topic list for the PAEA end of rotation exams, which

does not meet the ARC-PA definition for learning outcomes. The SCPE course syllabi submitted with the application in Appendix 17 and reviewed at the time of the site visit included similar learning outcomes (categorized as "learning objectives") for all rotations. None of the identified learning outcomes addressed preventive, emergent, acute care, or chronic care. In Appendix 12 of the application, the program identified a list of preventive, emergent, acute and chronic conditions with related skills, but this topic list did not reflect learning outcomes.

In its response, the narrative described how students would "have the opportunity to practice in" emergent, acute, and outpatient settings caring for acute and chronic diseases of elderly patients and in some settings that promoted preventive medicine. The program provided syllabi PASS 670 Family Medicine Rotation, PASS 671 Emergency Medicine Rotation, and PASS 675 Geriatric Rotation of which PASS 670 Family Medicine Rotation had one "learning objective" that contained acute and chronic care.

Required Report: Provide the supervised clinical practice experience (SCPE) expected learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning, and problem-solving abilities) for preventive, emergent, acute, and chronic patient encounters that must be attained by each student at the completion of a supervised clinical practice experience. Attach in an appendix.

Click here to enter program response

20. **Standard** B3.03b *Supervised clinical practice experiences must* enable all students to meet the program's *learning outcomes*:

    b) across the life span, to include infants, children, adolescents, adults, and the elderly,

Findings: The program did not provide evidence it had clearly defined learning outcomes for students in supervised clinical practice experiences for patients seeking medical care across the life span to include infants, children, adolescents, adults, and the elderly.

Comments: Standards B3.03a-e require that the program clearly define, for students and preceptors, the expected learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning, and problem-solving abilities) that must be achieved by each student.

The supervised clinical practice experience (SCPE) course syllabi, in Appendix 17 of the application and reviewed at the time of the site visit, included six "learning objectives" which were the same across all rotations, with no learning outcomes specifically related to care across the life span, to include infants, children, adolescents, adults, and the elderly.

The SCPE course syllabi, submitted with the application in appendices 12 and 17 and reviewed at the time of the site visit, included similar learning outcomes which were not specific to the SCPE, none of which specified infants, children, adolescents, adults, and the elderly. It is noted the program has a geriatric SCPE, however, none of the learning outcomes specified elderly or geriatric patients. Within Appendix 12, the program defined ages for infants, children, and

adolescents and provided lists of conditions and related skills, but these were not learning outcomes, and were not directly related to infants, children, adolescents, adults, and the elderly.

In the program's response to the observation, it stated the number of encounters required for each age group. Examples were the following:

- Infants (age 2 years of age), at least 40 encounters
- Children (age 2-11 years of age), at least 100 encounters
- Adolescents (age 12-18 years of age), at least 20 encounters

The program provided syllabi PASS 671 Emergency Medicine Rotation, PASS 677 Pediatrics Rotation, and PASS 675 Geriatric Rotation which did not include learning outcomes associated with care across the life span.

Required Report: Provide the expected learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning, and problem-solving abilities) for patients seeking medical care across the life span to include infants, children, adolescents, and the elderly that must be attained by each student at the completion of the SCPE. Attach in an appendix.

Click here to enter program response

21. **Standard** B3.03c *Supervised clinical practice experiences must* enable all students to meet the program's *learning outcomes*:

    c) for women's health (to include prenatal and gynecologic care),

Findings: The program did not provide evidence that it had defined learning outcomes for women's health including prenatal and gynecologic care for supervised clinical practice experiences.

Comments: Standards B3.03a-e require that the program clearly define, for students and preceptors, the expected learning outcomes (the medical knowledge, interpersonal, clinical, and technical skills, professional behaviors, clinical reasoning, and problem-solving abilities) that must be achieved by each student.

The supervised clinical practice experience (SCPE) course syllabi, submitted with the application in appendices 12 and 17 and reviewed at the time of the site visit, did not include learning outcomes for prenatal and gynecologic care. Although some skills listed in the course syllabus for PASS 673 Women's Health Rotation included procedures and were written in measurable terms such as "collect a sample for PAP smear", "collect a sample for a vaginal culture" etc., they were not identified as learning outcomes. The program defined requirements for the number of encounters for prenatal and gynecologic care and provided lists of conditions and related skills for gynecologic and prenatal care, but these were not learning outcomes.

In its response, the program explained that in the PASS 673 Women's Health Rotation syllabus students would encounter 160 patients, 80 of which should be prenatal and the other 80

gynecological. The program further stated that specific women's health learning outcomes were provided within the syllabus, which included both gynecological and prenatal conditions. The narrative described that students must perform each skill at least once and evaluate and manage each listed condition. However, this does not reflect learning outcomes as defined by the ARC-PA.

Required Report: Provide the supervised clinical practice experience (SCPE) expected learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning, and problem-solving abilities) for patients seeking gynecologic and prenatal care, that must be attained by each student at the completion of a supervised clinical practice experience. Attach in an appendix.

Click here to enter program response

22. **Standard** B3.03d *Supervised clinical practice experiences must* enable all students to meet the program's *learning outcomes*:

    d) for conditions requiring surgical management, including pre-operative, intra-operative, post-operative care,

Findings: The program did not provide evidence that it had clearly defined learning outcomes for students in supervised clinical practice experiences (SCPEs) for pre-operative, intra-operative, and post-operative care.

Comments: Standards B3.03a-e require that the program clearly define, for students and preceptors, the expected learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning and problem-solving abilities) that must be achieved by each student.

The SCPE course syllabi, submitted with the application in appendices 12 and 17 and reviewed at the time of the site visit, did not include learning outcomes for conditions requiring surgical management, including pre-operative, intra-operative, and post-operative care. Although some skills listed in the course syllabus for PASS 672 General Surgery Rotation included procedures and were written in measurable terms such as "demonstrate appropriate sterile technique", "perform surgical wound closure" etc., but were not identified as learning outcomes. There was one skill for post-operative care "provide post-op and discharge patient education" but was not identified as a learning outcome. The program defined requirements for the number of encounters for pre-operative, intra-operative and post-operative care and provided lists of conditions and related skills for pre-operative, intra-operative and post-operative care but these were not learning outcomes.

In its response, the program stated that the PASS 672 syllabus stated students would encounter 100 patients in the surgical setting with exposures to 1/3 of each area: pre-operative, intra-operative, and post-operative. The program further explained that specific surgical learning outcomes were provided in the syllabus that defined conditions that must be evaluated and managed as well as required skills performed. The program did not clearly define, for students and preceptors, the expected learning outcomes (the medical knowledge, interpersonal, clinical

and technical skills, professional behaviors, clinical reasoning, and problem-solving abilities) that must be achieved by each student.

Required Report: Provide the expected learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning, and problem-solving abilities) for conditions requiring surgical management, including pre-operative, intra-operative, and post-operative care that must be attained by each student at the completion of the supervised clinical practice experience (SCPE). Attach in an appendix.

Click here to enter program response

23. **Standard** B3.03e *Supervised clinical practice experiences must* enable all students to meet the program's *learning outcomes*:

    e) for behavioral and mental health conditions.

Findings: The program did not provide evidence that it has defined learning outcomes for behavioral and mental health conditions.

Comments: Standards B3.03a-e require that the program clearly define, for students and preceptors, the expected learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning and problem-solving abilities) that must be achieved by each student.

The supervised clinical practice experience (SCPE) course syllabi, submitted with the application in appendices 12 and 17 and reviewed at the time of the site visit, did not include learning outcomes for conditions that addressed behavioral and mental health conditions. Although some skills listed in the course syllabus for PASS 676 Behavioral Medicine Rotation included procedures and were written in measurable terms "utilization of CAGE tool", "utilization of anxiety scale" etc., but were not identified as learning outcomes. The program defined requirements for the number of encounters for age groups of patients and provided lists of conditions and related skills for behavioral and mental health care, but these were not learning outcomes.

In its response, the program stated the PASS 676 syllabus defined specific learning outcomes for the behavioral medicine rotation. The program further explained that the "learning objectives" were met by evaluating and treating each required condition and performing each required skill. However, the program did not provide expected learning outcomes (medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning and problem-solving abilities) that must be achieved by each student.

Required Report: Provide the expected learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning and problem-solving abilities) for behavioral and mental health conditions that must be attained by each student at the completion of the supervised clinical practice experience (SCPE). Attach in an appendix.

Click here to enter program response

24. **Standard** B3.06a *Supervised clinical practice experiences should* occur with:

    a) physicians who are specialty board certified in their area of instruction,

Findings: The program did not provide evidence that all supervised clinical practice experiences (SCPEs) occur with physicians who were specialty board certified in their area of instruction.

Comments: At the time of the site visit, a review of preceptor board certification documentation provided as evidence of compliance did not include evidence that all physician preceptors were currently board-certified in their area of instruction. Four of the listed active preceptors (Wilson, Hinshaw, Jaffri, and Ramierez) were not board-certified in their area of instruction. The program did not provide a compelling reason for SCPEs to occur with physicians who were not specialty board certified in their area of instruction.

In its response, the program stated it provided documentation with rationale for the four non-board-certified preceptors and had vetted each preceptor. It is the program's responsibility to meet the standard or, in the case of a "should" standard, detail a compelling reason why it did not do so. The program failed to present a compelling reason, acceptable to the commission, for the use of physicians who were not specialty board certified in the area of instruction.

Required Report: Provide a narrative that succinctly documents the process used by the program to verify all supervised clinical practice experiences (SCPEs) occur with physicians who are board certified in their area of instruction.

Alternately, describe why the requirement that students have SCPEs with physicians who are specialty board certified in their area of instruction cannot be met. Include a description of the evaluation process the program uses to determine physicians who are not specialty board certified in their area of instruction are appropriate for the specified area of instruction.

Append evidence of compliance, in the form of a table (Word or Excel), including the following information for all currently active physician preceptors: the physician preceptor's name, the area of instruction of the preceptor(s), the physician board certifying body and date of expiration.

Highlight, on the table, preceptors who are non-board certified or not board-certified in their area of instruction who have been evaluated and determined by program faculty to be appropriate for the specified area of instruction. Provide documentation of the completed vetting process for each preceptor.

Click here to enter program response

25. **Standard** B4.01a The program *must* conduct *frequent*, objective and documented evaluations of student performance in meeting the program's *learning outcomes* and

instructional objectives for both didactic and *supervised clinical practice experience* components. The evaluations *must*:

a) align with what is expected and taught,

Findings: The evaluation of student performance in meeting the program's learning outcomes and instructional objectives for supervised clinical practice experience components did not align with what was expected and taught.

Comments: The program's use of variable terminology to represent learning outcomes and objectives did not allow the program to align assessment methods with what was expected and taught for both the didactic and clinical years.

Within the didactic curriculum, the method of evaluation was not clearly and consistently aligned with the learning outcomes and instructional objectives. The program described that its methods of assessment included written exams, practical exams, oral presentations, group projects, research projects, OSCEs and simulations, however, the program did not provide evidence that evaluations were aligned with what was expected and taught. The program used variable terminology for learning outcomes and instructional objectives and not all didactic courses included learning outcomes and instructional objectives.

Examples were the following:

- PAS 624 Pharmacotherapeutics I and PAS 634 Pharmacotherapeutics II did not have learning outcomes or clear instructional objectives.
- PAS643 Clinical Skills had no learning outcomes.

Within the SCPE curriculum, the syllabi and evaluations of student performance in meeting the program's learning outcomes were not consistently aligned with what was expected and taught. The program described that its methods of assessment included end of rotation exams, preceptor evaluations, and assignments to determine whether students met the learning outcomes and instructional objectives for each rotation. At the time of the site visit the program described the alignment of evaluation methods to the learning outcomes except for the preceptor evaluation. The preceptor evaluation forms included in Appendix 13 were missing various elements.

Examples were the following:

- Evaluation of preventative, emergent, acute, or chronic care.
- Evaluation of care across the lifespan to include infants, children, adolescents, adults, and elderly.
- The PASS 672 General Surgery rotation did not include evaluation of pre-operative, intra-operative or post-operative care.
- The preceptor form for PASS 672 General Surgery included skills to be assessed that were not identified with course syllabi as a learning outcome or instructional objective including administer O2, place urinary catheter, place IV catheter, perform intubation, perform extubation.
- The PASS 673 Women's Health rotation did not include evaluation of learning outcomes for prenatal and gynecologic conditions.

- The PASS 676 Behavioral Medicine rotation did not include evaluation of learning outcomes for behavioral and mental health care.
- The preceptor evaluation form for PASS 677 Pediatric rotation was not included in the application.

In its response, the program only addressed the clinical year stating student performance was evaluated in the end of rotation exams, patient logs, and preceptor evaluations. The program explained that the learning outcomes related to encounters, across the life span, pre-operative, intra-operative, post-operative, prenatal, gynecologic, and behavioral health included student log review. The program further stated that the broad terms were not included in the preceptor evaluation "as they are evaluated on specific conditions and skills that occur in each of the above-mentioned settings with specific patient population requirements."

Required Report: Provide a succinct narrative describing how the program aligns student assessment with the learning outcomes and instructional objectives and describe the methods of evaluation.

Append the program's learning outcomes and instructional objectives for each course. Do not include the complete rotation syllabi; excerpt the learning outcomes and instructional objectives and place into a separate document organized by course.

Provide a succinct narrative describing how the program aligns student assessment with what the program expects of a student (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, and clinical reasoning and problem-solving abilities) on supervised clinical practice experiences (SCPEs).

Append the program's SCPE expectations (the learning outcomes, rotation objectives, etc.) for each required rotation. Do not include the complete rotation syllabi; excerpt the learning outcomes, instructional objectives, skills list, etc., and place into a separate document organized by rotation.

Append the document(s) necessary (e.g., preceptor evaluations and/or other evaluations) to verify the program has a means to determine whether each student has met the learning outcomes and instructional objectives on SCPEs by aligning evaluation with what is expected.

Click here to enter program response

26. **Standard** B4.01b The program *must* conduct *frequent*, objective and documented evaluations of student performance in meeting the program's *learning outcomes* and *instructional objectives* for both didactic and *supervised clinical practice experience* components. The evaluations *must*:

    b) allow the program to identify and address any student deficiencies in a *timely* manner.

Findings: The evaluation of student performance in meeting the program's learning outcomes and instructional objectives for supervised clinical practice experience components did not allow the program to identify and address any student deficiencies in a timely manner.

Comments: The program did not demonstrate evidence that the supervised clinical practice experience (SCPE) evaluations would allow the program to identify and address any student deficiencies in a timely manner. In the application and at the time of the site visit, the program stated it utilized the final preceptor evaluation form and the end of rotation exam to determine if the student required any remediation. The preceptor evaluation form was not rotation specific and did not allow the preceptor to identify deficiencies of learning outcomes in a timely manner. The program did not define how it addressed evaluation items that were marked with a "No" or "N/A". At the time of the site visit, the program did not consistently articulate how it determined section 3 of the preceptor evaluation form (a list of diagnoses and skills that the preceptor was to check off if the student met the level of expectation of the preceptor) was able to assist the program in the identification of deficiencies in a timely manner.

In its response, the narrative described how frequent evaluations of student performance take place during the clinical year. There were mid-point evaluations which occurred in week two of the rotation and at the completion of the SCPE. The program explained in its response that it changed the preceptor evaluation to a check off only for areas of deficiencies after receiving feedback from the preceptors that the evaluation was too long. The program also described that if only a couple of the learning outcomes were missed during a rotation, the student would be allowed to try to obtain the learning outcomes at a different SCPE. The program did not explain how this information would be tracked.

Required Report: Provide a succinct narrative describing how the preceptor evaluation allows the program to identify and address any student deficiencies in the program's expected learning outcomes in a timely manner. Include a narrative on how the program plans to track completion of learning outcomes missed during a rotation.

Append the program's supervised clinical practice experience (SCPE) learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, and clinical reasoning and problem-solving abilities) that are assessed by the preceptor for each required rotation. Do not include the complete rotation syllabi; excerpt the learning outcomes assessed by the preceptor, and place into a separate document organized by rotation.

Append the necessary assessment document(s) used by the preceptor to verify the program has a means to determine each student has met the program expected learning outcomes for the rotations in a timely manner.

Click here to enter program response

27. **Standard** C1.01a The program *must* define its ongoing self-assessment process that is designed to document program *effectiveness* and foster program improvement. At a minimum, the process *must* address:

    a) administrative aspects of the program and institutional resources,

Findings: The program did not define the program's ongoing self-assessment process to include administrative aspects of the program and institutional resources.

Comments: The program's ongoing self-assessment process did not include a complete process to address program effectiveness and foster program improvement for the administrative aspects of the program and institutional resources. In its self-study report, the program did not provide qualitative data or rationale for the identified qualitative benchmarks. The program did not provide data and critical analysis to demonstrate compliance for faculty development, clinical site development, curriculum design, program assessment, admissions outcomes, and diversity, equity, and inclusion for appendix 14B. The program's self-assessment process defined by the program did not consistently describe in sufficient detail how quantitative and qualitative data would be analyzed over time to identify correlational relationships.

In its response, the program explained how the program director was evaluated by the students in the exit survey as well as the students' perceptions of program strengths and areas in need of improvement. The program also stated that the department chair meets with the students annually to obtain feedback to determine trends and to evaluate the feedback against benchmarks. The program did not provide evidence of data and critical analysis of faculty development, clinical site development, curriculum design, program assessment, admissions outcomes and diversity, equity, and inclusion.

Required Report: Provide a narrative below describing the program's established, formal, continuous self-assessment process addressing the administrative aspects of the program and institutional resources.

The commission expects the program to define and document its ongoing self-assessment process including the administrative aspects of the program and institutional resources. Include a succinctly written narrative that describes its process of analyzing qualitative and quantitative data, including considerations for established benchmarks with rationale; and correlations, relationships, and trends in data the program will use in its analysis. The process described must be consistent with the data sources, timing of data collection and analysis listed in the Timeline for Data Gathering and Analysis TEMPLATE as well as any other documents the program provides in support of its description of the self-assessment process.

Click here to enter program response

28. **Standard** C1.02c.i. The program *must* implement its ongoing self-assessment process by:

    a) applying the results leading to conclusions that identify:
        i. program strengths,

Findings: The program did not provide consistent evidence that its identified strengths were the result of performing critical analysis of the data in its ongoing self-assessment process.

Comments: The program director and principal faculty did not describe a consistent process or provide examples of how the program identified strengths based on analysis. The program's

identification of strengths throughout the self-study report (SSR) was not based on defined strength benchmarks/thresholds established for quantitative or qualitative data, or measurement of trends over time. The program stated in its response that there were multiple strengths identified and written in the SSR and data provided in the appendices.

In its response, the program stated "in Appendix 14D Effectiveness of Clinical Curriculum, multiple strengths were identified based on critical analysis of data with benchmarks referenced. Student evaluations of the clinical team, site, and preceptor as well as aggregate tables were provided in the SSR and in physical forms" at the time of visit. The program further stated that in Appendix 14C Effectiveness of Didactic Curriculum, "supplemental data was provided concerning student course evaluations and instructor evaluations which were referenced in the program's strengths section." However, the program did not provide evidence that program strengths were identified as a result of data analysis.

Required Report: Within the next SSR, the commission expects the program to implement its ongoing self-assessment process by applying the results leading to conclusions that identify program strengths.

Click here to enter program response

29. **Standard** C1.03 The program *must* prepare a self-study report as part of the application for accreditation that *accurately* and *succinctly* documents the process, application and results of ongoing program self-assessment. The report *must* follow the guidelines provided by the ARC-PA.

Findings: Within the submitted self-study report (SSR), the program did not provide documentation of critical data analysis leading to data-driven conclusions and subsequent identification of program strengths, modifications, or areas in need of improvement.

Comments: Within the submitted SSR, the program did not provide documentation of critical data analysis and the ability to link analysis to data-driven conclusions and subsequent identification of program strengths, areas in need of improvement, and action plans.

While the SSR reflected the program was collecting data, evidence the program was critically analyzing data and drawing conclusions based on documented data analysis was inconsistent in each of the required SSR appendices.

Examples include but were not limited to:

<u>Appendix 14B: Administrative Aspects of the Program and Institution</u>

- Benchmarks were described without consistent rationale.
- A strength threshold was not defined.
- Documented analysis was a brief mix of describing analysis process and stating data above and below benchmark, without documented conclusions.
- The program did not document analysis of negative trends in data.
- Strengths, modifications, areas in need of improvement with plans were not linked to documented critical data analysis.

<u>Appendix 14C: Effectiveness of the Didactic Curriculum</u>

- A strength threshold was not defined.
- There was limited documentation of evaluation of instructors.
- Strengths, modifications, areas in need of improvement with plans were not linked to documented critical data analysis.

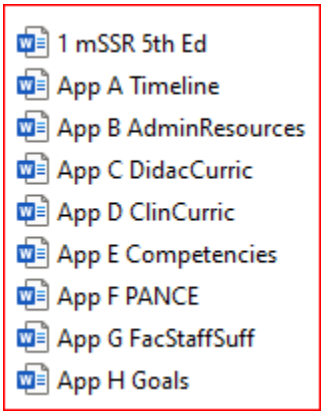
Appendix 14G: Sufficiency and Efficiency of Principal Instructional Faculty and Staff

- The Faculty and Staff Changes template was incomplete as the one principal faculty member hired in 2021 (Edmundson) was not listed.
- The program did not document how it defined "good or better" sufficiency and effectiveness which were used in data collection.
- The program did not include documentation of the effectiveness of instructional faculty, program director, or medical director.
- A strength threshold was not defined.
- Strengths and modifications with plans were not linked to documented critical data analysis.

In the next SSR, the commission expects the program to:

- Provide an overview of its self-assessment process that clearly and succinctly describes a comprehensive, ongoing self-assessment which critically assesses all aspects of the program relating to sponsorship, resources, students, faculty, operational policies, curriculum, clinical sites, and program goals.
- Reference relevant data used to support the analysis documented in the SSR.
- Explicitly document, in the analysis narrative, how quantitative and qualitative data is interpreted and critically analyzed to identify potential for improvement or change.
- Document the source of qualitative data, including data that may be informally collected from faculty or students.
- Document analysis of the relationship between the various data reported as collected.
- Explicitly document the links between data, analysis, conclusions, and actions.
- Identify modifications and plans to address needed improvements consistent with the conclusions drawn.
- Document how analysis is used as the basis for conclusions drawn.
- Ensure the lists of program strengths, modifications, and areas in need of improvement are supported by data and analysis documented within each appendix.

Required Report: The program is expected to complete a modified Appendix 14 SSR that incorporates data as specified in each appendix listed below. The commission expects to see the program place an emphasis on its continual program self-assessment process, designed to document program effectiveness and foster program improvement as a result of critical analysis.



These templates can be downloaded from the program's portal. Click on "Manage Program Documents" in the Action Center in the Program Dashboard. From the Program Documents page, click on the zip file titled "ARC-PA Request for Report."

The program should save and submit its mSSR as instructed in the Saving and Submission directions included in the mSSR 5th Ed document.

Click here to enter program response

30. **Standard** C2.01a The program *must* define and maintain effective processes and document the initial and ongoing evaluation of all sites and *preceptors* used for *supervised clinical practice experiences,* to ensure students are able to fulfill program *learning outcomes* with access to:

    a) physical facilities,

    Findings: The program did not maintain and document an initial and ongoing evaluation of all sites and preceptors for supervised clinical practice experiences (SCPEs) to ensure that students were able to fulfill program learning outcomes with access to physical facilities.

    Comments: The program did not provide evidence of initial and ongoing evaluation of the physical facilities used for supervised clinical practice experiences. The program included the student evaluation of the site and preceptor in the application of record (appendix 15) and not the initial and ongoing evaluation of the clinical site and preceptor.

    At the time of the site visit, a review of the clinical site form did not address evaluation of physical facilities.

    In response to the observation, the program acknowledged that it did not implement an initial assessment of physical facilities. The students were asked by the program at mid-rotation if physical facilities met their needs and felt safe.

    Required Report: Provide a succinct narrative describing the initial and ongoing evaluation process utilized to evaluate the physical facilities of all clinical sites used for *supervised clinical*

practice experiences. Include the criteria used to evaluate whether the physical facilities are appropriate to ensure students can fulfill the program's *learning outcomes*.

Append a blank copy of the form(s) or tool(s) used to document the initial and ongoing evaluation of all sites and *preceptors* used for supervised clinical practice experiences.

Click here to enter program response

31. **Standard** C2.01b The program *must* define and maintain effective processes and document the initial and ongoing evaluation of all sites and *preceptors* used for *supervised clinical practice experiences,* to ensure students are able to fulfill program *learning outcomes* with access to:

    b) patient populations,

    Findings: The program did not provide evidence it had an effective process of initial and ongoing evaluation of clinical sites and preceptors to ensure students could fulfill program learning outcomes with access to patient populations.

    Comments: The program did not provide evidence of initial and ongoing evaluation to ensure the patient population enables students to fulfill program learning outcomes. The Site/Preceptor Evaluation form submitted with the application and reviewed during the site visit did not assess sites used for supervised clinical practice experiences to ensure that students could fulfill program learning outcomes with access to patient populations. The program described that it used the EvalClinSitePre ISU PA along with patient logging for ongoing evaluation of the site and included general questions about the diversity of the patient population, but patient population types by age groups/encounter type were not present. The form used by the program was a student site/preceptor evaluation form. No initial or ongoing site evaluation form was presented during the site visit.

    In its response, the program provided one site and preceptor evaluation form (Site Evaluation for #27) of a pediatric rotation site which did include patient populations of infant, child, and adolescents, number of patients, and age ranges. However, the program only provided the evaluation for the pediatric rotation and not the initial and ongoing evaluation of SCPE sites for other disciplines.

    Required Report: See citation #30

Click here to enter program response

32. **Standard** C2.01c The program *must* define and maintain effective processes and document the initial and ongoing evaluation of all sites and *preceptors* used for *supervised clinical practice experiences,* to ensure students are able to fulfill program *learning outcomes* with access to:

    c) supervision.

Findings: The program did not maintain and document the initial and ongoing evaluation of all sites and preceptors for supervised clinical practice experiences (SCPEs) to ensure that students were able to fulfill program learning outcomes with access to supervision.

Comments: In the application and at the time of the site visit, the program provided EvalClinSitePre ISU which was the student evaluation of the site and preceptor which did not include access to supervision or a faculty evaluation of the site and preceptor. The principal faculty stated that the preceptors were questioned about the ability to provide supervision to the students, however, there was no documentation of responses from any clinical site for access to supervision.

In its response, the program provided a different site and preceptor evaluation form from what was presented in the application and at the site visit (Site Evaluation #27) and was specific to an initial evaluation of a pediatric site and preceptor. Included on the form was a question on supervision, "The student will receive an appropriate level of supervision, (i.e., no patient will be managed or discharged without a preceptor's involvement in the care of a patient)" which included a yes/no response. The program did not provide evidence of ensuring students were able to access supervision for all initial sites and preceptor evaluations of SCPE disciplines other than pediatrics which was submitted in the response to the observation. The program also did not provide evidence of ongoing evaluations of the site and preceptor to ensure students had access to supervision to fulfill program learning outcomes.

Required Report: See citation #30 C2.01a, #31 C2.01b for the response to C2.01a, C2.01b, and C2.01c.

Click here to enter program response

33. **Standard** E1.03 The program *must* submit reports or documents as required by the ARC-PA.

Findings: The program did not submit application documents as required by the ARC-PA.

Comments: The original submission omitted documents or included documents completed incorrectly.
The program was missing the following documents:

- The Clarified Standard Template for standards A2.16 and A2.17.
- The Standards Clarification Template dated 9/2022.
- Appendix 11a Supervised Clinical Practice Experiences Excel document.
- Appendix 14F PANCE Performance Summary Report

The program provided incorrect formats:

- Appendix 1a Program data sheet submitted as an Excel file instead of a Word document (original format).
- Appendix 1b The budget was not downloaded and saved as an Excel file per instructions.
- Appendix 3a The organizational chart submitted did not show how the PA program relates to the sponsoring institution.

- Appendix 16 There were tracked changes on documents submitted for: ClinPhasMan 21-22 ISU PA ad PA HB 2022-2023 ISU PA
- On a majority of the Faculty CV templates-the program did not use the most up to date template version (12-2021).

The program had a change in curriculum not reported to the ARC-PA for change in graduation requirements (removal of PASS 617 Health Behavior Science in spring 2020 and addition of the genetics course in summer 2021).

In its response, the program asserted:

- The Clarification to Standards A2.16 and A2.17 template was turned in on time and accepted by ARC-PA.
- Appendix 1b The document was submitted as an EXCEL file.
- Appendix 3a The organizational chart was included.
- Appendix 11a The SCPEs Excel document was submitted with the initial application.
- Appendix 4C: The program did provide the most up-to-date templates for all CVs (12/2021).
- Appendix 4F: The PANCE Performance report was included and submitted on time.

Required Report: No report due. The commission expects the program to submit documents and reports as required.

ADDITIONAL REPORTS

The ARC-PA reminds the program to review the *Standards* 5th edition which went into effect September 1, 2020, in particular Section E, regarding maintenance of accreditation. You will find the *Standards*, an accreditation manual and other helpful information on our website, www.arc-pa.org.

In reviewing the information in the ARC-PA Program Management Portal prior to the commission meeting, the ARC-PA noted some incomplete or inaccurate data. **The Personnel tab does not accurately display the required program personnel.**

The portal included Dr. Urban who is no longer with the program and Ms. Loudermilk, the program coordinator, was not listed on the portal.

The program must correct its portal information no later than **November 10, 2023,** and notify the ARC-PA via email to accreditationservices@arc-pa.org.

In order to be in compliance with standard A3.12i, the most current annual student attrition information on the **Attrition Table** provided by the ARC-PA, must be published on the program website no later than April first each year. In reviewing the program's website prior to the commission meeting, the ARC-PA noted a deceleration rate of 13% for the Class of 2023.

At the June 2023 meeting, the Commission voted and approved a motion to require programs to provide the ARC-PA with a report addressing significant attrition within a program. In any year that the program has a calculated attrition of 10.9% or higher, the program will be required to submit a Student Attrition Required Report within six (6) months of the cohort's completion.

The program must update its **Attrition Table** on its website so that it accurately reflects the Class of 2023 attrition and graduation rates of the program's three most recent graduated cohorts no later than **December 1, 2023,** and notify the ARC-PA of the update via email to accreditationservices@arc-pa.org .

SUMMARY OF REQUIRED REPORTS

Report #1 – Additional Reports:

- Portal update due **November 10, 2023**
- Attrition table with completed report sent to the ARC-PA by **December 1, 2023**

Report #2 – Response to citations #1-16, and #30-32 due **February 1, 2024**

Report #3 – Response to citations #17-26 due **May 15, 2024**

Report #4 –Response to citations #27-29 (modified SSR) due **February 6, 2025**

****Completed Statements and Signatures page must be submitted with each report required in this document, otherwise the report will not be accepted.****

The ARC-PA reminds the program to review the *Standards* 5th edition which went into effect September 1, 2020, in particular Section E, regarding maintenance of accreditation. The commission made some clarifying changes to Section E of the *Standards,* 5th edition, at its September 2022 meeting. This included changes to E1.04, E1.07, & E1.08. You will find the *Standards*, an accreditation manual and other helpful information on our website, www.arc-pa.org.

- -

The Syllabi, Program Competencies, Learning Outcomes & Instructional Objectives, Standards 5th edition resource may be beneficial to the program.

- -

Additional documents such as the Data Analysis Resource and Completing the Self-Study Report may be beneficial to the program and can be found on the Manuals and Guides page of the ARC-PA website.

- -

The Spring 2019 Newsletter, Common Missing Elements of the Self Study Report may also be beneficial to the program and can be located at http://www.arc-pa.org/newsletters-and-notes/ .

STATEMENTS AND SIGNATURES

I understand and agree that the Program will be subject to an adverse accreditation action which could include denial of accreditation or withdrawal of accreditation, and that future eligibility for accreditation may be denied in the event that any of the statements or answers made in this submitted response are false or in the event that the Program violates any of the policies governing accredited programs.

Response Submitted by: Click here to enter name **Date:** Click here to enter date

Program Director: Click here to enter name **Date:** Click here to enter date
The name that appears here is deemed an electronic signature.

Chief Administrative Officer of Program's Sponsoring Institution:
As listed in the Program Management Portal
Click here to enter name **Date:** Click here to enter date
The name that appears here is deemed an electronic signature.

****Completed Statements and Signatures page must be submitted with each report required in this document, otherwise the report will not be accepted.****

Accreditation Review Commission on Education for the Physician Assistant, Inc.

Indiana State University Physician Assistant Program

Citations

A succinct narrative response as detailed in the Required Report description must be included below each citation on this document in the response field provided. Follow the guidelines for responding to citations described in the Accreditation Manual - http://www.arc-pa.org/accreditation-manual/. Supplemental documents must be included as needed to complete a response and/or to provide verification of compliance. Please note their inclusion in the narrative and append them to the report as appendix 1, 2, 3, etc. Return this document in its current Word format; i.e., do NOT convert to a pdf document. Be sure to "save" the document before submitting.

The response is due no later than **as detailed below**.

The program should submit its report by uploading it as a Report Due document type from the program's portal page. From the portal Program Dashboard, click on Manage Program Documents in the Action Center or click the Documents icon, which looks like several sheets of paper, in the dashboard's upper-right corner. For help with uploading a document, click on "(i) How to Upload" in the upper right corner. If the report consists of multiple documents, put all documents in a zip file and upload the zip file.

The ARC-PA will review and consider the reports and any accompanying materials either by an expedited review process or at its next regularly scheduled meeting, as determined by the ARC-PA, in March, June, or September. Unless otherwise stated, the Commission will review reports as follows: Reports due on or before **October 1** are considered for the March meeting. Reports due on or before **February 1** are considered for the June meeting. Reports due on or before **May 15** are considered for the September meeting.

Citations

As you read the information below, please keep in mind the following: the ARC-PA defines "findings" as explanations that may accompany a citation. In addition, there may be "comments." Their purpose is to clarify the issue of noncompliance, but not to specify how a problem may be resolved.

Based on information contained in the program application and all appendices submitted to the ARC-PA, the report of the site visit team, the program's response to the site visit team's observations, and the program's accreditation history, the program failed to demonstrate compliance with the following standards:

1. **Standard** A1.02a The sponsoring institution is responsible for:

   a) supporting the planning by *program faculty* of curriculum design, course selection, and program assessment,

Findings: The sponsoring institution did not demonstrate responsibility for supporting program faculty in program assessment.

Comments: The commission added this citation. At the site visit, institutional officials verified that they had reviewed the application and self-study report (SSR) prior to submission. However, there were multiple areas omitted and incomplete within the submitted documentation of the SSR. Examples include but were not limited to missing areas of assessment in Appendix 14B and omission of the collection and analysis of data from faculty and staff. Refer to the following citations for further details: C1.01a, C1.02c.i, and C1.03.

Required Report: Provide a succinct narrative response indicating how the institution demonstrates its responsibility to support the program faculty in application and documentation of program assessment and assure compliance with this standard in the future. The program is also required to submit a modified self-study report (mSSR) as part of its accreditation probation application. See Citations #27-29.

As noted in the Indiana State University Conceptual Framework for Curricular Development, https://www.indstate.edu/academic-affairs/curriculum/caps2013
program faculty are the authors of the curriculum, courses, and assessment plan and are empowered as content experts by the ISU Constitution 145.2,
https://www.indstate.edu/policy-library/constitution-faculty-indiana-state-university.

The ISU Division of Academic Affairs infrastructure and faculty governance are designed to provide institutional support to faculty by allocating resources for peer review that promotes continuous quality improvement through curriculum development and review, program assessment, and review for accreditation. A summary of ISU Infrastructure and Resources available to Support Faculty and Programs in Curriculum and Assessment is included (Appendix 1). This table illustrates the institutional process and resources that are at the disposal of faculty engaged in curriculum and program development and assessment. More information on these resources may be found at https://www.indstate.edu/academic-affairs/curriculum/ca/roles-and-levels.

Program assessment takes a modified path that does not include curriculum committees.

ISU's Assessment Council (https://www.indstate.edu/assessment) is charged with guiding and overseeing institution-wide assessment activities to facilitate more consistent and effective assessment that improves student outcomes. The Council conducts its activities with the recognition that the faculty have the primary responsibility for student learning and in conjunction with the principles of shared governance. The Assessment Council interacts directly with programs by reviewing assessment plans and making recommendations. Please see the example assessment feedback (Appendix 2). An evaluation summary of programs within the College Health and Human Services for 2021-2022 is included (Appendix 3). Our PA program achieved for most Student Outcomes Assessment and Success Report a rating of mature. Similarly, the Graduate Council commits faculty resources to support curriculum and course improvement. A conceptual framework of ISU Graduate Program Assessment is included (Appendix 4).

The Division of Academic Affairs, the College of Health and Human Services (CHHS), and the Department of Applied Medicine and Rehabilitation (AMR) collaborate to ensure that the PA Program faculty and staff have adequate financial and personnel resources to engage in continuous quality improvement

through accreditation and program assessment. To support PA program faculty to apply and document program assessment, ISU commits resources in the form of personnel – Vice Provost for Academic Affairs, Director of Assessment and Program Effectiveness, Dean of the College of Health and Human Services (CHHS), and workload allocation for Chair of Applied Medicine and Rehabilitation. The PA Program Director presently receives a 50% allocation of workload and a stipend for administrative duties including assessment and accreditation. The PA Didactic and Clinical Coordinators also receive 50% workload allocation and stipends for administrative duties including assessment and accreditation. ISU allocates funds for professional staff and consultants, including Dr. Gloria Rogers, a consultant on program assessment for the PA program. Dr. Rogers, a Higher Learning Commission Senior Scholar Emerita, is an international expert on assessment. ISU, CHHS, and AMR allocate resources for PA program faculty and staff to receive training on and off campus in program assessment and accreditation, including refresher courses with ARC-PA in January 2024 – Accreditation and You Workshop – attended by Mr. Douglas Stevens, Program Director, and Dr. Brittany Edmondson, Clinical Coordinator, and the Self-Study Workshop – attended by Mrs. Chelsea Elwood, Didactic Coordinator. Continuing education and tool kits for faculty on program and course assessment are offered by the ISU Faculty Center for Teaching Excellence and resources and consultation are available through the Director of Assessment and Program Effectiveness in Academic Affairs.

The PA program has a robust approach to support the assessment of program outcomes using student assessment of preceptor experience and sites, preceptor evaluation of the student and clinical coordinator assessment of the clinical site, student exit and alumni surveys, graduation rates, and PANCE performance to evaluate appropriate curriculum design and program assessment. Assessment tools, program objectives, and competencies are updated and reviewed after each semester to determine areas of strength or weaknesses in each program. Examples of Program Outcome Analyses are included and discussed in Citation 4, Faculty Sufficiency.

Program outcomes are then presented to the PA Advisory Council twice a year, which includes participation from the Medical Director, Dean of the College of Health and Human Services, and Department Chair, along with ISU PA faculty and staff. The Advisory Council reviews and advises ISU PA faculty on curriculum requirements, assists with accreditation teams, and assists the PA program in participating in ongoing planning activities. The Charter for our ISU's PA Advisory Council is included (Appendix 5). Our last Advisory Council Meeting was on July 6th and the meeting minutes are included (Appendix 6). Our next Advisory Council Meeting will be on April 30th, 2024, to evaluate our current Program outcomes and assess our progress in resolving ARC-PA accreditation citations.

Plan for Improvement. After consultation with PA program faculty and staff, the Chair of AMR, and the Dean of CHHS, the Provost and Vice President for Academic Affairs will promote a stronger integration of the Vice Provost for Academic Affairs and the Director of Assessment and Program Effectiveness with PA program faculty and staff to support the documentation of PA program assessment (Appendix 7). The PA program will include the Director of Assessment and Program Effectiveness in one meeting per month in the lead-up to the submission of the modified self-study and site visit, and annually after that. In addition, support from the CHHS and AMR has hired an expert consultant, David Asprey, PhD, PA-C, to guide the faculty in practices that will consistently meet the standards and that can be documented (Appendix 8). Dr. Asprey is the Denis R. Oliver Endowed Chair, Professor in the Physician Assistant Studies program, and Associate Dean for Medical Education & Professional Programs in the Carver College of Medicine at the University of Iowa.

2. **Standard** A1.02c The sponsoring institution is responsible for:

   c) ensuring effective program leadership,

   Findings: The sponsoring institution did not ensure the program director provided effective program leadership.

   Comments: The commission added this citation. There was no evidence at the time of the site visit that the institution was taking steps to support the program director to ensure effective leadership as evidenced by the number and broad nature of citations in this document. In the application, the program described its process for annual evaluation and self-assessment of the program director which included the program's assessment plan, data from faculty peer evaluations, student advising feedback, student course evaluations, and staff evaluations. However, at the site visit, the institution did not provide evidence of data or analysis related to the evaluation of the program director's leadership.

   Required Report: Provide a succinct narrative response indicating how the institution plans to resolve the citation and assure compliance with this *Standard* in the future. The institution is also expected to demonstrate its responsibility for complying with this *Standard* at the subsequent accreditation probation visit.

The process and criteria for evaluation of program directors in the College of Health and Human Services are determined in each department/school. The PA Program evaluates the Program Director's effectiveness from the student perspective in the Student Exit Survey (Appendix 9). We agree that a more comprehensive evaluation of the Program Director's leadership will assist the PA program in identifying strengths and areas for improvement.

Plans for Improvement.
With support from the CHHS, The PA Program has adopted the following approaches to strengthen the data collection and analysis of leadership effectiveness for the PA Program Director. Development of an annual evaluation process for the PA Program Director Department Chair for Applied Medicine and Rehabilitation aligned with the position description that includes Self-evaluation. Survey of faculty, staff, advisory board, and other stakeholders to provide anonymous data to determine the leadership effectiveness of the Program Director. Observations and analysis of strengths and areas of improvement from the Department Chair for Applied Medicine and Rehabilitation. A professional development plan created by the Department Chair and the Program Director to build on strengths and address areas for improvement. Such a plan will include ARC-PA workshops, leadership development, and individualized coaching.

The Department Chair for Applied Medicine and Rehabilitation will report these findings in writing to the Dean of the College of Health and Human Services and a copy placed in the Program Director's personnel file. The Dean of the College will include this information in the annual review of compliance with standards and make recommendations for improvement. The PA Program Director will be responsible for sharing appropriate aspects of the annual evaluation with PA faculty, staff, and students for continuous improvement. ISU, CHHS, and

AMR have allocated resources for PA program faculty and staff to receive training on and off campus in program assessment and accreditation, including refresher courses with ARC-PA in January 2024 – Accreditation and You Workshop – attended by Mr. Douglas Stevens, Program Director (Appendix 10), and Dr. Brittany Edmondson (Appendix 11), Clinical Coordinator, and the Self-Study Workshop – attended by Mrs. Chelsea Elwood, Didactic Coordinator (Appendix 12). Further, Mr. Stevens attended a Program Director Jumpstart Online Workshop, sponsored by the PAEA, on May 7, 2021 (Appendix 13) and a PAEA Assessment Workshop on December 13, 2023 (Appendix 14). Continuing education and tool kits for faculty on program and course (Assessment are offered by the ISU Faculty Center for Teaching Excellence and resources and consultation are available through the Director of Assessment and Program Effectiveness in Academic Affairs.

3. **Standard** A1.02d The sponsoring institution is responsible for:

   d) complying with ARC-PA accreditation *Standards* and policies,

   Findings: The sponsoring institution did not demonstrate responsibility for complying with ARC-PA accreditation *Standards* and policies as indicated by the quality of the self-study report submitted and the lack of evidence of compliance with the *Standards*.

   Comments: There was a lack of evidence that the sponsoring institution supported the program in complying with the ARC-PA *Standards*. The sponsoring institution is expected to demonstrate responsible intervention and oversight. As evidenced by the number and broad nature of citations, the sponsoring institution did not support the program in compliance with ARC-PA accreditation *Standards.*

   In its response, the program stated that the university recognizes, supports, and accepts responsibility for compliance with the *Standards*. The narrative explained that the program director was responsible for compliance and expected to function as the accreditation expert under the direction of the Department Chair of Applied Medicine and Rehabilitation, the university's Assessment Coordinator, and the Dean of the College of Health and Human Services (CHHS). The Dean of the College of Health and Human Services stated that the Dean's Office reviews and provides feedback on all accreditation reports and self-studies, including the PA program. However, the institutional support that may have been provided to the program was insufficient to demonstrate compliance with the accreditation Standards.

   Required Report: Provide a succinct narrative response indicating how the institution plans to resolve the citation and assure compliance with this *Standard* in the future.

Indiana State University, the College of Health and Human Services (CHHS), and the Department of Applied Medicine and Rehabilitation (AMR) allocate resources for PA program faculty and staff to receive training on and off campus in program assessment and accreditation Standards, including refresher courses with ARC-PA on January 18-19, 2024 Accreditation and You Workshop, which focused on the Standards– attended by Mr. Douglas Stevens, Program Director (Appendix 10, Citation 2), and Dr. Brittany Edmondson, Clinical Coordinator (Appendix 11, Citation 2). The cost for each faculty to attend the workshop is $1800 plus travel and hotel. Mrs. Chelsea Elwood, Didactic Coordinator attended the

ARC-PA Self-Study Workshop on January 20-22, 2024, which cost $2000 plus travel and hotel (Appendix 12, Citation 2). Continuing education and tool kits for faculty on program and course assessment are offered by the ISU Faculty Center for Teaching Excellence.

Plans for Improvement.
After consultation with PA program faculty and staff, the Chair of AMR, and the Dean of CHHS, the Provost and Vice President for Academic Affairs will promote a stronger integration of the Vice Provost for Academic Affairs and the Director of Assessment and Program Effectiveness with PA program faculty and staff to support the PA program faculty and staff in designing, carrying out, and documenting assessment plans and outcomes (Appendix 7, Citation 1) and complying with the Standards. In addition, support from the CHHS and AMR is being provided to hire an expert consultant, David Asprey, PhD, PA-C (Appendix 8, Citation 1). The College of Health and Human Services and the Dean's Office will provide ongoing support for ensuring that documentation is complete.

The PA Program Director, Physician Assistant Committee (PAC), and Data Analyst will conduct a brief self-assessment at the end of each academic term to identify any areas of non-compliance or marginal compliance and will inform the development of an action plan. The self-assessment and action plan will be relayed in writing to the Department Chair, the Dean, and the Director of Assessment and Program Effectiveness for review and approval.

4. **Standard** A1.07 The sponsoring institution *must* provide the program with the human resources, including *sufficient* faculty, *administrative* and technical staff, necessary to operate the educational program, comply with the *Standards*, and fulfill obligations to matriculating and enrolled students.

   Findings: The sponsoring institution did not provide the program with sufficient faculty to operate the program.

   Comments: The sponsoring institution did not provide the program with sufficient human resources to operate the program and fulfill obligations to matriculating and enrolled students. Institutional officials stated support for the program through providing funds for instructional faculty where needed or providing principal faculty with supplementary pay for working extra; however, the program director did not verify the program had sufficient principal faculty in its current situation. At the time of the site visit, the program director was carrying a 15-semester hr. annual teaching load in addition to assigned administrative duties. In addition, a principal faculty member was on administrative leave with no timeframe to return to the program.

   In its response, the program stated that collaboration with the department chair ensured the program had sufficient academic and administrative personnel to fulfill obligations to enrolled and prospective students. The narrative discussed that the provost provided oversight of accreditation compliance concerning the sufficiency and effectiveness of personnel through the dean and collection and analysis of data from the PA students, faculty, and staff. The program did not provide a clear rationale as to how it determined sufficiency of faculty to fulfill obligations to matriculating and prospective students.

Required Report: Provide a succinct narrative below indicating how the sponsoring institution has provided sufficient faculty to operate the educational program, comply with the *Standards*, and fulfill obligations to matriculating and enrolled students.

Indiana State University is committed to maintaining sufficient faculty and staff to meet the Standards and high-quality outcomes of our Physician Assistant Program. ISU PA faculty who are clinically practicing are given an 8-hour release time per week to allow them to maintain clinical skills. The Faculty Center for Teaching Excellence (FCTE) provides several workshops to help innovate and inform faculty of professional development opportunities. Further, ISU currently provides two tenure track positions to the PA program which allows for PA faculty participation in upper administrative roles and committees. Indiana State University workload policy 310.1.1 outlines the usual teaching expectations for faculty across all ranks, https://www.indstate.edu/policy-library/faculty-duties-and-responsibilities and ISU maintains a per-semester credit hour limit, stating that teaching assignments shall not exceed 16 credit hours per semester, or 12 credit hours in the summer, except under exceptional circumstances, with the mutual agreement of the faculty member and dean. The credit hours taught by each faculty member remain within ISU's normal teaching load and do not exceed ISU's per semester credit hour limit. In 2017, Provost Mike Licari approved workload practices for the PA program and Chair of Applied Medicine and Rehabilitation to better align with the administrative and teaching needs of the program (Appendix 15). All ISU PA program faculty have a twelve-month appointment, which specifies that the department chair will assign the specific teaching load.

When faculty are on leave, ISU complies with federal regulations regarding paid (https://www.indstate.edu/policy-library/sabbatical-leaves) and unpaid leave (https://www.indstate.edu/policy-library/leave-policies). In the case where a faculty or staff member is on unpaid leave, the University uses the salary from that position to hire part-time or full-time replacements. When a faculty or staff member is on paid leave the University uses funds kept aside to hire part-time or full-time replacements. During Mr. Bailey's absence and in collaboration with the PA program we have employed guest speakers and affiliate faculty to manage short-term student learning needs. All guest speakers are evaluated to ensure they meet our students' expectations. A summary of guest speaker evaluation is included (Appendix 16).

The PA program defines faculty sufficiency as "the deployment of faculty sufficient to ensure quality outcomes across the range of courses it offers and to achieve other components of its mission." The PA program currently has five full-time principal faculty, not including the Program Director, and one adjunct faculty. The faculty and their instructional obligations as listed (Appendix 17). Quality outcomes include the percentage of principal faculty delivering didactic instruction, maintaining an SFR comparable to the national average, student satisfaction measured through Exit Survey, Alumni Survey, and student performance including successful graduation from the program and successful PANCE performance. These outcomes substantiate the ISU PA program's definition of faculty sufficiency.

SFR Compared to National Average.
ISU's PA program calculated our student-faculty-ratio (SFR) using the method outlined by PAEA in their program report 35 (Physician Assistant Education Association, By the Numbers: Program Report 35: Data from the 2020 Program Survey, Washington, DC: PAEA: 2020), whereby SFR was calculated by dividing the program's total number of enrolled students by the full-time faculty headcount. Using this method, ISU's PA SFR is currently 18 (90:5). With the addition of a new principal faculty line the anticipated SFR for the next matriculating class will be reduced to 15 (90:6).

As of 2019, the median student-to-faculty ratio for all PA programs in the United States is 13.4 with a 5.0 standard deviation and for the Midwest east north central division it is 12.7 with a SD of 4.5 (Physician Assistant Education Association, By the Numbers: Program Report 35: Data from the 2020 Program Survey, Washington, DC: PAEA: 2020). ISU's PA program is within 1 standard deviation of these averages. With the addition of a new principal faculty line, ISU SFR will be closer to the national median. ISU's PA program will continue to analyze faculty sufficiency and work to retain enough principal faculty to maintain a comparable ratio.

Exit Surveys by Graduating Students.
Faculty Sufficiency is further evaluated through the analysis of exit surveys administered to students graduating from the PA program. This survey asks students to rate aspects of the program, including the effectiveness of faculty to meet the PA student's needs. For the past three cohorts (CO2019 - CO2022) ISU's PA program has exceeded the benchmark of 4.0 (Appendix 18). To improve our analysis of faculty sufficiency, our exit survey is currently being modified to include a question that specifically asks the students to rate the number of faculty and staff to meet the student's needs for their PA education on a Likert scale from 1=very ineffective to 5=very effective. This updated survey is found in Appendix 19, PA Student Exit Survey 2024, and will be deployed to the class of 2024.

Alumni Surveys.
ISU's PA program also analyzes data completed by our Alumni each year in the fall. It is analyzed by the Assessment and Data Analyst along with the program faculty. Alumni are asked questions about the quality of our faculty in preparation and their overall satisfaction with our program. We ask alumni to rank on a scale from 1 – 5 (1 = very dissatisfied and 5 = very satisfied) their overall satisfaction with our program. We set our benchmark for this survey at 3 indicating they weren't dissatisfied with our program, and scores above 3 indicated positive satisfaction. Alumni have been consistently satisfied with our program since 2013 (Appendix 20). We also ask alumni to rate the quality of their experience in our program (Appendix 21). In all years, except for 2017, alumni have indicated they have either had a good or very good experience in the program, including good faculty/staff interactions. Finally, we asked our alumni whether they would recommend ISU's PA program to others (Appendix 22). Here, the results for the past four years alumni responses were positive with only minor reservations.

Graduation Rates.
According to the PAEA Annual Report (Physician Assistant Education Association, By the Numbers: Program Report 35: Data from the 2020 Program Survey, Washington, DC: PAEA: 2020), the national average for graduation rates is 93.6%. The ISU PA program graduation rate is at or above 93.6%.

PANCE Report.
ISU strives to maintain a PANCE pass rate above the 85% benchmark pass rate set by ARC-PA. According to the PANCE analysis from NCCPA, the 2023 first-time takers from all programs pass rate was 92%. The ISU pass rate for first-time takers in 2023 was 93% (Appendix 23). While this is only one data point in our analysis, ISU's PA students' success rate in graduating from our program and completing their PANCE on their first attempt, supports ISU's PA faculties' ability to successfully graduate their students successfully and prepare them for their PANCE Board exams.

Plans for Improvement.
Given the uncertainty around the timing of Mr. Bailey's return and after consultation with PA program faculty and staff, the Chair of Applied Medicine and Rehab (AMR), the Dean of the College of Health and

Human Service (CHHS), the Provost and Vice President for Academic Affairs have allocated one new full-time principal faculty line to the PA program and we have begun the search (https://jobs.indstate.edu/postings/46857) and has posted this to HigherEdJobs.com. This line is in addition to the part-time guest speakers that ISU employs to support teaching and learning. To determine the need for adding one full-time faculty we considered four factors. First, the allocation of an additional line provides a more reasonable workload for the Program Director, Didactic Coordinator, and Clinical Coordinator to conduct their administrative duties. Second, it brings ISU's SFR closer to the national average as determined by PAEA. Third, it reduces the amount of administrative duties ISU PA faculty conduct, such as student advising, recruitment and admissions, and curriculum committees. Adding one principal faculty has the potential to improve the retention of faculty and their ability to support student learning and continue to demonstrate excellent program outcomes.

With the addition of a new faculty line, the program director position will transition to teaching only 1 credit hour per year and otherwise focus on administrative duties. Workload calculations with the additional faculty line created by ISU specifies the principal and instructional faculty, the nature of their appointment, and their current workload (Appendix 24).

Further, the PA Program has created and approved a Faculty Feedback Survey and Staff Feedback Survey regarding their perceived workload, challenges, and suggestions for improvement. These are included in (Appendix 25) and will be distributed each year with an annual review for ongoing assessment of faculty and staff sufficiency. Finally, our student exit survey has been edited to include a question to address institutional support regarding the sufficiency of faculty and staff. This revision will be deployed to the class of 2024 and is available in Appendix 26. These assessments will be circulated to the Department Chair, Dean of the CHHS, and the Director of Assessment and Program Effectiveness as part of the annual review of standards.

***STANDARDS* CLARIFICATION**

The commission made clarifying changes to the *Standards,* 5th edition, at its March and September 2023 meetings. This included changes to A1.11a-d. The latest version of the *Standards* is available on the ARC-PA website.

In response to citations received following accreditation reviews, programs will address standards A1.11a-d as they are currently clarified.

Previous version:

Standard A1.11 The sponsoring institution *must* demonstrate its commitment to student, faculty and staff *diversity,* and *inclusion* by:

a) supporting the program in defining its goal(s) for *diversity,* and *inclusion*,
b) supporting the program in implementing recruitment strategies,
c) supporting the program in implementing retention strategies, and
d) making available, resources which promote *diversity,* and *inclusion*.

9.2023 Clarified Standard:

Standard A1.11 The sponsoring institution *must,* in a manner consistent with its own mission and applicable laws demonstrate a commitment to student, faculty and staff *diversity, equity,* and *inclusion* by:

a) supporting the program in having a documented action plan for *diversity, equity* and *inclusion*,
b) supporting the program in implementing recruitment strategies,
c) supporting the program in implementing retention strategies, and
d) making available, resources which promote *diversity, equity* and *inclusion*.

The March 2023 clarification includes the addition of the term "equity" to the stem of the standard and to sub standards a and d and the inclusion of a definition of equity in the Standards glossary. Diversity affords appreciation for the many ways people differ. Inclusion provides a sense of belonging through active engagement. Equity allows for the allocation of personalized support and resources required for success. The September 2023 clarification adjusts the requirement for substandard A1.11a. The program does not need to have identified "goals," but the institution must support the program in documenting an action plan that addresses diversity, equity, and inclusion for all 3 groups: students, faculty, and staff. This could be one plan that addresses all three groups or three different plans (or some combination). The same concept applies to sub standards A1.11b and A1.11c for recruitment and retention strategies. Strategies must address all three groups (students, faculty, and staff).

5. **Standard** A1.11a The sponsoring institution *must* demonstrate its commitment to student, faculty and staff *diversity, equity,* and *inclusion* by:

    a) supporting the program in defining its goal(s) for *diversity, equity* and *inclusion,*

    Findings: The sponsoring institution did not demonstrate its commitment to supporting the program in defining its goals for faculty and staff diversity, equity, and inclusion.

    Comments: At the site visit, institutional officials verified they were aware of the ARC-PA *Standards* but could not describe program-defined goals toward diversity, equity, and inclusion. Institutional officials stated it would support program goals related to diversity, equity, and inclusion but had not required the program to put these goals in place. In addition, the program did not articulate why it had not implemented goals for diversity, equity, and inclusion.

    In its response, the program stated that the sponsoring institution supports the program goals for diversity, equity, and inclusion because it agreed with the core values of the university. The response also reiterated that the provost stated programs were not required nor prohibited from establishing DEI goals.

    Required Report: The ARC-PA reminds the program that the commission made clarifying changes to Standard A1.11a, 5th edition, at its September 2023 meeting as described above. This required report addresses the clarified A1.11a Standard.

    Provide a succinct narrative below indicating how the institution has demonstrated its support of the program in developing a written action plan for diversity, equity, and inclusion of students, faculty, and staff.

    Append the program action plan for diversity, equity, and inclusion that addresses students, faculty, and staff.

Indiana State University embodies our commitment to diversity, equity, inclusion, and belonging. ISU's strategic plan, "Focusing on Our Future Together" (https://www.indstate.edu/sites/default/files/media/president/pdfs/strategic-plan-as-of-april-19-3.15-p.m.pdf) was created to strategically advance our commitment to equity and inclusive excellence. This action plan outlines the University-wide plan for establishing and analyzing DEI goals regarding student success, faculty and staff recruitment, and retention. In addition, ISU's Office of Diversity, Inclusion, and Belonging (DIB) (https://www.indstate.edu/inclusive-excellence) was established to support our goal of becoming an inclusive-excellent campus. The Director of the Office of Diversity, Inclusion, and Belonging, Dr. Xavia Burton has helped ISU create a program-level action plan, called the Advancing Inclusive Excellence (https://www.indstate.edu/sites/default/files/media/aie-action-plan-update.pdf) to serve as a guide to help programs fulfill important goals that will be included in the University's strategic plan. While programs may use the DEI goals outlined in this action plan, the Office of DIB and Dr. Burton are charged with supporting faculty and staff to establish their own DEI goals and collaborate to develop an action plan.

Plan for Improvement.
To meet the standard for diversity, equity, and inclusion, the ISU PA program worked strategically with Dr. Xavia Burton, Executive Director for the Office of Diversity, Inclusion, and Belonging to develop a program-specific action plan for diversity, equity, and inclusion for students, faculty, and staff (Appendix 27). With counsel from Dr. Burton, the ISU PA program established its program-specific DEI action plan (Appendix 28). The DEI action plan was evaluated, refined, and approved by the PA Committee (PAC) on 12.14.23 (Appendix 29) and can be found in the appendix folder (Appendix 30).

6. **Standard** A2.01 All *program faculty must* possess the educational and experiential qualifications to perform their assigned duties.

   Findings: All program faculty did not possess the educational qualifications to perform assigned duties.

   Comments: All program principal faculty did not possess the required educational and experiential qualifications to perform their assigned duties as described in the principal faculty job description. The job descriptions, in the application's appendix 4 and reviewed at the time of the site visit, listed the educational qualifications for the clinical coordinator (Edmondson) as a master's degree, current NCCPA certification, and Indiana PA Licensure. In the application and at the time of the site visit, the clinical coordinator (Edmondson) was an advanced practice nurse and did not meet the principal faculty qualifications on the program's job description. The program stated it determined Edmondson was qualified based on the equivalency of her education to that of a PA and was licensed and certified, and had the skills needed by the program. However, the program did not provide documentation of how it determined she was qualified to perform her assigned duties.

   In its response, the program acknowledged the error of providing the wrong job description for the clinical coordinator and attached the job description that was used for the job posting. The posting showed the qualifications were a master's degree and health care experience with education preferred in allied health, business, communications, administration, or marketing. In addition, the program provided the ad for the clinical coordinator position which did include

qualifications for the position, but these qualifications were not reflected in the job description which was not included in the response. The program did not provide evidence of how Edmondson met the education qualifications provided in the ad.

Required Report: Append the job description for the clinical coordinator that includes the educational and experiential qualifications required to perform their assigned duties and the current CV for the clinical coordinator.

Please see the current job description (Appendix 31) and CV for Dr. Edmondson (Appendix 32).

Plan for Improvement. The program will review all future position's job descriptions to ensure they accurately reflect the position and the required qualifications. The program will work with ISU Human Resources to ensure that any new positions list the required qualifications for the position and that faculty and staff meet those requirements.

7. **Standard** A2.03 *Principal faculty must* be *sufficient* in number to meet the academic needs of enrolled students and manage the administrative responsibilities consistent with the complexity of the program.

   Findings: The program did not have sufficient principal faculty to meet the academic and administrative needs of the program.

   Comments: Principal faculty were not sufficient in number to meet the academic needs of enrolled students and manage the administrative responsibilities consistent with the complexity of the program. In the application, the program stated it utilized six full-time faculty members. However, this included the program director, who by ARC-PA definition is not considered principal faculty. The program director stated that the principal faculty was sufficient in number except when any principal faculty were on leave. During the site visit, one principal faculty (1.0 FTE) was on administrative leave. There was no timeframe given for when that principal faculty member would return to work. The program director and institutional officials stated that the work was covered by the remaining principal faculty, program director, and instructional faculty. Although the program director stated that this individual was “doing some work at home”, the conditions of the leave prevented this individual from completing a significant portion of their job duties.

   In its response, the program stated that the program director was not included in the calculation for student-to-faculty ratios. The narrative stated that at the time of the site visit the program consisted of the program director and four principal faculty with one principal faculty on administrative leave. The program also stated the faculty member on administrative leave “was a new situation and therefore was not included in the initial application.” The narrative explained that the principal faculty on administrative leave was still working on lecture preparation and admissions review. The program also noted that the program director and three didactic faculty taught most of the curriculum. Despite these assurances, the program had insufficient faculty at the time of the site visit as defined by its own calculation for faculty sufficiency.

Required Report: Provide a succinct narrative below indicating how the institution will resolve the citation and assure compliance with this *standard* in the future. Provide evidence that principal faculty as defined by ARC-PA are sufficient to meet the academic needs of enrolled students and manage the administrative responsibilities consistent with the complexity of the program.

Indiana State University is committed to maintaining sufficient faculty and staff to meet the high-quality outcomes of our Physician Assistant Program. Several methods are used to determine faculty sufficiency and are discussed in ISU's response to citation 4.

ARC-PA Standards for Faculty Sufficiency. ISU utilizes multiple methods when determining faculty sufficiency for our PA program. First, our PA program refers to the ARC-PA requirements for qualified faculty sufficiency. Standard A2.02 requires an accredited program to have a). an NCCPA-certified program director, at least two NCCPA-certified principal faculty, a medical director, and instructional faculty, and at least three FTE principal faculty, of which two FTE principal faculty must be PAs who are currently NCCPA-certified. ISU continually ensures our PA program not only meets but exceeds these criteria. Currently, our program includes 1 medical director, Dr. George Bittar, 1.0 program director, Doug Stevens, PA-C, and 5.0 FTE faculty for a class of 90 students, which includes 30 didactic students, 30 students at clinical sites, and 30 students in the pre/post clinical phases (Appendix 33). These faculty members account for a majority of didactic instruction, with well-qualified guest lecturers and adjunct faculty supplementing the rest.

Concerning the allocation of resources when faculty are on leave, ISU complies with federal regulations regarding paid (https://www.indstate.edu/policy-library/sabbatical-leaves) and unpaid leave (https://www.indstate.edu/policy-library/leave-policies). As discussed in the narrative for citation 4, in the case where a faculty or staff member is on unpaid leave, the University uses the salary from that position to hire part-time or full-time replacements. When a faculty or staff member is on paid leave the University uses funds kept aside to hire part-time or full-time replacements. During Mr. Bailey's absence and in collaboration with the PA program we have utilized qualified guest speakers to manage short-term student learning needs.

PA Faculty Remain Within ISU's Normal Teaching Loads. ISU provides institutional guidelines for determining faculty instructional obligations which are described in their University workload policy 310.1.1, (https://www.indstate.edu/policy-library/faculty-duties-and-responsibilities). As noted on the website and in our response to citation 4, the institutional policy defines a normal teaching load for tenure-track is 12 semester credit hours of coursework per semester or 24 semester credit hours per academic year, while the normal teaching load for instructors is 15 semester credit hours of work per semester or 30 semester credit hours per academic year. An academic year from an accredited educational university, such as ISU, is usually defined as occurring from September to June. In addition, ISU establishes limits to per semester credit hours teaching assignments, whereby teaching assignments shall not exceed 16 semester credit hours per semester or 12 semester credit hours in the summer, except under exceptional circumstances with the mutual agreement of the faculty member and the dean.

As demonstrated in Appendix 33 the PA faculty instructional load remains well within ISU's policy for normal teaching loads for each semester. Currently, faculty with administrative appointments such as program director, clinical, and didactic coordinators receive 50% workload allocation for those roles, plus a stipend. ISU employs adjunct faculty and guest speakers who have been an integral part of our

program since its inception in 2010. Even with their supplementary contributions to instruction, however, most of the program course offerings are overseen by full-time principal faculty. ISU's PA program continually analyzes several factors of the program to ensure faculty sufficiency, including the percentage of principal faculty delivering didactic instruction, comparisons to the national average, exit surveys of graduating students and alumni, along with graduation rates and PANCE pass rates.
As described in our response to Citation 4, ISU's PA faculty are currently within 1 Standard Deviation of the national median as calculated by PAEA (Physician Assistant Education Association, By the Numbers: Program Report 35: Data from the 2020 Program Survey, Washington, DC: PAEA: 2020). With our program director and two of our faculty members being relatively new to PA education and to the ARC-PA accreditation process, and because of the uncertainty around when Mr. Bailey will return from leave, the Provost and Vice President have allocated one new full-time principal faculty line to the PA program and we have begun the search. This line will bring the number of principal faculty to six and we will continue to employ part-time and guest speakers to support teaching and learning. To determine the need for adding one full-time faculty we considered four factors. First, the allocation of an additional line provides a more reasonable workload for the Program Director, Didactic Coordinator, and Clinical Coordinator to conduct their administrative duties. Second, it brings ISU's SFR closer to the national average as determined by PAEA. Third, it reduces the amount of administrative duties ISU PA faculty conduct, such as student advising, recruitment and admissions, and curriculum committees. This strategic investment will relieve the program director of most instructional duties, so he/she can focus on their administrative responsibilities for effective program management. This investment also redistributes the administrative duties of PA faculty, dividing the duties of recruitment, admissions, and student advising among the 6 remaining members, instead of 5.

ISU Maintains an SFR Comparable to the National Average.
As mentioned above and in response to citation 4, the mean student-to-faculty ratio (SFR) for all PA programs in the United States is 13.4 with a 5.0 standard deviation (Physician Assistant Education Association, By the Numbers: Program Report 36: Data from the 2020 Program Survey, Washington, DC: PAEA: 2020). ISU's PA program is currently within 1 standard deviation of the national median with a SFR of 18 (90:5). As mentioned in citation 4, ISU is committed to ensuring we maintain enough faculty to meet our obligations to current, matriculated, and prospective PA students.

After careful analysis of current ISU faculty sufficiency and prospective ISU sufficiency, ISU has approved funding to open a new line, which will add a new faculty position, raising the number of 1.0 FTE faculty to 6. This addition will decrease our SFR from 18 to 15 (90:6), which is very near the national median. ISU anticipates the added line will have multiple positive downstream effects. It will reallocate instructional hours previously carried out by our program director, and clinical and didactic coordinators, so they can now be more focused on their administrative duties to the program. Furthermore, it adds one additional faculty member to help cover the administrative responsibilities of our faculty, such as recruitment, admissions, advising, and maintaining ARC-PA accreditation.

Exit Surveys by Graduating Students.
Faculty Sufficiency is further evaluated through the analysis of exit surveys administered to students graduating from the PA program. This survey asks students to rate several aspects of the program, including our program's effectiveness in meeting our Program Goals. In this survey, our PA program has established a benchmark of 4.0/5.0 on a Likert scale because it indicates that most ISU PA students agreed that ISU's system was successful in helping students achieve their program goals. Our program has consistently been successful in meeting our benchmarks since 2019 (Appendix 18).

We also analyze students' opinions of our faculty's effectiveness in providing them with a high-quality learning experience. Appendix 34 displays the results of exit surveys given to graduating students. A benchmark of 4.0 was chosen because it indicates that students found our is providing our students with a positive PA experience. Faculty effectiveness and advising meet our benchmark every year, since 2019. Students indicate two areas of improvement including clinical rotation placement and clinical sites, whereby students rated their ISU PA experience as neither effective nor ineffective. We have taken action to make more clinical sites available to students, including advertising and increasing preceptor pay in areas that are challenging to find preceptors. In addition, ISU employs two staff members who support our Clinical Coordinator during our students' clinical phase. To improve our analysis of faculty sufficiency, our exit survey is currently being edited to include a question that specifically asks the students to rate the number of faculty and staff to meet the student's needs for their PA education. This updated survey is found in Appendix 26, Citation 4, PA Student Exit Survey 2024, and will be deployed to the class of 2024.

Alumni Surveys.
ISU's PA program also analyzes data completed by our Alumni each year. Alumni are asked questions about the quality of our faculty in preparation and their overall satisfaction with our program. We ask alumni to rank on a scale from 1 – 5 (1 = very dissatisfied and 5 = very satisfied) their overall satisfaction with our program. We set our benchmark for this survey at 3 indicating they weren't dissatisfied with our program, and any score above 3 indicated positive satisfaction. As can be seen in Appendix 20, Citation 4, alumni have been consistently satisfied with our program since 2013. In Appendix 21, Citation 4 we evaluate our PA Alumni overall satisfaction of our program. Here, we note that students from each cohort were overall satisfied with the PA experience provided by our faculty.

We also ask alumni to rate the quality of their experience in our program. The results and analysis of this data can be seen in (Appendix 35). In all years, except for 2017, alumni have indicated they have either had a good or very good experience in the program, including good faculty/staff interactions. Finally, we asked our alumni whether they would recommend ISU's PA program to others. These results are shown in Appendix 36. Here, the results for the past four years alumni responses were positive with only minor reservations.

Graduation Rates.
ISU's PA program maintains a goal of maintaining a graduation rate above the national average. Achievement of this goal requires maintaining enough qualified faculty and staff to graduate students successfully and provide them with a positive PA experience. According to the PAEA Annual Report (Physician Assistant Education Association, By the Numbers: Program Report 35: Data from the 2020 Program Survey, Washington, DC: PAEA: 2020), the national average for graduation rates is 93.6%. Based on program history, ISU's PA graduation rate is 95%, which is above the 93.6% national average.

PANCE Report.
ISU strives to maintain a PANCE pass rate above the 85% benchmark pass rate set by ARC-PA. According to the PANCE analysis from NCCPA, the 2023 first-time takers from all programs pass rate was 92%. (Appendix 23, Citation 4). The ISU pass rate for first-time takers in 2023 was 93%. While this is only one data point in our analysis, ISU's PA students' success rate in graduating from our program and completing their PANCE on their first attempt, supports ISU's PA faculties' ability to successfully graduate their students successfully and prepare them for their PANCE Board exams.

Plan for Improvement.

Given the uncertainty around the timing of Mr. Bailey's return and after consultation with PA program faculty and staff, the Chair of Applied Medicine and Rehab (AMR), the Dean of the College of Health and Human Services (CHHS), the Provost and Vice President for Academic Affairs have allocated one new full-time principal faculty line to the PA program and we have begun the search. This line is in addition to the part-time guest speakers that ISU employs to support teaching and learning. To determine the need for adding one full-time faculty we considered four factors. First, the allocation of an additional line provides a more reasonable workload for the Program Director, Didactic Coordinator, and Clinical Coordinator to conduct their administrative duties. Second, it brings ISU's SFR closer to the national average as determined by PAEA. Third, it reduces the amount of administrative duties ISU PA faculty conduct, such as student advising, recruitment and admissions, and curriculum committees. Adding one principal faculty has the potential to improve the retention of faculty and their ability to support student learning, participate in a weekly clinical day to maintain their practice skills, and continue to demonstrate excellent program outcomes.

With the addition of a new faculty line, the program director position will transition to teaching only 1 credit hour per year and otherwise focus on administrative duties. Appendix 24, Citation 4 specifies the principal and instructional faculty, the nature of their appointment, and their current workload as well as calculations with the newly approved principal faculty line.

Further, the PA Program has created and approved a Faculty Feedback Survey and Staff Feedback Survey regarding their perceived workload, challenges, and suggestions for improvement (Appendix 25, Citation 4). These will be distributed yearly with an annual review for ongoing assessment of faculty and staff sufficiency. Finally, our student exit survey has been edited to include a question to address institutional support regarding the sufficiency of faculty and staff. This revision will be deployed to the class of 2024 (Appendix 26, Citation 4). These assessments will be circulated to the Department Chair, Dean of the CHHS, and the Director of Assessment and Program Effectiveness as part of the annual review of standards.

8. **Standard** A2.09d The program director *must* be knowledgeable about and responsible for:

   d) continuous programmatic review and *analysis,*

   Findings: The program director did not demonstrate knowledge of the program's continuous review and analysis.

   Comments: The program director was not knowledgeable about and responsible for continuous programmatic review and analysis. The program director did not demonstrate the requisite knowledge of continuous programmatic review and analysis as noted by the provision of the self-study report (SSR) that did not accurately and succinctly document the process and results of ongoing program self-assessment. Despite feedback provided by the ARC-PA in the March 2017 mSSR, the most recently submitted SSR failed to provide consistent evidence of the program's process of analysis, reaching conclusions including identifying strengths and areas needing improvement. The analysis was not consistent within the submitted SSR and was not clearly articulated at the time of the site visit, specifically in relation to the identification of program strengths. In addition, the program did not articulate the reason(s) for incomplete or missing data for multiple aspects of the program, which was inconsistent with the described program's self-assessment plan.

In its response, the program referred to the assessment calendar that was provided on-site and appended with the response. At the site visit, the narrative explained that the program was asked for exit survey results from the cohort of 2023 at which time the program stated that it analyzed this data in June (per the assessment calendar). The analysis was not available at the time of the site visit.

Required Report: Provide a succinct narrative response below indicating how the program and institution will resolve the citation and assure compliance with this *standard* in the future.

In preparing the accreditation application, the program director and principal faculty followed the Accreditation Manual, for Accreditation Standards for Physician Assistant Education, 5th edition (Accred manual (arc-pa.org))as a guide for preparing the continuing accreditation application. The ISU PA program has clear guidelines for the analysis of and uses established benchmarks (Appendix 37) as a threshold for indicating strengths and areas for improvement. ISU has an experienced data analyst, Dr. Gloria Rogers, who is a Higher Learning Commission Senior Scholar Emerita and international expert on assessment, to oversee the development of instruments, data collection, aggregation of results, and reporting to faculty. The Data Analyst works closely with the program director and faculty to ensure the administration of the program's comprehensive assessment plan and to continuously evaluate and report areas where benchmarks are being met and areas where they need improvement. The high quality of this process was recognized by the University when the PA program received the Provost's Award for Excellence in Student Learning Assessment and Improvement in 2022.

Upon careful review of citation #8, feedback provided by the ARC-PA in the 2017 mSSR (Appendix 38), and the stand-alone Data Analysis and Self Study Report (https://www.arc-pa.org/wp-content/uploads/2020/07/Data-Analysis-Resource-for-Programs-February-2020.pdf), the ISU PA program is implementing the following actions to ensure that the program director is knowledgeable and responsible for continuous review and analysis.

Plan for Improvement.
ISU will continue to provide time and funding for the Program Director to attend PAEA and ARC-PA training/workshops dedicated to accreditation and program review yearly. The Program Director participated in the PAEA Assessment Virtual Retreat Workshop on December 13, 2023 (Appendix 14, Citation 2). This collaborative experience allowed the director to hear what other programs were doing to address and understand the assessment process. ISU has provided funding for the Program Director and one other principal faculty to attend the ARC-PA Accreditation and You Workshop on January 18-19, 2024, to support the Program Director to improve his competencies in the PA accreditation process, including continuous and consistent analysis of collected data.

Furthermore, ISU PA faculty will follow the Data Analysis Resource provided by the ARC-PA (https://www.arc-pa.org/wp-content/uploads/2020/07/Data-Analysis-Resource-for-Programs-February-2020.pdf). Faculty will continue to collect data, analyze it and make changes based on the data. An example of a meeting's log in included (Appendix 39).

Lastly, the ISU Director of Assessment and Program Effectiveness offers regular workshops and coaching sessions for faculty engaged in program assessment and the Program Director will take advantage of these.

The Data Analyst, Dr. Gloria Rogers will provide continuing education and support for the Program Director and faculty on the analysis of assessment data and to link the analysis with conclusions, and action plans in The Action Narratives. The ISU PA program faculty and staff are reviewing the established assessment calendar, the data it contains, and how to interpret information gleaned from the published assessment calendar. Training and clear communication of data collection and analytical procedures to all faculty members will help ensure consistency and completeness in data collection and analysis of our program's self-assessment plan.

Finally, the Data Analyst will verify that the analyses published in the SSR are in accordance with the Data Analysis Resource published on the ARC-PA website. Other analyses, such as trends over time, thematic analysis of qualitative data and correlational analysis will continue to be conducted as potential areas for demonstrating the program's strengths, or areas in need of improvement.

9. **Standard** A2.09g The program director *must* be knowledgeable about and responsible for:

    g) completion of ARC-PA required documents,

    Findings: The program director was not knowledgeable about and responsible for the completion of ARC-PA required documents.

    Comments: The program application was submitted with multiple incomplete and inaccurate documents (see Citation #33 (E1.03) below for further details). Upon contact by ARC-PA staff, the program did provide the correct documentation apart from the NCCPA PANCE Exam Performance Summary Report Last 5 Years which was submitted on the second attempt.

    The site visit team commented that it was necessary to repeatedly request additional information including items identified in the Application of Record List of Documents that must be readily available for site visitors at the time of the site visit. In addition, the Program Data Sheet in Appendix 1a was inaccurate, the program website was missing items such as technical standards and admissions preferences, and course syllabi were disorganized and incomplete.

    In the program's response, the program responded by saying that the Indiana State University PA program does not require technical standards, therefore there was nothing posted on the website. The program also noted that it utilized university-provided syllabi templates, which were provided in Appendix 17 and contained "learning objectives" in each syllabus. The program's response did not address the program director's lack of responsibility in completing documents to demonstrate compliance with ARC-PA accreditation standards.

    Required Report: Provide a succinct narrative indicating how the program and institution will resolve the citation and assure future compliance.

Indiana State University (ISU) and our Physician Assistant program understand that the program director must be knowledgeable about and responsible for the completion of ARC-PA required documents to satisfy Standard A2.09g.

Plans for Improvement. To improve documentation of compliance with ARC-PA accreditation standards, the program director and institution will or have:

1. Build in time for the Physician Assistant Committee (PAC) "group review" of all report/s requirements to ensure the director as well as faculty understand what forms to utilize, and to ensure that any ARC-PA requirements for special editing/formatting are understood and addressed.

2. Collaborate with the CHHS Dean's Office in developing a document tracking system located in the ISU Microsoft SharePoint application. This system provides a cloud-based collaborative document development space and archive that will improve recordkeeping and access to assessment processes and documentation.

3. Since our accreditation site visit, the program director has reviewed all of the ARC-PA portal training videos on how to prepare the annual report. Further, our current PD and an additional principal faculty attended the ARC-PA Accreditation and You workshop on January 18-19, 2024. Indiana State University has provided funding to cover the $1800 fee along with airline and lodging costs, and release time to allow this training.

4. Implementation of a new annual report to the department chair and the dean of the college for communicating any areas of potential or actual non-compliance with standards for the purpose of improvement.

10. **Standard** A2.09h The program director *must* be knowledgeable about and responsible for:

    h) adherence to the *Standards* and ARC-PA policies.

    Findings: The program director did not demonstrate responsibility for adherence to the *Standards* and ARC-PA policies.

    Comments: At the time of the site visit, the program director did not demonstrate understanding and responsibility to adhere to the *Standards.* This was evidenced by the number and broad nature of areas of non-compliance with the *Standards* found at the site visit.

    The program did not respond to the observation.

    Required Report: Provide a succinct narrative indicating how the program and institution will resolve the citation and assure future compliance.

Indiana State University (ISU) and the Physician Assistant program understand that the program director must be knowledgeable about and responsible for adherence to ARC-PA policies to satisfy Standard A2.09h. In evidence of the Program Director's commitment to and responsibility for adhering to standards, the Program Director attended the PAEA "New Program Directors Jump Start Workshop" in the spring of 2021 funded by program fees. The program director also communicates directly with ARC-PA staff with questions about policies and procedures whenever there is a need for clarification or assistance. Therefore, ISU is committed to immediately resolving this issue and taking corrective actions, to ensure future compliance through the following actions.

Plan for Improvement. ISU has paid for ISU's PA program director and one principal faculty to attend the ARC-PA Accreditation and You Workshop on January 18-19, 2024. These sessions will help ensure our

program director is familiar with the accreditation application, data collection, and analysis for the self-study report, and learn how to remain compliant with Standards that are often cited during a site visit. The Program Director is committed to carefully reviewing all ARC-PA correspondence, including the newsletters from ARC-PA that guide ARC-PA policies. The Program Director will also continue to attend annual PAEA meetings and sessions offered by ARC-PA about accreditation activities.

The Program Director will be evaluated annually by the Program Chair and Dean to ensure that the program remains in compliance with ARC-PA Standards. Evaluations will include an evaluation of the SSR and comments made by ARC-PA site visit teams. Part of the evaluation will be focused on staying in compliance with ARC-PA standards, and how timely and accurately the program director can resolve any areas of non-compliance.

ISU has made available funding to hire an expert consultant who is well-experienced in ARC-PA Standards. This person has provided invaluable insight and perspective from an accreditor's lens. Moving forward, we will continue to use external consultants to review ISU's PA application prior to submitting it for approval.

11. **Standard** A3.12b The program *must* define, publish and make *readily available* to enrolled and *prospective students* general program information to include:

    b) evidence of its *effectiveness* in meeting its goals,

    Findings: The program did not define evidence of its effectiveness in meeting its goals.

    Comments: The commission added this citation. The program published five goals on its website https://www.indstate.edu/health/program/pa/info#goal but did not provide evidence of its effectiveness in meeting all these goals. The program did not provide any benchmarks to allow the prospective students to understand the program's effectiveness in meeting any of its goals. In addition, the data provided on the website was from the Class of 2020 and was not updated to include the program's most recent outcomes.

    Required Report: Provide a brief, succinct narrative clarifying the current program goals. Submit evidence that all program goals have a defined benchmark in which to measure effectiveness and are accurately defined, published, and made readily available to enrolled and prospective students on the program's website. Provide the URL where this information is published on the website along with updated data that demonstrates effectiveness in meeting its goals.

The current program goals are listed on our website along with survey data from exiting students and alumni that demonstrates effectiveness in meeting each goal, (https://www.indstate.edu/health/program/pa/info#goals). The PA program faculty have set these goals and have defined benchmarks using the Alumni survey and Exit survey.

The exit survey is given every year to students who are completing the program. They are asked to respond to the question, "Based on your experiences in the ISU-PA Program, indicate your level of agreement that you are prepared to be successful in each of the following areas:" They respond on a 5-point scale, "1-Strongly disagree; 2-Disagree; 3-Neither agree nor disagree; 4-Agree; 5-Strongly agree."

The faculty have identified "Agree" (4 on a scale of 1-5) as the benchmark for the minimum response average for each of the program goals. For the past five years, the benchmark has been exceeded on all program goals (Appendix 40)

The alumni survey is given to a cohort of graduates who have been practicing in the profession for two years. This means that the assessment given in 2022 will reflect the responses of the ISU Cohort of 2020 alumni. These practicing professionals are asked to provide feedback on the program's achievement of its goals by responding to the question, "How would you rate the quality of the preparation you received from ISU in each of these (goal) areas?" They respond on a 5-point scale, 1- Poor; 2- Fair; 3- Good; 4- Very Good; 5-Excellent. The faculty have identified the average between "Good" and "Very Good" (3.5 on a scale of 1-5) as the benchmark for the minimum response average for each of the program goals. For the past three years, all responses, except two, have met or exceeded the benchmark for each goal. (Appendix 40). Faculty review results against benchmarks after each administration including 5-year trend data to determine need for action.

Previously, our program has reported on our website the percentage of respondents replying agree/strongly agree and good/very good/excellent average on the 1-5 scale data, without including established benchmarks to demonstrate our effectiveness in meeting our PA program's established goals. ISU has corrected this and now displays benchmarks on our website that are readily available to current and prospective students. Moving forward, ISU's PA program will ensure that benchmark values are well-defined and published on our website, so they are readily available to prospective students. ISU will continue to review and analyze their effectiveness at meeting our set benchmarks and publish this data annually so that it is readily available to prospective and enrolled students.

12. **Standard** A3.12g The program *must* define, publish and make *readily available* to enrolled and *prospective students* general program information to include:

    g) program required *competencies* for entry level practice, consistent with the competencies as defined by the PA profession,

    Findings: The program did not define, publish or make readily available to enrolled and prospective students the program required competencies for entry level practice.

    Comments: At the time of the site visit, the terms 'goals', 'competencies', and 'objectives' were used variably and inconsistently in documents such as the PA Student Handbook, Clinical Phase Manual, evaluation rubrics and Appendix 9. In Appendix 9, the program provided the "Physician Assistant Program Defined Competencies/Goals and Student Learning Outcomes Curriculum Map which was a table of the program's goals and how those goals were accomplished through each of the courses. This document did not include any of the program required competencies for entry-level practice. On the website in the Clinical Phase Manual (https://www.indstate.edu/health/program/pa/physician-assistant-clinical-phase-manual), p. 2 was a list of "Competencies: Clinical Year Competencies and Rotation Requirements" which were specific to the clinical curriculum and different than the goals included in Appendix 9. In addition, on p. 31 of the Clinical Phase Manual was another set of physician assistant competencies which were different than both the information in Appendix 9 and p. 2 of the Clinical Phase Manual. The multiple references to competencies with different items listed did not provide a clear identification of the program's defined competencies for entry level practice.

In addition, the summative evaluation rubric listed competencies that were related to each part of the exam and were consistent with those as defined by the PA profession but not the same competencies listed in the Clinical Phase Manual.

At the site visit, faculty explained the correct program competencies were those listed on pages 1 and 31 of the Clinical Phase Manual. The students stated that they were aware of the competencies needed for successful completion of each rotation, post-clinical phase, and graduation.

In its response, the program stated that meeting clinical competencies was required for students to advance to the summative semester. The program further stated that the summative evaluation competencies differed from clinical competencies as the summative evaluation does not occur in the clinical phase. However, the program did not publish and make readily available to enrolled and prospective students its program-required competencies as defined by the ARC-PA.

Required Report: Provide a succinct narrative that includes evidence that the program defines, publishes and makes readily available to enrolled and prospective students the program required *competencies* for entry level practice. Provide the URL(s) to the information if published online (including page number if within a document[s]) or append a copy of the information provided to prospective and enrolled students.

In response to citation 12 for Standard A3.12g, ISU's PA program has adopted standard competencies for the PA profession. The program has reviewed, evaluated, and ultimately adopted core competencies from NCCPA, ARC-PA, PAEA, and AAPA for the PA profession. The program has explicitly outlined the program's competencies in seven domains that capture the skills required throughout a PA's career. The selected competencies have been voted on and approved by the Physician Assistant Committee (PAC) on 12.14.2023. See item #4 in the meeting minutes (Appendix 41).

Current and prospective students can now find the published competencies on pages 6-8 in the student handbook found here (https://www.indstate.edu/health/program/pa/pa-student-handbook) and pages 29-32 in the clinical manual (https://www.indstate.edu/health/program/pa/physician-assistant-clinical-phase-manual). The competencies are also readily available by visiting https://www.indstate.edu/health/program/pa/info#accred.

This correction clarifies to enrolled and prospective students the competencies required for PA practice. The ISU PA's program competencies demonstrate the ISU PA's program's dedication to adhering to the ARC-PA accreditation standards.

13. **Standard** A3.13c The program *must* define, publish, consistently apply and make *readily available* to *prospective students,* policies and procedures to include:

    c) practices for awarding or granting *advanced placement,*

Findings: The program did not define, publish and make readily available to prospective students its policies and procedures for awarding or granting advanced placement.

Comments: In the application and reviewed at the site visit, the program website https://www.indstate.edu/health/program/pa/pa-admission-criteria stated that "Advanced placement credits may be accepted for prerequisite courses at the discretion of the PAC." The program did not include any other statement regarding advanced placement that would be available to prospective students. The program director stated that advanced placement was not offered for program courses; however, the website did not include any information about whether the program awarded or granted advanced placement.

The program did not respond to the observation.

Required Report: Provide the policies and procedures concerning awarding and granting advanced placement. Identify how these policies and procedures will be made readily available to prospective students. Provide the URL to the policy (and page number if on an online document).

The ISU PA program is designed to build medical knowledge and clinical experience in a stepwise fashion, across the curriculum to ensure that ISU PAs are sufficiently trained in both medical knowledge and clinical skills required to perform the required duties of a physician assistant. Therefore, Indiana State University's Physician Assistant program does not grant advanced placement under any circumstance. No transfer or credit from other medical/PA training programs or institutions will be accepted for the ISU PA program. All ISU PA courses must be completed in the order outlined in the student handbook. ISU's policy for advanced placement is available on our website on page 1 of our PA Admissions Criteria, which can be viewed here.
https://www.indstate.edu/health/program/pa/pa-admission-criteria.

14. **Standard** A3.13e The program *must* define, publish, consistently apply and make *readily available* to *prospective students,* policies and procedures to include:

    e) any required *technical standards* for enrollment.

Findings: The program did not define, publish, and make readily available to prospective students its policies and procedures for any required technical standards for enrollment.

Comments: The program did not define, publish, and make readily available to prospective students its policies related to any required technical standards. Although the program stated that it did not require technical standards, there was no evidence that this information was readily available to prospective PA students.

Required Report: Provide the policies and procedures concerning any required technical standards. Identify how these policies and procedures will be made readily available to prospective students. Provide the URL to the policy (and page number if on an online document).

The ISU PA program recognizes the importance of having clear technical standards available to prospective PA students. Therefore, in response to citation 13. Standard A3.13e the ISU PA program has

implemented the following changes.

Adoption and Publication of Technical Standards
The program, in collaboration with the institution, has created, adopted, and published technical standards that specify nonacademic requirements for participation in an educational program or activity. These include physical, cognitive, and behavioral abilities required for satisfactory completion of all aspects of the curriculum and entry into the profession with or without reasonable accommodations. The technical standards were created and reviewed by approved by the Physician Assistant Committee (PAC), then reviewed and approved by Indiana State University's legal counsel led by Joyce D. Thompson Mills, ISU's Executive Director of Legal Services (Appendix 42), and subsequently approved by the PAC. Program Meeting Minutes, item 3.1 show the approval of the technical standards (Appendix 43). The Technical Standards are now included on page 2 of ISU's admissions criteria, which can be found on ISU's PA website here https://www.indstate.edu/health/program/pa/pa-admission-criteria.

It is also available for review on the day the student is interviewed for a seat in the program. Once a student is offered a seat and accepted into the program, the technical standards document is sent to them as a part of an email package for onboarding in the program. The Technical Standards document is then signed and returned along with all required documents for matriculation into the program before the student is on campus for their first day (Appendix 44). Accepted students with a disability who believe they may require special accommodations are given the information to contact the Accessibility Resources Office (https://www.indstate.edu/services/student-success/cfss/student-support-services/disability-student-services) or by calling 812-237-2700, immediately upon accepting the offer of admission. This action satisfies SA3.13e.

15. **Standard** A3.14 The program *must* make student admission decisions in accordance with clearly defined and *published* practices of the institution and program.

    Findings: The program did not provide evidence that it made admission decisions in accordance with published practices.

    Comments: The admission rubrics provided by the program in the application appendix 6 (app 6C-"Interview Tool ISU PA" and "Stud Screen App") and reviewed on-site did not include the preference for applicants interested in rural health medicine and veterans (active duty and reservists). On the website, the program stated that health care experience was highly recommended, but the FAQ website https://www.indstate.edu/health/program/pa/pa-faq, stated that "applications lacking hours in these areas will still be considered until further notice." The rubric in Appendix 6c for Stud Screen App showed points awarded by the number of health care hours completed.

    At the site visit, the program director and principal faculty explained that points for rural health interest were awarded in the personal statement of the file review rubric. The principal faculty and program director noted there was an additional guide used by faculty that specified how to use the rubric scaling in more specific terms. However, the additional guide for the admissions file reviewers was not provided at the time of the site visit despite repeated requests by the site visit team.

In its response, the program stated the admissions rubric was provided to the site visit team and appended to its response. However, the program only appended the interview tool rubric and did not provide the guide nor information related to points for interest in rural health medicine or veteran status.

Required Report: Provide a brief narrative that describes how the program makes admission decisions in accordance with the published practices of the institution and program.

Provide a weblink URL to the program's published admission criteria.

Append the admission rubric(s) used by the program to screen and select candidates for admission and the admissions guide used by faculty in reviewing files.

Indiana State University understands the importance of making admission decisions in accordance with the published practices of the institution and program. We have edited the admissions rubrics used during the selection process. Our admissions criteria is readily available on our website for prospective students and can be found here. https://www.indstate.edu/health/program/pa/pa-admission-criteria

Our updated admissions rubric is included (Appendix 45). Our admission process is as follows. Applicants submit their application through CASPA. The applications are distributed to faculty for evaluation using the Physician Assistant Program Admissions Rubric. Faculty use GRE Scores, Veteran Status, Indiana Resident, Undergraduate GPA, Letters of Recommendation, Healthcare/Patient Care Experience, Community Service, Leadership Experience, and Personal Statement, to evaluate applications. The Physician Assistant Program Admissions Rubric has a total of 100 points possible. Each criterion offers a unique maximum number of points and has a guide for faculty to assist with scoring. Faculty score the Personal Statement category on the Physician Assistant Program Admission Rubric, if the applicant mentions our mission statement which focuses on rural health, they receive an additional 5 points. This higher score gives them a greater chance of admission to our program . Healthcare experience hours are a vital category during our admissions process. During the years 2021-2023, we had a sentence on our FAQ page that mentioned those applicants with low hours will still be considered. This was due to the trend of applicants not being able to access healthcare hours due to COVID-related issues. We have since removed this statement as applicants can now access the appropriate number of hours. At least 500 healthcare experience hours are required for consideration into our PA program.

After each faculty member reviews their assigned applications, the Physician Assistant Committe (PAC) review each application, along with the applicant's CASPA score, and the faculty review score, which is out of 15 points. There are three components of the faculty review score: review of letters of recommendation, review of personal statement essay, and finally review of experience. Using each of these numbers, we then select candidates to interview.

We then hold in-person interviews 3-4 times per year. We invite 20-25 applicants to campus to be interviewed, of which usually around 15-18 attend. Each applicant is interviewed by two faculty members, who ask a series of 8 questions from the Physician Assistant Studies Master's Interview Tool (Appendix 46). Each response is scored according to the rubrics outlined in the Interview Tool. Following each interview, faculty members also rate students on their interpersonal skills and confidence, which is added to the scores from the 8 responses given by each applicant. Each faculty member adds a brief narrative summarizing their overall impression of the applicant.

The faculty members meet as a committee (PAC) to decide which candidates to accept into our PA program. Students selected for admission are then offered a seat into the program.

In summary, our admission criteria, listed on the website, and the revised admissions rubric, along with the interview tool, serve as our admissions guide to faculty (App 46b).

16. **Standard** A3.15c The program *must* define, publish, consistently apply and make *readily available* to students upon admission:

    c) policies and procedures for *remediation* and *deceleration,*

    Findings: The program did not define, publish, or make readily available its policy and procedure for deceleration.

    Comments: In the application of record and at the time of the site visit, the program did not define, publish, or make readily available its policy and procedure for deceleration. At the time of the site visit, the PA Student Handbook p. 18, included a heading of "Goals of Remediation/Deceleration and Guidelines for Remediation/Deceleration." In the policy, the program described the process for remediation, but did not show evidence of a policy for deceleration. The program director also provided a link to the ISU Policy Library but there was no evidence of a policy for deceleration provided in the ISU Policy Library.

    The program did not respond to the observation.

    Required Report: Provide evidence that the program clearly defines, publishes, and makes *readily available* to students upon admission, policies, and procedures for deceleration**.** Provide the URL to the information if published online (including page number if within a document or append a copy of the information provided to students upon admission that includes policies and procedures for deceleration.

The ISU PA program has defined deceleration policies for the program during a program meeting on 12.7.23 (Appendix 47). These policies were then updated in the handbook, placed on the website, and referenced within the syllabi for the program. The policies and procedures are available for students upon admission and can be found on page 23 of the handbook found here: https://www.indstate.edu/health/program/pa/pa-student-handbook.

Deceleration
Deceleration is defined as any event/action that causes a student to be removed from their entering cohort, who remains matriculated in the program. Deceleration may occur as a result of academic probation, a leave of absence, or withdrawal from a course or semester. Remediation (above) is the priority over deceleration if possible. A student requesting deceleration must communicate the request in writing to the Program Director who will present the request to the PAC for discussion and recommendations and make a final decision. Reinstatement following deceleration includes a remediation plan to ensure that the student meets the criteria to successfully proceed in the program. Deceleration may occur only once.

Deceleration will not be approved in the following circumstances:
· Academic dismissal
· To avoid being dismissed

· Dismissal for behavioral or professionalism issues

Didactic Phase
A student who is decelerated in the Didactic Phase will not be permitted to enter the Clinical Phase until they have successfully completed the Didactic and Preclinical phases, including any courses they remediated. The student acknowledges that additional tuition and fees may be incurred with repeat coursework, and that said coursework might not be eligible for financial aid.

Clinical Phase
A student who has decelerated during their clinical year must successfully complete all rotations required by the ISU PA curriculum, earning 70% (C) or above in each to be able to graduate. If a decelerated student consistently demonstrates academic, professional, or attitudinal difficulties the student's performance will be reviewed by the Physician Assistant Committee (PAC) and may result in dismissal from the program.

STANDARDS CLARIFICATION

The commission made some clarifying changes to the *Standards,* 5th edition, at its September 2022 meeting. This included changes to B1.03 and B3.01. The latest version of the *Standards* is available on the ARC-PA website.

In response to citations received following accreditation reviews, programs will address standards B1.03 and B3.01 as they are currently clarified.

Previous version:
Standard B1.03 For each didactic and clinical course (including *required* and *elective rotations*), the program *must* define and publish *learning outcomes* and *instructional objectives,* in measurable terms that can be assessed, and that guide student acquisition of required *competencies.*

9.2022 Clarified Standard:
Standard B1.03 For each didactic and clinical course (including *required* and *elective* rotations), the program *must* define and *publish* for students the following detailed information in syllabi or appendix to the syllabi:

a) course name,
b) course description,
c) faculty instructor of record,
d) course goal/rationale,
e) *learning outcomes* and *instructional objectives*, in measurable terms that can be assessed, that guide student acquisition of required *competencies*,
f) outline of topics to be covered that align with *learning outcomes* and *instructional objectives*,
g) methods of student assessment/evaluation, and
h) plan for grading.

For every didactic and clinical course (including required and elective rotations), students must be informed of the items listed within the sub standards. The word 'syllabus' is purposefully not defined in the ARC-PA glossary. The Commission expects this information to be defined and published for students in a written or electronic document. The Commission recognizes that some institutions may have restrictions in place for syllabus development. If there are institutional restrictions on what is included in the program's course syllabi, programs are expected to include the information as an addendum to the course syllabus.

17. **Standard** B1.03d For each didactic and clinical course (including *required* and *elective rotations*), the program *must* define and *publish* for students the following detailed information in syllabi or appendix to the syllabi:

    d) course goal/rationale,

    Findings: The program did not consistently define and publish for each didactic and clinical course detailed information in syllabi to include course goal/rationale.

    Comments: Course information, provided in the application Appendix 17 and reviewed at the time of the site visit, did not include a detailed course goal/rationale in any of the program's didactic and clinical courses.

    In the application and at the time of the site visit, there were no course goals listed for the didactic courses. The PASS 643 Clinical Skills did include a heading labeled course goals, but the items listed reflected instructional objectives. Clinical year syllabi were inconsistent with listing the course goals which reflected rotation expectations and were not present in all clinical year syllabi. For example, the rotation goals included for the General Surgery rotation stated:

    - Each condition will be seen at least once.
    - Each skill will be performed at least once.
    - 60% of the population will be adults (60 patient encounters).
    - 1/3 of encounters must be pre-op, 1/3 intra-op, and 1/3 post-op, with a minimum of 100 patient encounters.

    In addition, goals were not defined and published in the course syllabi for PASS 655 PASS 671, PASS 674, PASS 677, PASS 678, PASS 679, PASS 680.

    In response to the observation, the program stated the goals/rationale were in progress for the program at the time of the site visit.

    Required Report: Provide the course goal/rationale for each didactic and clinical course (including required and elective rotations). Do not provide the whole syllabus, but an excerpt of the course goal/rationale with each syllabus.

Click here to enter program response

18. **Standard** B1.03e For each didactic and clinical course (including *required* and *elective rotations*), the program *must* define and *publish* for students the following detailed information in syllabi or appendix to the syllabi:

e) *learning outcomes* and *instructional objectives*, in measurable terms that can be assessed, that guide student acquisition of required *competencies*,

Findings: The program did not consistently define and publish learning outcomes and instructional objectives in measurable terms for each clinical course that would guide student acquisition of required competencies.

Comments: Course syllabi submitted in the application of record (Appendix 17) and reviewed at the site visit did not include detailed information that each course offered in the didactic and clinical curriculum included learning outcomes and instructional objectives. The program provided its learning outcomes with multiple titles such as, "learning objectives", "course outcomes", etc.
For example:

- PASS 687 Physician Assistant Practice Transition and PASS 686 Clinical Management III: There were "learning goals" that took the student to the PAEA blueprint website.
- PASS 624 Pharmacotherapeutics I, PASS 628 General Surgery, PASS 643 Clinical Skills, and PASS 687 PA Practice Transition: No learning outcomes were present.
- PASS 624 & PASS 634 Pharmacotherapeutics I & II had one instructional objective tied to a list of topics that did not guide the learner.
- No instructional objectives were present in PASS 626 Clinical Management I, PASS 624 Pharmacotherapeutic I, and PASS 634 Pharmacotherapeutics II.

When present, the learning outcomes and instructional objectives were poorly written, not measurable, and did not guide student acquisition of *competencies*. "Learning Objectives" were the same for SCPEs and did not guide students toward acquisition of competencies specific for each course. For example, "students will be able to demonstrate for the clinical conditions listed below, the ability to:

- Describe the clinical presentation (signs and symptoms).
- Select appropriate diagnostic studies (lab, radiology, special studies).
- Formulate a comprehensive differential diagnosis.
- Develop a competent management plan for patients presenting with acute and chronic conditions.
- Demonstrate an understanding of pharmacotherapeutics, first line and second line, commonly and effectively used.
- Describe appropriate patient education/follow-up instructions.

Each course syllabus contained a list of conditions and skills to which students were expected to be "exposed to" or perform but did not include statements to guide student acquisition of skills.

In the clinical year, the program did not define any learning outcomes for professional behavior and interpersonal skills in any of the clinical rotation syllabi. No instructional objectives were present in all of the clinical rotations. "Skills" identified on p. 3 of the syllabi were not identified as learning outcomes or instructional objectives. In these cases, it was a list of exposures to conditions and skills to be performed.

In its response, as evidence of compliance the program referenced the same six "learning objectives" across all rotations that faculty identified as the learning outcomes. None of the learning objectives included detailed information necessary to guide student acquisition of required competencies for each rotation.

Required Report: Provide both the didactic and clinical syllabi with learning outcomes and instructional objectives that are measurable and can guide student acquisition of the competencies. Provide only the excerpt of each course syllabus for these sections.

Click here to enter program response

19. **Standard** B3.03a *Supervised clinical practice experiences must* enable all students to meet the program's *learning outcomes*:

    a) for preventive, emergent, acute, and chronic patient encounters,

Findings: The program did not provide evidence that it had defined supervised clinical practice experience learning outcomes for preventive, emergent, acute, and chronic patient encounters.

Comments: Standards B3.03a-e require that the program clearly define, for students and preceptors, the expected learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning and problem-solving abilities) that must be achieved by each student.

The program did not provide evidence that it had defined its learning outcomes for preventive, emergent, acute, and chronic patient encounters. The Director of Clinical Education stated the learning outcomes were in the form of the topic list for the PAEA end of rotation exams, which does not meet the ARC-PA definition for learning outcomes. The SCPE course syllabi submitted with the application in Appendix 17 and reviewed at the time of the site visit included similar learning outcomes (categorized as "learning objectives") for all rotations. None of the identified learning outcomes addressed preventive, emergent, acute care, or chronic care. In Appendix 12 of the application, the program identified a list of preventive, emergent, acute and chronic conditions with related skills, but this topic list did not reflect learning outcomes.

In its response, the narrative described how students would "have the opportunity to practice in" emergent, acute, and outpatient settings caring for acute and chronic diseases of elderly patients and in some settings that promoted preventive medicine. The program provided syllabi PASS 670 Family Medicine Rotation, PASS 671 Emergency Medicine Rotation, and PASS 675 Geriatric Rotation of which PASS 670 Family Medicine Rotation had one "learning objective" that contained acute and chronic care.

Required Report: Provide the supervised clinical practice experience (SCPE) expected learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning, and problem-solving abilities) for preventive, emergent, acute, and chronic patient encounters that must be attained by each student at the completion of a supervised clinical practice experience. Attach in an appendix.

Click here to enter program response

20. **Standard** B3.03b *Supervised clinical practice experiences must* enable all students to meet the program's *learning outcomes*:

    b) across the life span, to include infants, children, adolescents, adults, and the elderly,

Findings: The program did not provide evidence it had clearly defined learning outcomes for students in supervised clinical practice experiences for patients seeking medical care across the life span to include infants, children, adolescents, adults, and the elderly.

Comments: Standards B3.03a-e require that the program clearly define, for students and preceptors, the expected learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning, and problem-solving abilities) that must be achieved by each student.

The supervised clinical practice experience (SCPE) course syllabi, in Appendix 17 of the application and reviewed at the time of the site visit, included six "learning objectives" which were the same across all rotations, with no learning outcomes specifically related to care across the life span, to include infants, children, adolescents, adults, and the elderly.

The SCPE course syllabi, submitted with the application in appendices 12 and 17 and reviewed at the time of the site visit, included similar learning outcomes which were not specific to the SCPE, none of which specified infants, children, adolescents, adults, and the elderly. It is noted the program has a geriatric SCPE, however, none of the learning outcomes specified elderly or geriatric patients. Within Appendix 12, the program defined ages for infants, children, and adolescents and provided lists of conditions and related skills, but these were not learning outcomes, and were not directly related to infants, children, adolescents, adults, and the elderly.

In the program's response to the observation, it stated the number of encounters required for each age group. Examples were the following:

- Infants (age 2 years of age), at least 40 encounters
- Children (age 2-11 years of age), at least 100 encounters
- Adolescents (age 12-18 years of age), at least 20 encounters

The program provided syllabi PASS 671 Emergency Medicine Rotation, PASS 677 Pediatrics Rotation, and PASS 675 Geriatric Rotation which did not include learning outcomes associated with care across the life span.

Required Report: Provide the expected learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning, and problem-solving abilities) for patients seeking medical care across the life span to include infants, children, adolescents, and the elderly that must be attained by each student at the completion of the SCPE. Attach in an appendix.

Click here to enter program response

21. **Standard** B3.03c *Supervised clinical practice experiences must* enable all students to meet the program's *learning outcomes*:

    c) for women's health (to include prenatal and gynecologic care),

    Findings: The program did not provide evidence that it had defined learning outcomes for women's health including prenatal and gynecologic care for supervised clinical practice experiences.

    Comments: Standards B3.03a-e require that the program clearly define, for students and preceptors, the expected learning outcomes (the medical knowledge, interpersonal, clinical, and technical skills, professional behaviors, clinical reasoning, and problem-solving abilities) that must be achieved by each student.

    The supervised clinical practice experience (SCPE) course syllabi, submitted with the application in appendices 12 and 17 and reviewed at the time of the site visit, did not include learning outcomes for prenatal and gynecologic care. Although some skills listed in the course syllabus for PASS 673 Women's Health Rotation included procedures and were written in measurable terms such as "collect a sample for PAP smear", "collect a sample for a vaginal culture" etc., they were not identified as learning outcomes. The program defined requirements for the number of encounters for prenatal and gynecologic care and provided lists of conditions and related skills for gynecologic and prenatal care, but these were not learning outcomes.

    In its response, the program explained that in the PASS 673 Women's Health Rotation syllabus students would encounter 160 patients, 80 of which should be prenatal and the other 80 gynecological. The program further stated that specific women's health learning outcomes were provided within the syllabus, which included both gynecological and prenatal conditions. The narrative described that students must perform each skill at least once and evaluate and manage each listed condition. However, this does not reflect learning outcomes as defined by the ARC-PA.

    Required Report: Provide the supervised clinical practice experience (SCPE) expected learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning, and problem-solving abilities) for patients seeking gynecologic and prenatal care, that must be attained by each student at the completion of a supervised clinical practice experience. Attach in an appendix.

Click here to enter program response

22. **Standard** B3.03d *Supervised clinical practice experiences must* enable all students to meet the program's *learning outcomes*:

    d) for conditions requiring surgical management, including pre-operative, intra-operative, post-operative care,

Findings: The program did not provide evidence that it had clearly defined learning outcomes for students in supervised clinical practice experiences (SCPEs) for pre-operative, intra-operative, and post-operative care.

Comments: Standards B3.03a-e require that the program clearly define, for students and preceptors, the expected learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning and problem-solving abilities) that must be achieved by each student.

The SCPE course syllabi, submitted with the application in appendices 12 and 17 and reviewed at the time of the site visit, did not include learning outcomes for conditions requiring surgical management, including pre-operative, intra-operative, and post-operative care. Although some skills listed in the course syllabus for PASS 672 General Surgery Rotation included procedures and were written in measurable terms such as "demonstrate appropriate sterile technique", "perform surgical wound closure" etc., but were not identified as learning outcomes. There was one skill for post-operative care "provide post-op and discharge patient education" but was not identified as a learning outcome. The program defined requirements for the number of encounters for pre-operative, intra-operative and post-operative care and provided lists of conditions and related skills for pre-operative, intra-operative and post-operative care but these were not learning outcomes.

In its response, the program stated that the PASS 672 syllabus stated students would encounter 100 patients in the surgical setting with exposures to 1/3 of each area: pre-operative, intra-operative, and post-operative. The program further explained that specific surgical learning outcomes were provided in the syllabus that defined conditions that must be evaluated and managed as well as required skills performed. The program did not clearly define, for students and preceptors, the expected learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning, and problem-solving abilities) that must be achieved by each student.

Required Report: Provide the expected learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning, and problem-solving abilities) for conditions requiring surgical management, including pre-operative, intra-operative, and post-operative care that must be attained by each student at the completion of the supervised clinical practice experience (SCPE). Attach in an appendix.

Click here to enter program response

23. **Standard** B3.03e *Supervised clinical practice experiences must* enable all students to meet the program's *learning outcomes*:

    e) for behavioral and mental health conditions.

Findings: The program did not provide evidence that it has defined learning outcomes for behavioral and mental health conditions.

Comments: Standards B3.03a-e require that the program clearly define, for students and preceptors, the expected learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning and problem-solving abilities) that must be achieved by each student.

The supervised clinical practice experience (SCPE) course syllabi, submitted with the application in appendices 12 and 17 and reviewed at the time of the site visit, did not include learning outcomes for conditions that addressed behavioral and mental health conditions. Although some skills listed in the course syllabus for PASS 676 Behavioral Medicine Rotation included procedures and were written in measurable terms "utilization of CAGE tool", "utilization of anxiety scale" etc., but were not identified as learning outcomes. The program defined requirements for the number of encounters for age groups of patients and provided lists of conditions and related skills for behavioral and mental health care, but these were not learning outcomes.

In its response, the program stated the PASS 676 syllabus defined specific learning outcomes for the behavioral medicine rotation. The program further explained that the "learning objectives" were met by evaluating and treating each required condition and performing each required skill. However, the program did not provide expected learning outcomes (medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning and problem-solving abilities) that must be achieved by each student.

Required Report: Provide the expected learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, clinical reasoning and problem-solving abilities) for behavioral and mental health conditions that must be attained by each student at the completion of the supervised clinical practice experience (SCPE). Attach in an appendix.

Click here to enter program response

24. **Standard** B3.06a *Supervised clinical practice experiences should* occur with:

    a) physicians who are specialty board certified in their area of instruction,

Findings: The program did not provide evidence that all supervised clinical practice experiences (SCPEs) occur with physicians who were specialty board certified in their area of instruction.

Comments: At the time of the site visit, a review of preceptor board certification documentation provided as evidence of compliance did not include evidence that all physician preceptors were currently board-certified in their area of instruction. Four of the listed active preceptors (Wilson, Hinshaw, Jaffri, and Ramierez) were not board-certified in their area of instruction. The program did not provide a compelling reason for SCPEs to occur with physicians who were not specialty board certified in their area of instruction.

In its response, the program stated it provided documentation with rationale for the four non-board-certified preceptors and had vetted each preceptor. It is the program's responsibility to meet the standard or, in the case of a "should" standard, detail a compelling reason why it did

not do so. The program failed to present a compelling reason, acceptable to the commission, for the use of physicians who were not specialty board certified in the area of instruction.

Required Report: Provide a narrative that succinctly documents the process used by the program to verify all supervised clinical practice experiences (SCPEs) occur with physicians who are board certified in their area of instruction.

Alternately, describe why the requirement that students have SCPEs with physicians who are specialty board certified in their area of instruction cannot be met. Include a description of the evaluation process the program uses to determine physicians who are not specialty board certified in their area of instruction are appropriate for the specified area of instruction.

Append evidence of compliance, in the form of a table (Word or Excel), including the following information for all currently active physician preceptors: the physician preceptor's name, the area of instruction of the preceptor(s), the physician board certifying body and date of expiration.

Highlight, on the table, preceptors who are non-board certified or not board-certified in their area of instruction who have been evaluated and determined by program faculty to be appropriate for the specified area of instruction. Provide documentation of the completed vetting process for each preceptor.

Click here to enter program response

25. **Standard** B4.01a The program *must* conduct *frequent*, objective and documented evaluations of student performance in meeting the program's *learning outcomes* and *instructional objectives* for both didactic and *supervised clinical practice experience* components. The evaluations *must*:

    a) align with what is expected and taught,

Findings: The evaluation of student performance in meeting the program's learning outcomes and instructional objectives for supervised clinical practice experience components did not align with what was expected and taught.

Comments: The program's use of variable terminology to represent learning outcomes and objectives did not allow the program to align assessment methods with what was expected and taught for both the didactic and clinical years.

Within the didactic curriculum, the method of evaluation was not clearly and consistently aligned with the learning outcomes and instructional objectives. The program described that its methods of assessment included written exams, practical exams, oral presentations, group projects, research projects, OSCEs and simulations, however, the program did not provide evidence that evaluations were aligned with what was expected and taught. The program used variable terminology for learning outcomes and instructional objectives and not all didactic courses included learning outcomes and instructional objectives.

Examples were the following:

- PAS 624 Pharmacotherapeutics I and PAS 634 Pharmacotherapeutics II did not have learning outcomes or clear instructional objectives.
- PAS643 Clinical Skills had no learning outcomes.

Within the SCPE curriculum, the syllabi and evaluations of student performance in meeting the program's learning outcomes were not consistently aligned with what was expected and taught. The program described that its methods of assessment included end of rotation exams, preceptor evaluations, and assignments to determine whether students met the learning outcomes and instructional objectives for each rotation. At the time of the site visit the program described the alignment of evaluation methods to the learning outcomes except for the preceptor evaluation. The preceptor evaluation forms included in Appendix 13 were missing various elements.

Examples were the following:

- Evaluation of preventative, emergent, acute, or chronic care.
- Evaluation of care across the lifespan to include infants, children, adolescents, adults, and elderly.
- The PASS 672 General Surgery rotation did not include evaluation of pre-operative, intra-operative or post-operative care.
- The preceptor form for PASS 672 General Surgery included skills to be assessed that were not identified with course syllabi as a learning outcome or instructional objective including administer O2, place urinary catheter, place IV catheter, perform intubation, perform extubation.
- The PASS 673 Women's Health rotation did not include evaluation of learning outcomes for prenatal and gynecologic conditions.
- The PASS 676 Behavioral Medicine rotation did not include evaluation of learning outcomes for behavioral and mental health care.
- The preceptor evaluation form for PASS 677 Pediatric rotation was not included in the application.

In its response, the program only addressed the clinical year stating student performance was evaluated in the end of rotation exams, patient logs, and preceptor evaluations. The program explained that the learning outcomes related to encounters, across the life span, pre-operative, intra-operative, post-operative, prenatal, gynecologic, and behavioral health included student log review. The program further stated that the broad terms were not included in the preceptor evaluation "as they are evaluated on specific conditions and skills that occur in each of the above-mentioned settings with specific patient population requirements."

Required Report: Provide a succinct narrative describing how the program aligns student assessment with the learning outcomes and instructional objectives and describe the methods of evaluation.

Append the program's learning outcomes and instructional objectives for each course. Do not include the complete rotation syllabi; excerpt the learning outcomes and instructional objectives and place into a separate document organized by course.

Provide a succinct narrative describing how the program aligns student assessment with what the program expects of a student (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, and clinical reasoning and problem-solving abilities) on supervised clinical practice experiences (SCPEs).

Append the program's SCPE expectations (the learning outcomes, rotation objectives, etc.) for each required rotation. Do not include the complete rotation syllabi; excerpt the learning outcomes, instructional objectives, skills list, etc., and place into a separate document organized by rotation.

Append the document(s) necessary (e.g., preceptor evaluations and/or other evaluations) to verify the program has a means to determine whether each student has met the learning outcomes and instructional objectives on SCPEs by aligning evaluation with what is expected.

Click here to enter program response

26. **Standard** B4.01b The program *must* conduct *frequent*, objective and documented evaluations of student performance in meeting the program's *learning outcomes* and *instructional objectives* for both didactic and *supervised clinical practice experience* components. The evaluations *must*:

    b) allow the program to identify and address any student deficiencies in a *timely* manner.

Findings: The evaluation of student performance in meeting the program's learning outcomes and instructional objectives for supervised clinical practice experience components did not allow the program to identify and address any student deficiencies in a timely manner.

Comments: The program did not demonstrate evidence that the supervised clinical practice experience (SCPE) evaluations would allow the program to identify and address any student deficiencies in a timely manner. In the application and at the time of the site visit, the program stated it utilized the final preceptor evaluation form and the end of rotation exam to determine if the student required any remediation. The preceptor evaluation form was not rotation specific and did not allow the preceptor to identify deficiencies of learning outcomes in a timely manner. The program did not define how it addressed evaluation items that were marked with a "No" or "N/A". At the time of the site visit, the program did not consistently articulate how it determined section 3 of the preceptor evaluation form (a list of diagnoses and skills that the preceptor was to check off if the student met the level of expectation of the preceptor) was able to assist the program in the identification of deficiencies in a timely manner.

In its response, the narrative described how frequent evaluations of student performance take place during the clinical year. There were mid-point evaluations which occurred in week two of the rotation and at the completion of the SCPE. The program explained in its response that it changed the preceptor evaluation to a check off only for areas of deficiencies after receiving feedback from the preceptors that the evaluation was too long. The program also described that if only a couple of the learning outcomes were missed during a rotation, the student would

be allowed to try to obtain the learning outcomes at a different SCPE. The program did not explain how this information would be tracked.

Required Report: Provide a succinct narrative describing how the preceptor evaluation allows the program to identify and address any student deficiencies in the program's expected learning outcomes in a timely manner. Include a narrative on how the program plans to track completion of learning outcomes missed during a rotation.

Append the program's supervised clinical practice experience (SCPE) learning outcomes (the medical knowledge, interpersonal, clinical and technical skills, professional behaviors, and clinical reasoning and problem-solving abilities) that are assessed by the preceptor for each required rotation. Do not include the complete rotation syllabi; excerpt the learning outcomes assessed by the preceptor, and place into a separate document organized by rotation.

Append the necessary assessment document(s) used by the preceptor to verify the program has a means to determine each student has met the program expected learning outcomes for the rotations in a timely manner.

Click here to enter program response

27. **Standard** C1.01a The program *must* define its ongoing self-assessment process that is designed to document program *effectiveness* and foster program improvement. At a minimum, the process *must* address:

    a) administrative aspects of the program and institutional resources,

Findings: The program did not define the program's ongoing self-assessment process to include administrative aspects of the program and institutional resources.

Comments: The program's ongoing self-assessment process did not include a complete process to address program effectiveness and foster program improvement for the administrative aspects of the program and institutional resources. In its self-study report, the program did not provide qualitative data or rationale for the identified qualitative benchmarks. The program did not provide data and critical analysis to demonstrate compliance for faculty development, clinical site development, curriculum design, program assessment, admissions outcomes, and diversity, equity, and inclusion for appendix 14B. The program's self-assessment process defined by the program did not consistently describe in sufficient detail how quantitative and qualitative data would be analyzed over time to identify correlational relationships.

In its response, the program explained how the program director was evaluated by the students in the exit survey as well as the students' perceptions of program strengths and areas in need of improvement. The program also stated that the department chair meets with the students annually to obtain feedback to determine trends and to evaluate the feedback against benchmarks. The program did not provide evidence of data and critical analysis of faculty development, clinical site development, curriculum design, program assessment, admissions outcomes and diversity, equity, and inclusion.

Required Report: Provide a narrative below describing the program's established, formal, continuous self-assessment process addressing the administrative aspects of the program and institutional resources.

The commission expects the program to define and document its ongoing self-assessment process including the administrative aspects of the program and institutional resources. Include a succinctly written narrative that describes its process of analyzing qualitative and quantitative data, including considerations for established benchmarks with rationale; and correlations, relationships, and trends in data the program will use in its analysis. The process described must be consistent with the data sources, timing of data collection and analysis listed in the Timeline for Data Gathering and Analysis TEMPLATE as well as any other documents the program provides in support of its description of the self-assessment process.

Click here to enter program response

28. **Standard** C1.02c.i. The program *must* implement its ongoing self-assessment process by:

    a) applying the results leading to conclusions that identify:
        i. program strengths,

Findings: The program did not provide consistent evidence that its identified strengths were the result of performing critical analysis of the data in its ongoing self-assessment process.

Comments: The program director and principal faculty did not describe a consistent process or provide examples of how the program identified strengths based on analysis. The program's identification of strengths throughout the self-study report (SSR) was not based on defined strength benchmarks/thresholds established for quantitative or qualitative data, or measurement of trends over time. The program stated in its response that there were multiple strengths identified and written in the SSR and data provided in the appendices.

In its response, the program stated "in Appendix 14D Effectiveness of Clinical Curriculum, multiple strengths were identified based on critical analysis of data with benchmarks referenced. Student evaluations of the clinical team, site, and preceptor as well as aggregate tables were provided in the SSR and in physical forms" at the time of visit. The program further stated that in Appendix 14C Effectiveness of Didactic Curriculum, "supplemental data was provided concerning student course evaluations and instructor evaluations which were referenced in the program's strengths section." However, the program did not provide evidence that program strengths were identified as a result of data analysis.

Required Report: Within the next SSR, the commission expects the program to implement its ongoing self-assessment process by applying the results leading to conclusions that identify program strengths.

Click here to enter program response

29. **Standard** C1.03 The program *must* prepare a self-study report as part of the application for accreditation that *accurately* and *succinctly* documents the process, application and results of ongoing program self-assessment. The report *must* follow the guidelines provided by the ARC-PA.

Findings: Within the submitted self-study report (SSR), the program did not provide documentation of critical data analysis leading to data-driven conclusions and subsequent identification of program strengths, modifications, or areas in need of improvement.

Comments: Within the submitted SSR, the program did not provide documentation of critical data analysis and the ability to link analysis to data-driven conclusions and subsequent identification of program strengths, areas in need of improvement, and action plans.

While the SSR reflected the program was collecting data, evidence the program was critically analyzing data and drawing conclusions based on documented data analysis was inconsistent in each of the required SSR appendices.

Examples include but were not limited to:

<u>Appendix 14B: Administrative Aspects of the Program and Institution</u>

- Benchmarks were described without consistent rationale.
- A strength threshold was not defined.
- Documented analysis was a brief mix of describing analysis process and stating data above and below benchmark, without documented conclusions.
- The program did not document analysis of negative trends in data.
- Strengths, modifications, areas in need of improvement with plans were not linked to documented critical data analysis.

<u>Appendix 14C: Effectiveness of the Didactic Curriculum</u>

- A strength threshold was not defined.
- There was limited documentation of evaluation of instructors.
- Strengths, modifications, areas in need of improvement with plans were not linked to documented critical data analysis.

<u>Appendix 14G: Sufficiency and Efficiency of Principal Instructional Faculty and Staff</u>

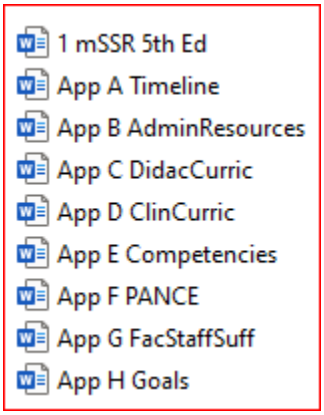
- The Faculty and Staff Changes template was incomplete as the one principal faculty member hired in 2021 (Edmundson) was not listed.
- The program did not document how it defined “good or better” sufficiency and effectiveness which were used in data collection.
- The program did not include documentation of the effectiveness of instructional faculty, program director, or medical director.
- A strength threshold was not defined.
- Strengths and modifications with plans were not linked to documented critical data analysis.

In the next SSR, the commission expects the program to:

- Provide an overview of its self-assessment process that clearly and succinctly describes a comprehensive, ongoing self-assessment which critically assesses all aspects of the program relating to sponsorship, resources, students, faculty, operational policies, curriculum, clinical sites, and program goals.
- Reference relevant data used to support the analysis documented in the SSR.

- Explicitly document, in the analysis narrative, how quantitative and qualitative data is interpreted and critically analyzed to identify potential for improvement or change.
- Document the source of qualitative data, including data that may be informally collected from faculty or students.
- Document analysis of the relationship between the various data reported as collected.
- Explicitly document the links between data, analysis, conclusions, and actions.
- Identify modifications and plans to address needed improvements consistent with the conclusions drawn.
- Document how analysis is used as the basis for conclusions drawn.
- Ensure the lists of program strengths, modifications, and areas in need of improvement are supported by data and analysis documented within each appendix.

Required Report: The program is expected to complete a modified Appendix 14 SSR that incorporates data as specified in each appendix listed below. The commission expects to see the program place an emphasis on its continual program self-assessment process, designed to document program effectiveness and foster program improvement as a result of critical analysis.



These templates can be downloaded from the program's portal. Click on "Manage Program Documents" in the Action Center in the Program Dashboard. From the Program Documents page, click on the zip file titled "ARC-PA Request for Report."

The program should save and submit its mSSR as instructed in the Saving and Submission directions included in the mSSR 5th Ed document.

Click here to enter program response

30. **Standard** C2.01a The program *must* define and maintain effective processes and document the initial and ongoing evaluation of all sites and *preceptors* used for *supervised clinical practice experiences,* to ensure students are able to fulfill program *learning outcomes* with access to:

    a) physical facilities,

Findings: The program did not maintain and document an initial and ongoing evaluation of all sites and preceptors for supervised clinical practice experiences (SCPEs) to ensure that students were able to fulfill program learning outcomes with access to physical facilities.

Comments: The program did not provide evidence of initial and ongoing evaluation of the physical facilities used for supervised clinical practice experiences. The program included the student evaluation of the site and preceptor in the application of record (appendix 15) and not the initial and ongoing evaluation of the clinical site and preceptor.

At the time of the site visit, a review of the clinical site form did not address evaluation of physical facilities.

In response to the observation, the program acknowledged that it did not implement an initial assessment of physical facilities. The students were asked by the program at mid-rotation if physical facilities met their needs and felt safe.

Required Report: Provide a succinct narrative describing the initial and ongoing evaluation process utilized to evaluate the physical facilities of all clinical sites used for *supervised clinical practice experiences*. Include the criteria used to evaluate whether the physical facilities are appropriate to ensure students can fulfill the program's *learning outcomes*.

Append a blank copy of the form(s) or tool(s) used to document the initial and ongoing evaluation of all sites and *preceptors* used for supervised clinical practice experiences.

Initial Evaluation Process: The initial site evaluation (ISE) is a crucial step in assessing the suitability of clinical sites for Supervised Clinical Practice Experiences (SCPEs). Preceptors play a pivotal role in this process by completing a site evaluation form annually. The form encompasses various criteria essential for a conducive learning environment, including:

- Computer/Internet Access: Ensuring that students have access to necessary technological resources.
- Available Workspace: Evaluating the provision of adequate space for patient evaluation and skill practice.
- Medical Library/E-Library: Ensuring access to relevant medical literature and online resources.

Parking: Evaluating the accessibility and adequacy of parking facilities for students.

The completion of the site evaluation form by preceptors during the initial assessment ensures that the selected clinical sites meet these criteria, setting the stage for an effective SCPE. These forms are then reviewed by the clinical coordinator and the rotation is either approved or not approved. Please see appendix 48 for a copy of the blank form used for documentation. Any identified deficiencies are listed on the form with details on how the student will make up or overcome identified deficiencies such as hours, encounters, or specific skills.

Ongoing Evaluation Process: To maintain the learning environment's quality, ongoing evaluations are conducted annually. Preceptors are required to submit updated site evaluation forms annually, to ensure the facilities continue to meet the specified criteria. This iterative process enables the program to adapt to any changes in the clinical sites and ensures the sustained ability of students to achieve their learning outcomes. See appendix 49 for details surrounding the ongoing evaluation process.

Mid-rotation Evaluation: During the mid-rotation call with faculty, students are asked if the physical facilities are adequate, specifically if they have access to clinical space, internet, parking, and electronic health record access (appendix 50).

Comprehensive Site Evaluation: As part of the ongoing evaluation, a comprehensive site evaluation is conducted either in person or virtually every two years. In-person visits are performed sooner if an issue is identified or by preceptor request. This allows the program to physically assess and tour the learning environment. During this assessment, particular attention is given to the physical facilities, ensuring they align with the evolving needs of the educational program and the best interests of the students. The Clinical Coordinator then completes the Comprehensive Site Evaluation form in Exxat to serve as evidence of ongoing compliance (appendix 51).

Appendix: Forms for Evaluation: Included in this report are blank copies of all ISE forms utilized in all settings during the initial evaluation process (appendices 52-60). Appendix 51 contains the Comprehensive Site Evaluation form used for ongoing site assessment. These forms serve as standardized tools during the continuous assessment of SCPE sites. By utilizing comprehensive criteria and involving preceptors in the evaluation process, we ensure that our students have access to facilities that support their educational goals.

31. **Standard** C2.01b The program *must* define and maintain effective processes and document the initial and ongoing evaluation of all sites and *preceptors* used for *supervised clinical practice experiences,* to ensure students are able to fulfill program *learning outcomes* with access to:

    b) patient populations,

    Findings: The program did not provide evidence it had an effective process of initial and ongoing evaluation of clinical sites and preceptors to ensure students could fulfill program learning outcomes with access to patient populations.

    Comments: The program did not provide evidence of initial and ongoing evaluation to ensure the patient population enables students to fulfill program learning outcomes. The Site/Preceptor Evaluation form submitted with the application and reviewed during the site visit did not assess sites used for supervised clinical practice experiences to ensure that students could fulfill program learning outcomes with access to patient populations. The program described that it used the EvalClinSitePre ISU PA along with patient logging for ongoing evaluation of the site and included general questions about the diversity of the patient population, but patient population types by age groups/encounter type were not present. The form used by the program was a student site/preceptor evaluation form. No initial or ongoing site evaluation form was presented during the site visit.

    In its response, the program provided one site and preceptor evaluation form (Site Evaluation for #27) of a pediatric rotation site which did include patient populations of infant, child, and adolescents, number of patients, and age ranges. However, the program only provided the evaluation for the pediatric rotation and not the initial and ongoing evaluation of SCPE sites for other disciplines.

Required Report: See citation #30

Initial Evaluation Process: The Initial Site Evaluation (ISE) is a pivotal step in assessing the suitability of clinical sites for Supervised Clinical Practice Experiences (SCPEs). Preceptors actively contribute to this process by completing a detailed site evaluation form. This form encompasses a range of criteria essential for creating an optimal learning environment, including:

- Age Range: Categorized into Infant (<1 year), Child (1-12 years), Adolescent (13-17 years), Adult (18-64 years), and Geriatric (>65 years).
- Patient Contact Hours: Ensuring students will be onsite 40 hours per week.
- Daily Patient Interaction: Ensuring students can see an average of 40 patients per week.
- Specific Patient Populations: Tailoring the experience by granting access to specific patient populations such as Women's Health, Surgery, Geriatrics, and Pediatrics.

Ongoing Evaluation Process: To sustain the quality of the learning environment, ongoing evaluations are conducted. Preceptors play a key role by submitting updated site evaluation forms annually, affirming the continued alignment with specified criteria. Additionally, students participate in mid-rotation phone calls with faculty advisors where they confirm their progress in meeting patient population requirements. Appendix 50 from Citation 30, represents the mid-rotation survey completed by each student monthly. Upon completion of each rotation, a thorough evaluation of student logs is conducted to ensure that the clinical site facilitates the fulfillment of patient population requirements for program learning outcomes. Appendix 61 depicts an example of student logs utilized for patient population evaluation.

Comprehensive Site Evaluation: Further, a comprehensive site evaluation is conducted either in person or virtually every two years. In-person visits are performed sooner if an issue is identified or by preceptor request. This allows the program to physically assess and tour the learning environment. During this assessment, particular attention is given to the patient populations, ensuring they align with the evolving needs of the educational program and the best interests of the students. The Clinical Coordinator then completes the Comprehensive Site Evaluation form in Exxat to serve as evidence of ongoing compliance (appendix 51 citation 30).

Appendix: Forms for Evaluation: Included in this report are blank copies of all ISE forms utilized in all settings during the initial evaluation process (appendices 52-60 citation 30). Appendix 51 from citation 30, contains the Comprehensive Site Evaluation form used for ongoing site assessment. These forms serve as standardized tools during the continuous assessment of SCPE sites. By utilizing comprehensive criteria and involving preceptors in the evaluation process, we ensure that our students have access to facilities that support their educational goals.

32. **Standard** C2.01c The program *must* define and maintain effective processes and document the initial and ongoing evaluation of all sites and *preceptors* used for *supervised clinical practice experiences,* to ensure students are able to fulfill program *learning outcomes* with access to:

    c) supervision.

Findings: The program did not maintain and document the initial and ongoing evaluation of all sites and preceptors for supervised clinical practice experiences (SCPEs) to ensure that students were able to fulfill program learning outcomes with access to supervision.

Comments: In the application and at the time of the site visit, the program provided EvalClinSitePre ISU which was the student evaluation of the site and preceptor which did not include access to supervision or a faculty evaluation of the site and preceptor. The principal faculty stated that the preceptors were questioned about the ability to provide supervision to the students, however, there was no documentation of responses from any clinical site for access to supervision.

In its response, the program provided a different site and preceptor evaluation form from what was presented in the application and at the site visit (Site Evaluation #27) and was specific to an initial evaluation of a pediatric site and preceptor. Included on the form was a question on supervision, "The student will receive an appropriate level of supervision, (i.e., no patient will be managed or discharged without a preceptor's involvement in the care of a patient)" which included a yes/no response. The program did not provide evidence of ensuring students were able to access supervision for all initial sites and preceptor evaluations of SCPE disciplines other than pediatrics which was submitted in the response to the observation. The program also did not provide evidence of ongoing evaluations of the site and preceptor to ensure students had access to supervision to fulfill program learning outcomes.

Required Report: See citation #30 C2.01a, #31 C2.01b for the response to C2.01a, C2.01b, and C2.01c.

Initial Evaluation Process: The Initial Site Evaluation (ISE) is a critical step in assessing the suitability of clinical sites for Supervised Clinical Practice Experiences (SCPEs). Preceptors actively contribute to this process by completing a detailed site evaluation form. Preceptors are asked to attest to providing the appropriate level of supervision at all times, with continuous oversight (i.e. no patient will be managed or discharged without the preceptor's involvement in the care).

Ongoing Evaluation Process: To sustain the quality of the learning environment, ongoing evaluations are conducted. Preceptors play a central role by submitting updated site evaluation forms annually, reaffirming their commitment to providing appropriate supervision to students. Supervision is evaluated at periodic comprehensive site evaluations. Additionally, students specify in their patient logs, the level of supervision received during each patient encounter:

- Preceptor Performed: The preceptor completed more than 50% of the encounter.
- Student Performed with Supervision: The student completed more than 50% of the encounter with preceptor supervision and input as needed.
- Preceptor Observed with Verification: The preceptor observed the student perform most of the encounter with verification of findings.

At the mid-rotation call with the faculty advisor, students are asked about their preceptor's supervision (appendix 50 citation 30). If a student is concerned about the supervision level, it is addressed at or before the mid-rotation call. The faculty advisor alerts the clinical coordinator of the concerns, and the clinical coordinator addresses it immediately with the preceptor to ensure successful completion of the rotation. Upon completion of each rotation, the Clinical Coordinator performs a thorough evaluation of each student's logs on a monthly basis to evaluate documented supervision levels. This is to ensure

ongoing compliance of the clinical site and its ability to fulfill all program learning outcomes.

Appendix: Forms for Evaluation: Included in this report are blank copies of all ISE forms utilized in all settings during the initial evaluation process (appendices 52-60 citation 30). Appendix 51 in citation 30 contains the Comprehensive Site Evaluation form used for ongoing site assessment where supervision is addressed. These forms serve as standardized tools during the continuous assessment of SCPE sites. By utilizing comprehensive criteria and involving preceptors in the evaluation process, we ensure that our students have access to facilities that support their educational goals.

33. **Standard** E1.03 The program *must* submit reports or documents as required by the ARC-PA.

Findings: The program did not submit application documents as required by the ARC-PA.

Comments: The original submission omitted documents or included documents completed incorrectly.
The program was missing the following documents:

- The Clarified Standard Template for standards A2.16 and A2.17.
- The Standards Clarification Template dated 9/2022.
- Appendix 11a Supervised Clinical Practice Experiences Excel document.
- Appendix 14F PANCE Performance Summary Report

The program provided incorrect formats:

- Appendix 1a Program data sheet submitted as an Excel file instead of a Word document (original format).
- Appendix 1b The budget was not downloaded and saved as an Excel file per instructions.
- Appendix 3a The organizational chart submitted did not show how the PA program relates to the sponsoring institution.
- Appendix 16 There were tracked changes on documents submitted for: ClinPhasMan 21-22 ISU PA ad PA HB 2022-2023 ISU PA
- On a majority of the Faculty CV templates-the program did not use the most up to date template version (12-2021).

The program had a change in curriculum not reported to the ARC-PA for change in graduation requirements (removal of PASS 617 Health Behavior Science in spring 2020 and addition of the genetics course in summer 2021).

In its response, the program asserted:

- The Clarification to Standards A2.16 and A2.17 template was turned in on time and accepted by ARC-PA.
- Appendix 1b The document was submitted as an EXCEL file.
- Appendix 3a The organizational chart was included.
- Appendix 11a The SCPEs Excel document was submitted with the initial application.
- Appendix 4C: The program did provide the most up-to-date templates for all CVs (12/2021).
- Appendix 4F: The PANCE Performance report was included and submitted on time.

Required Report: No report due. The commission expects the program to submit documents and reports as required.

ADDITIONAL REPORTS

The ARC-PA reminds the program to review the *Standards* 5th edition which went into effect September 1, 2020, in particular Section E, regarding maintenance of accreditation. You will find the *Standards*, an accreditation manual and other helpful information on our website, www.arc-pa.org.

In reviewing the information in the ARC-PA Program Management Portal prior to the commission meeting, the ARC-PA noted some incomplete or inaccurate data. **The Personnel tab does not accurately display the required program personnel.**

The portal included Dr. Urban who is no longer with the program and Ms. Loudermilk, the program coordinator, was not listed on the portal.

The program must correct its portal information no later than **November 10, 2023,** and notify the ARC-PA via email to accreditationservices@arc-pa.org.

In order to be in compliance with standard A3.12i, the most current annual student attrition information on the **Attrition Table** provided by the ARC-PA, must be published on the program website no later than April first each year. In reviewing the program's website prior to the commission meeting, the ARC-PA noted a deceleration rate of 13% for the Class of 2023.

At the June 2023 meeting, the Commission voted and approved a motion to require programs to provide the ARC-PA with a report addressing significant attrition within a program. In any year that the program has a calculated attrition of 10.9% or higher, the program will be required to submit a Student Attrition Required Report within six (6) months of the cohort's completion.

The program must update its **Attrition Table** on its website so that it accurately reflects the Class of 2023 attrition and graduation rates of the program's three most recent graduated cohorts no later than **December 1, 2023,** and notify the ARC-PA of the update via email to accreditationservices@arc-pa.org .

SUMMARY OF REQUIRED REPORTS

Report #1 – Additional Reports:

- Portal update due **November 10, 2023**
- Attrition table with completed report sent to the ARC-PA by **December 1, 2023**

Report #2 – Response to citations #1-16, and #30-32 due **February 1, 2024**

Report #3 – Response to citations #17-26 due **May 15, 2024**

Report #4 –Response to citations #27-29 (modified SSR) due **February 6, 2025**

****Completed Statements and Signatures page must be submitted with each report required in this document, otherwise the report will not be accepted.****

The ARC-PA reminds the program to review the *Standards* 5th edition which went into effect September 1, 2020, in particular Section E, regarding maintenance of accreditation. The commission made some clarifying changes to Section E of the *Standards,* 5th edition, at its September 2022 meeting. This included changes to E1.04, E1.07, & E1.08. You will find the *Standards*, an accreditation manual and other helpful information on our website, www.arc-pa.org.

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The Syllabi, Program Competencies, Learning Outcomes & Instructional Objectives, Standards 5th edition resource may be beneficial to the program.

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Additional documents such as the Data Analysis Resource and Completing the Self-Study Report may be beneficial to the program and can be found on the Manuals and Guides page of the ARC-PA website.

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The Spring 2019 Newsletter, Common Missing Elements of the Self Study Report may also be beneficial to the program and can be located at http://www.arc-pa.org/newsletters-and-notes/ .

STATEMENTS AND SIGNATURES

I understand and agree that the Program will be subject to an adverse accreditation action which could include denial of accreditation or withdrawal of accreditation, and that future eligibility for accreditation may be denied in the event that any of the statements or answers made in this submitted response are false or in the event that the Program violates any of the policies governing accredited programs.

Response Submitted by: Douglas Stevens PA-C **Date:** 1/25/2024

Program Director: Douglas Stevens PA-C **Date:** 1/25/2024
The name that appears here is deemed an electronic signature.

Chief Administrative Officer of Program's Sponsoring Institution:
As listed in the Program Management Portal
Deborah J. Curtis, President **Date:** 1/29/2024
The name that appears here is deemed an electronic signature.

****Completed Statements and Signatures page must be submitted with each report required in this document, otherwise the report will not be accepted.****