Challenges of accrediting distance education allied health programs with clinical components

Auburne Kay Deming Hutchins
Iowa State University

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Challenges of accrediting distance education allied health education programs with clinical components

by

Auburne Kay Deming Hutchins

A dissertation submitted to the graduate faculty
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

Major: Education (Educational Leadership)

Program of Study Committee:
Larry H. Ebbers, Major Professor
Sharon K. Drake
Nancy Franz
Mack C. Shelley II
Jan Westerman-Beatty

Iowa State University
Ames, Iowa
2016
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I can honestly say that I am a completely different person than I was when my doctoral journey began. I have been given the opportunity to grow not only academically but also professionally and, most importantly, personally. I have had the pleasure of having the support and encouragement of many people who have been instrumental in seeing me through to the other side of this transformation.

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Kathy McGivern, the CAAHEP Board of Directors and Staff and all of the CoAs—

The hours you commit and the passion that you employ to the quality of higher education is beyond admirable.

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To my children, Jackson and Leighton—When our world seemed to fall apart, you were my reason for collecting new pieces and building a beautiful future. You have felt the joys and pains of this journey with me since it began, and now we celebrate together. My wish for you is that from this experience you will always have the strength and courage to succeed despite any odds. Always believe in yourself and act with integrity.

Most of all, I am thankful to my husband, Guarasi, through your love you have empowered me to find more strength within myself that I ever knew existed. You gave me the courage to do many things, including finishing this degree. You have been my rock and I look forward to so many new adventures with you.
ABSTRACT

This qualitative study examined the challenges of assessing allied health education programs with clinical components offered in a distance education (DE) format from the perspective of the educational accreditor. As technology continues to expand our virtual horizons of educational opportunity, so does the ability to offer programs of higher education in ways that before may have never been imagined possible. The mark of a high quality education in healthcare is that the student graduates from an accredited program. It is the responsibility of the accrediting body to ensure that these programs meet all of the necessary standards, regardless of the mode of delivery of the curriculum.

This study used three forms of data to determine the primary needs of evaluators reviewing DE programs for accreditation: focus groups of accreditation professionals at a national Commission on Accreditation of Allied Health Education Programs (CAAHEP) meeting, surveys of evaluators who had just completed the review of a DE program, and the review of recent site visitor reports from CAAHEP accredited DE programs. Common themes emerged that indicated specific needs of the evaluators to be best prepared to review DE programs: (a) accreditation standards as they relate to DE; (b) professional development of faculty, students, clinical preceptors and accreditation evaluators; and (c) quality of the program, resources and assessments. The data were compared with the findings of best practices in DE from the review of the literature. It was suggested that professional
development be created by a CAAHEP task force for DE to train accreditation evaluators to review DE programs.

Although there is an abundance of information available on the validity and essential components of a high quality DE program, there is a paucity of information available on the accreditation evaluation of DE programs with clinical curriculum components. This study could be used by accreditors or academic program directors regarding development and evaluation of a DE program with or without clinical components. Future research might include an evaluation of the satisfaction and effectiveness of the CAAHEP evaluator professional development for DE accreditation as well as the experiences of these individuals when conducting the evaluations.
CHAPTER 1. INTRODUCTION

Background of the Study

Online education in higher education has increased dramatically in the 21st century. Currently, over 7.1 million students are enrolled in at least one distance education (DE) course (Allen & Seaman, 2014). This number accounts for one third (33%) of all higher education students in the United States. According to the same study, over 20% of higher education institutions claimed that online education was a critical piece of their strategic plan and long-term strategies (Allen & Seamon).

This study was conducted to determine the best practices in DE that can be used to develop a standard guide for evaluating DE programs with clinical components for accreditation. There are measures available for distance education programs to appropriately develop and execute such programs. These include evaluation methods for administrators and instructors to use while developing their programs and courses to ensure they teach and assess students effectively. Accreditation of these programs can also be used to provide continuous review of goals and outcomes to illuminate areas of inequity that need to be addressed. Over time, technological advances have made it possible to transform teaching platforms into distance education opportunities to programs that traditionally require a large amount of hands-on practice as part of the learning process. Programs such as biology, chemistry, and allied health professions education are now available via DE to students that were previously unavailable due to geographical limitations. Use of distance education brings forth a new concern that must be addressed to ensure
traditionally hands-on programs are presented in ways that provide, at the least, as high quality as face-to-face classroom experiences. School administrators and educators who use DE must also seek to determine ways to continuously evaluate such educational opportunities through their accrediting bodies. Currently, it is uncertain whether accreditation evaluators are experienced specifically regarding DE and methodology to ensure CAAHEP accreditation standards are being met.

Distance education has become a popular platform for providing educational opportunities for current healthcare professionals as well as those just entering their fields of study (Greenhalgh, 2001). It enables flexibility for one to schedule time to complete coursework in addition to a busy working lifestyle. Distance education and also enables educators and students the freedom to participate in a meaningful educational experience despite other life commitments that may otherwise be limited by participation in traditional classroom setting (Billings, 2007). Technological advances in education have now made it possible to offer from the same platform not only traditional lecture courses in a DE format but also clinical allied health programs. By using tools which include virtual simulation and real-time video conferencing, students are now able to earn degrees in clinical fields without the need to relocate to a school that offers a specific educational program.

The importance of providing web-based education has been widely reported in many areas of healthcare education, such as diabetes (Bell et al., 2006), prenatal breastfeeding education (Huang, Kuo, Chen, Lin, & Gau, 2007; Lewin & O’Connor, 2012), anesthesiology (Doyle, 2008), nutrition (Oenema, Brug, & Lechner, 2001; Underbakke, McBride, & Spencer, 2006), and many others. Students continually
express their positive experiences with distance education, including flexibility, convenience and lack of transportation worries (Yu & Yang, 2006). Perhaps, most importantly, however, are the opportunities that distance education provides regarding delivery of education in health professions to those who otherwise would not have access. In turn, distance education provides an effective way to provide professional development for the workforce in numerous health care professions, specifically in geographic areas where it is difficult to hire appropriately trained employees (Stotzer, 2012).

Nevertheless, the opportunity to provide such educational programs does not come without its own set of challenges. Programs are faced with providing education at a distance in fields of study that require students to have hands-on, caretaking experience in clinical settings as part of their professional development. There are ways to ensure that the quality of the clinical experience can be as effective and of the same quality as would be provided in a traditional educational delivery method. However, it is of the utmost importance the educators ensure that the students who complete their clinical work at a distance not only receive the same quality of educational experience but also a sound clinical experience. Even though the instructor is not physically present with the students, there must be some kind of oversight by the instructor to ensure that the preceptors practice consistent instruction while the students are at the clinical site. The educational program coordinators must develop ways to ensure that their students’ experiences are of the best quality and monitor the process and outcomes of their DE students the same as
they would for the students whom they see while face to face with the instructor during in clinical settings.

**Accreditation**

In most cases, healthcare education programs are required to be accredited by national accreditation specialists in their fields of study. This is to ensure that the programs are meeting standardized quality and outcomes measures as set by each individual profession to properly prepare students to sit for their professional credentialing exams and enter the workforce.

The largest accreditor for health care education is the Commission on Accreditation of Allied Health Education Programs (CAAHEP). CAAHEP currently accredits more than two thousand programs in twenty-six different allied health professions (CAAHEP.org). Table 1:1 lists the allied health programs that CAAHEP accredits, the number of programs each board accredits, and the programs that offer DE options in their curriculum.

To ensure accordance is maintained with the requirements and standards of each of the professions they accredit, Committees on Accreditation, or CoA’s, have been developed by CAAHEP for each of the professions. These CoAs are comprised of individuals who are considered to be leaders in their own allied health professions, and are typically nominated to their positions from their own national professional organizations.
Table 1.1. CAAHEP programs compared to programs offered as distance education by profession

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<th>Total programs accredited</th>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Anesthesia Technology</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Anesthesiologist Assistant</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Cardiovascular Technology</td>
<td>56</td>
<td>0</td>
</tr>
<tr>
<td>Clinical Research Professional</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cytotechnology</td>
<td>27</td>
<td>1</td>
</tr>
<tr>
<td>Diagnostic Medical Sonography</td>
<td>209</td>
<td>3</td>
</tr>
<tr>
<td>Emergency Medical Services - Paramedic</td>
<td>415</td>
<td>2</td>
</tr>
<tr>
<td>Exercise Physiology</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Exercise Science</td>
<td>44</td>
<td>0</td>
</tr>
<tr>
<td>Kinesiotherapy</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lactation Consultant</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Medical Assisting</td>
<td>571</td>
<td>3</td>
</tr>
<tr>
<td>Medical Illustration</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Medical Scribe</td>
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<td>0</td>
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<tr>
<td>Neurodiagnostic Technology</td>
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<tr>
<td>Orthotic and Prosthetic Technician</td>
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<td>Orthotist/Prosthetist</td>
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<td>1</td>
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<td>Perfusion</td>
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<tr>
<td>Personal Fitness Training</td>
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<td>1</td>
</tr>
<tr>
<td>Polysomnographic Technologist</td>
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<td>6</td>
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<tr>
<td>Recreational Therapy</td>
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<td>0</td>
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<tr>
<td>Specialist in Blood Bank</td>
<td></td>
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<tr>
<td>Technology/Transfusion Medicine</td>
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<td>5</td>
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<tr>
<td>Surgical Assisting</td>
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<td>2</td>
</tr>
<tr>
<td>Surgical Technology</td>
<td>464</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,933</strong></td>
<td><strong>28</strong></td>
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Because it is their charge to investigate and attest to programs meeting their Standards of Accreditation, Committees on Accreditation (CoAs) are required to determine if clinical DE programs meet the Standards and the needs of students in the same way that traditional Face-to-Face (FTF) programs do. Fortunately, the Standards of Accreditation are the same for a program of higher education, regardless of the method of delivery of the curriculum. However, it is essential for the
program assessment to be performed by someone with experience in DE to effectively evaluate the programs.

**Objective and Rationale for the Study**

As professional allied health educational programs are expanded to provide educational opportunities through distance education, accreditors are faced with a new set of challenges. Using distance education for programs to deliver clinical components is a new concept. However, currently there are no standards in place for the formal evaluation of these programs. Although the individuals representing the accrediting committees are very experienced in reviewing and performing site visits for traditional FTF programs, the majority of these individuals are inexperienced regarding the nuances of DE. In addition, most evaluators are unsure about the requirements for these programs to deliver an educational experience that meets the same accreditation standards as traditional programming. The challenge, then, becomes the responsibility of the accrediting body to: (a) understand what to look for when assessing these programs; (b) determine which programs meet the standards of accreditation (which are set by each Committee on Accreditation and used to evaluate every program as part of the accreditation process for adherence); and (c) find individuals who are experienced in DE to review these programs.

Each CoA has a selected group of individuals within the profession who are appointed to review the educational programs seeking accreditation. The accreditation process, itself, begins with a request for accreditation services by the educational program. An online form is submitted electronically directly to CAAHEP
and the appropriate CoA. It includes demographic and other basic information about the program. Once the form is received, the CoA creates a billing statement for the program, which includes instructions on how to complete a Self Study Report. The Self Study Report is a comprehensive document that is completed by the program to provide the evaluators from the CoA with the necessary descriptions and documentation to attest the program is in compliance with each of the standards of accreditation for that particular CoA. The report must be completed within 12 months of submission of the Request for Accreditation form. After the Self Study Report has been completed, it is submitted to the CoA along with additional fees, which are used to cover the costs of the site visit. Upon receiving the Self Study Report and site visit fees, the CoA assigns an individual or a team of evaluators to review the report and serve as a liaison between the program and the CoA. After the review has been completed, and the evaluator has confirmed that the program is in compliance with the standards, a site visit is scheduled.

Generally, a team of two or more site visitors conduct the site visit. Depending on the CoA, the site visitors may or may not be the same evaluators who reviewed the Self Study Report. The site visit enables the evaluators to meet the programmatic personnel, students, graduates, administration, advisory committee, and other key stakeholders associated with the program. This is a key part of the accreditation process because it provides the site visitors with first-hand knowledge of the intricacies of the program so they can determine whether the program meets their CoA’s Standards of Accreditation. Once the site visit is complete, the evaluators report their findings to the CoA board with a recommendation for approval.
or denial of accreditation. Next, the board votes and sends their final accreditation recommendation to CAAHEP’s Board of Directors, who will conduct the final vote and approval for the official accreditation action. Further explanation of the accreditation process is provided in Appendix A.

**Purpose of the Study**

The purpose of this study was to determine the best practices in DE that can be used to develop a standard guide for evaluating DE programs with clinical components for accreditation. As determined by the data collected and presented as a capstone report leading to this research, most CoAs feel unprepared when reviewing programs structured with DE delivery of the curriculum, and seek assistance from CAAHEP to bridge the gaps between their level of knowledge and experience with DE programs and the standards of accreditation that these programs are expected to meet. It is essential that the evaluators who review the Self Study Reports also conduct site visits because they need to know what to look for when reviewing DE programs and be able to compare new programs with FTF programs already in place.

**Problem Statement**

The majority of CoA evaluators have limited experience with the delivery of programs in a DE format; therefore, there is a need to establish a set of criteria that evaluators should address when reviewing DE allied health programs to ensure that those programs meet the standards for accreditation. CoA evaluators are expected to review programs applying for accreditation to establish adherence to the CoA’s
Standards of Accreditation, regardless of the delivery method of the program. The evaluators are often inexperienced in the nuances of a DE program to establish whether there is sufficient quality to meet the Standards of Accreditation. Consequently, there is often a gap between level of knowledge of evaluators regarding DE program review, and the expectation that the evaluators are able to objectively review the programs and attest to their adherence to those standards.

Research Question

The following research question guided this study: What indicators should CoA evaluators use to determine if DE allied health programs are meeting the standards of accreditation? The question was divided into two sub-questions:

a. What are the major challenges CoA evaluators experience when reviewing clinical DE programs for accreditation?

b. What professional development opportunities should be available for CoA evaluators of clinical DE programs to prepare them to overcome those identified challenges?

Theoretical Framework

The theoretical framework for this study used grounded theory as the main structure for the research. Grounded theory provides a way to use empirical data to explain social phenomena by exploring what people think and experience, and how they propose to resolve those problems (Engward, 2013). Specifically, this study applied the traditional Glaser and Strauss (1967) model of grounded theory that focuses more on a general sense of where to begin the research by establishing
neutral research questions and developing a conceptual theory. This explains why there is only one primary research question that is very broad in focus. The researcher must employ theoretical awareness through the ability to derive variables and relationships from the collected data and then use those discovered relationships to ground their developed theory.

Although an abundance of data and best practice information are available regarding instructional design and the transition of traditional classroom programs to those that utilize the distance education delivery method; however, there is very little information available about the evaluation process used when actually accrediting DE clinical education programs, particularly those with clinical components. Because this is a relatively unexplored topic with little evidence on which to base precedence, the data gathered to complete this research served as the framework on which the analysis was based (Engward, 2013).

**Methodology**

The traditional Glaser model of grounded theory was used for this study. Therefore, the methodology employed was objectivism based on positivism as defined in Glaser’s model. As further explained in Chapter 2 and 3, the methodology used in the study was carried out according to the theoretical framework using grounded theory. Due to this, the procedures shifted and changed frequently as the data were analyzed. This is because of the nature of grounded theory, itself, being based on the framework actually being molded by the themes that emerged from the data as it was being coded and fully analyzed for outcomes. Ultimately, the data
were coded and compiled into a useable matrix for the summary by using input from experts and professionals who work directly with CoA evaluation for accreditation.

**Limitations and Delimitations**

The primary limitation of this study was the lack of information available specifically on the accreditation of clinical DE programs. To determine the best practices for DE, in general, a literature review was conducted to determine previous models of accreditation standards as well as differences between DE and FTF educational programs, specifically in allied health fields. Because most allied health professions are just beginning to explore the possibility of providing their educational programs with a DE delivery option, there is a paucity of literature directly related to allied health programs. Thus, related literature of studies on DE was accessed. Likewise, current information from the CoAs on their experiences with accrediting DE programs was limited because many of the CoAs have not yet had to perform an evaluation. Nevertheless, most evaluators have expressed concern because they realize that DE is becoming a viable method to deliver programs in most allied health professions. Valuable information can be gleaned from reviewers who have navigated their way through the accreditation process, and this information may potentially be used to answer the research question.

Another limitation of this study is that students and clinical preceptors were not included in the surveyed persons nor the focus groups when gathering data for this study. This was due to the fact that because so little information was available on the specific subject, the professionals working in and with the accreditation of the
allied health programs directly were used in order to develop initial recommendations as a result of the data collected in this study. Further research on this topic could include student, graduate, and clinical preceptor input into the data to create expanded and more robust data from which to develop additional results and recommendations.

The primary delimitation of the study was that the data collection and analysis were performed in collaboration with CAAHEP and their CoA boards. Although other allied health accreditation organizations provided accreditation for additional professions, for the purpose of this study, only those accredited through CAAHEP were included in the data. Thus, some cross-referenced information was provided from other professions in the literature review, but not in the actual data collected as part of the analysis performed for this study.

Researcher Positionality

It is important for me, as the researcher, to disclose that this study was conducted as a result of personal experiences and my recognition of a need that was revealed through personal interactions with colleagues. I have significant experience with allied health education programs with clinical curriculum components offered in both FTF and DE delivery formats. In 2007, I accepted a position as the director of a Polysomnographic Technology program at a small private college. When I accepted the position as director, it was a two-year, Associate Degree program that was offered FTF. I worked diligently to go through the process of having the program accredited by CAAHEP through the CoA PSG in
2008. As a result, it became the 11th program in the country to earn such a distinction.

As the director, it quickly became apparent to me that the rural state where our program was housed did not have enough population to maintain sufficient enrollment in my program. Because there were so few programs in the country at the time offered this program and, in an effort to maintain the program, I decided to transition the delivery method and offer the program as DE to enable students from other states to enroll. Soon after this project was completed, I accepted a new position at the University of North Carolina at Charlotte (UNCC) to be the director of a similar program, but at the baccalaureate level. This program at UNCC was, and still is, the only baccalaureate level program in neurodiagnostics and sleep science (NDSS) in the world. The NDSS program at UNCC is also offered in its entirety as DE, and UNCC allows students from around the world to enroll in our program. In 2014, the NDSS program was also granted accreditation by CAAHEP through the CoA PSG.

I have worked with CAAHEP and specifically, the Committee on Accreditation of Polysomnographic Technologist Education Programs (CoA PSG) since 2007. At that time, I was asked to participate in a professional development session to become a site visitor for the CoA PSG, which was quickly followed by an offer to sit on their Board of Directors. Since that time, I have served on the CoA PSG as a board member (2007–2009), Secretary (2009–2011), President-Elect (2011–2013), President (2013–2015), and I currently serve as Past President (2015–2017). During these years, I have attended multiple CAAHEP meetings each year and have
come to notice that the growth of distance education in the allied health fields was becoming an often-discussed topic of concern. Not only were more professions beginning to look into the possibility of offering educational programs in a DE format, but the professions who had already developed DE programs were also transitioning many of their FTF programs into DE.

The primary purpose of the educational accreditor is to ensure that the standards of quality for these programs are met, regardless of the method of delivery. The growth and expansion of DE in allied health education created unique challenges for the CoAs because not only were many of them unsure of how to make sure the programs were meeting the standards, but they were also very concerned with the fact that most of these programs had clinical curriculum components. Without a background in DE and the capability to monitor students remotely and use technological classroom and other educational tools, it is hard to understand how clinical educational experiences with instructor oversight can occur at a distance.

As a result, most CoAs were voicing their concerns of needs for more information and direction to the CAAHEP Board of Directors. Being rather inexperienced in DE, themselves, the CAAHEP administration staff were also unsure of the answers to some of these questions. Seeing the needs of the accrediting committees, I offered to lend my experience and expertise in the delivery of an allied health education program with clinical requirements in a DE delivery method to assist CAAHEP in developing a plan to provide information and direction to CoAs being asked to accredit and monitor DE programs. This eventually evolved into my
leading discussion groups on the topic of accrediting distance education programs in allied health at a national CAAHEP conference in 2014. Much of the data analyzed in this study was gathered from these discussion groups. It should also be noted that, at the time of the conference, my name appeared on the schedule as “Abby Overton.” Although my given name is Auburne, in many circumstances I go by my nickname, “Abby.” I have since remarried and changed my last name to Hutchins, thus my name appears differently throughout the research. Although different forms of my name are used, all of the research was done by me.

Nevertheless, before information and direction could be provided, we needed to know exactly what problems the CoAs were facing and what questions they had. Once we answered these questions, we would then be able to review the literature to determine best practices and establish a way to comprehensively provide guidance to the CoAs in regards to accreditation of DE programs. These needs formed the basis for my dissertation research and choice of methodological approach. Because of my positionality and long-standing relationships with the CoAs and CAAHEP administration, I had access to key individuals at an annual meeting so that the focus group discussions could be conducted. I was also provided with contact information of members of a CoA that had recently conducted a site visit at a DE program with a clinical component so that I could interview them and learn more about their experience. When comparing these data with the literature that was reviewed, along with my own experience directly with the topic, I was then able to examine the problem in the most comprehensive way in order to offer potential solutions as a conclusion to this research.
Definition of Terms

The following terms were defined for this study:

**Accreditation:** “…accreditation is granted when a program is in substantial compliance with the Standards of Accreditation and remains in effect until due process has demonstrated cause for its withdrawal. Only the CAAHEP Board of Directors has the authority to remove accreditation” (www.caahep.org).

**Allied Health:** “…a collection of health care professions that employ healthcare practitioners with formal education and clinical professional development who are credentialed through certification, registration and/or licensure. They collaborate with physicians and other members of the health care team to deliver high quality patient care services for the identification, prevention, and treatment of diseases, disabilities and disorders” (www.caahep.org).

**Asynchronous Course:** Courses or portions of courses that are offered via distance education that can be accessed by students at any time, regardless of whether other students and/or the instructor are logged in to the course or not (Dziuban, Hartman & Moskal, 2004).

**Commission on Accreditation of Allied Health Education Programs (CAAHEP):** “Currently accredits over 2000 educational programs in 26 health sciences fields. CAAHEP is an accreditor of programs at the entry level of each profession. CAAHEP was formed in 1994. Its predecessor organization was the Committee on Allied Health Education and Accreditation (CAHEA). CAHEA was part of the American Medical Association (AMA). CAAHEP is a Section 501(c)(3) tax-exempt organization” (www.caahep.org).
Committee on Accreditation (CoA): “…a group that participates in the CAAHEP system of accreditation. They work in cooperation with CAAHEP by managing the accreditation process in their respective professions and then forwarding recommendations for accreditation to CAAHEP. They are also responsible for providing CAAHEP with the draft language for the Standards and Guidelines for their specific profession” (www.caahep.org).

Distance Education: “…a formal educational process in which the majority of synchronous and asynchronous instruction occurs when student and instructor are not in the same place. Distance education includes, but is not limited to, correspondence study or audio, visual and/or computer/internet technologies” (www.caahep.org).

Distance Education Program: “…the delivery of the complete program that allows the completion of the entire curriculum without the need to attend any instruction on a campus location (Note: this delivery is not hybrid or partial e-learning delivery.)” (www.caahep.org).

Hybrid and Blended Courses: Each institution of higher education may create their own definition of hybrid courses. Typically, courses containing 25-75% of the course material in a distance education delivery method are considered hybrid. The programs discussed in this research are not hybrid, but 100% online distance education programs. (Dziuban, Hartman, & Moskal, 2004).

Standard: “…a requirement that educational programs must meet to be accredited” (www.caahep.org).
Standards of Accreditation: “...qualitative and quantitative measures used in assessing a health science education program’s compliance with established national norms as described in a document called Standards and Guidelines for an Educational Program in…” (www.caahep.org).

Synchronous Course: Courses or portions of courses that are offered via distance education that are presented to all course participants at the same time via live streaming and presentation (Dziuban, Hartman, & Moskal, 2004).

Overview of the Dissertation

Chapter 2 provides a comprehensive review of the literature that was conducted to determine best practices for DE accreditation. The literature review also served as the basis for the theoretical framework using Grounded Theory as the structure for this research. Chapter 3 discusses the methodology used to carry out the study, and includes the data collection and analysis methods, discussion of the quality and integration of the data sources, and the limitations and analysis of the data collected. Chapter 4 presents the results of the data that were collected for this study, and Chapter 5 provides a summary of the research findings, conclusions, and recommendations for practice and future research.
CHAPTER 2. LITERATURE REVIEW

Historical Background

Distance education (DE) has experienced monumental growth in the past 10 years as a viable mode of educational delivery in U.S. institutions of higher education. According to a recent study by Allen and Seaman (2014), most higher education students have taken at least one online course, reaching an all-time high of 33.5%, or nearly 7.1 million students. The outward reach of DE is extending continually. Currently, most types of schools, including both public and private K-12, charter, universities, and technical and community colleges, deliver at least some of their content via DE. As several models of DE are available to students; it is important that the students enrolling in a DE program are educated about the quality of the program before choosing to enroll in such an experience. DE is most typically perceived as education delivered in some manner over the internet. Distance education may be used to deliver one specific component of a course or an entire course comprised of many lessons with a common theme or purpose. Instruction may be delivered as a self-guided series of tasks previously developed and set up by a course developer. Alternatively, the DE experience may be used simply to enhance a face-to-face course. However, for the purpose of the current research, DE was defined as full courses offered entirely online by institutions of higher education.
Distance education versus traditional delivery

Distance education has been reported to have advantages over traditional face-to-face (FTF) course delivery methods. For example, Maki, Maki, Patterson, and Whittaker (2000) found that students enrolled in DE courses performed better than their peers in the same FTF course. Convenience, time and resource management, and improved student learning have all been touted as some of the reasons underlying this observation (Emerson & McKay, 2011). Conversely, some individuals perceive that online courses are inferior to traditional FTF courses and are unconvinced of their redeeming qualities. Mottarella, Fritzsche, and Parrish (2004) reported that students received lower grades in the DE course than their counterparts in the FTF course despite the fact that the groups had comparable GPAs. In another study, Del Corral, Guevara, Luquin, Pena, and Otero (2006) concluded that there was no significant difference in learned information when comparing increased knowledge of DE and FTF students in the same course that differed only in the method of delivery. As suggested in these studies, data comparing the outcomes of students in DE versus FTF courses are inconclusive (Hughes, McLeod, Brown, Maeda, & Choi, 2007; Toth, Fougler, & Amrein-Beardsly, 2008; Rivera & Rice, 2002).

Providing DE opportunities can be advantageous for institutions of higher education not only because these schools are able to offer their programs to students in remote geographical locations, but also because DE can result in an increase diversity by including students, faculty and guest speakers with a wide variety of ethnic, lifestyle and socio-economic backgrounds to coursework in ways
that were previously not otherwise possible (Quinn & Barth, 2014). The high costs involved in maintaining physical campus facilities, faculty time and presence, and other associated technological costs have resulted in traditional FTF learning environments becoming increasingly unsustainable. What was once considered required for certain types of educational opportunities, such as the delivery of lab or other hands-on course activities is now available in much more cost-effective and student accessible DE learning modalities. Distance education is becoming more accepted at as commonplace rather than as an appendage to educational offerings at most institutions of higher education. Programs that have been conventionally considered to only be feasible as FTF programs are beginning to adopt DE practices not only because they are cheaper but also because they are able to reach a larger audience in a more efficient way without additional costs (Gallagher & Garrett, 2013). Distance education is simply more accessible and more sustainable than traditional classroom practices and, as such, is touted as the way of the future for providing higher education. Distance education is also provides a way to make educational opportunities available for those who have the greatest need but can least afford the cost when considering students who may have to move to another state to complete education in their desired fields (Naidu, 2014).

Inconsistencies have also been found in the level of interaction of students in DE courses compared to traditional students. Findings of some studies have revealed that online students are more active learners compared to traditional students, and that they participate more in the course as reflected in completing assignments and online discussions (Del Corral et al., 2006; Skorga, 2002). Other
studies have revealed that, typically, there is very little student interaction in online courses, with the result that students lose important elements of collaboration and understanding of the course material (Toth et al., 2008).

A study by Del Corral et al. (2006) revealed that, when comparing the outcomes of FTF and DE students, there was statistically no difference in student learning, which suggests that both methods of delivery have the same teaching capabilities. Similarly, Mgutshini (2013) found that, although the comparison of student outcomes in online and FTF courses revealed comparable academic success, the online students were more likely to be less satisfied with their experience in the course than their on-campus peers. However, findings of other studies have revealed that there may be inconsistencies between the actual learning outcomes of students in an online environment as compared to those taking a course in a more traditional FTF delivery (Ali, Hodson-Carlton, & Ryan, 2004; Atack & Rankin, 2002; Mitchell, Ryan, Carson, & McCann, 2007)

Due of the inconsistencies in the research findings, questions are now being posed regarding the quality of education with DE delivery methods. It may be that the inconclusive results can be attributed to factors beyond the delivery method itself. Emerson and McKay (2011) posited that the relationship between the delivery mode and the learning outcomes should be further examined to determine if other factors contribute to the disparate findings of the DE students’ achieved learning. This may potentially be determined by evaluating if the DE courses are set up in a way that students may achieve their full potential for learning in the course.
The merits of DE have been doubted by many in higher education for several years. Most traditional educators have been of the opinion that DE is nothing more than a correspondence course or “mail-order” degree. Although this may have been true for some of the pioneering courses offered via DE, many changes have occurred over the past 35 years that have made DE a respected and accepted delivery method in higher education. One of the major problems in the development of clinical distance education, in particular, has been the reluctance of the medical community to embrace the reality that we now have the technology to provide high quality educational experiences via DE, even when hands-on clinical components are (Robbins & Hoke, 2008; Reynolds, 2010). In order to understand the mindset of these nay-sayers and their position on DE, it is important to understand where DE once was, how it has changed, and what is considered to be the best practice today (Allen, Seaman, Lederman, & Jaschik, 2012).

**Accreditation of DE programs**

Accreditation standards for DE programs should not be any different than those established for traditional FTF programs. The delivery method is different, but the programmatic quality, goals, and outcomes of the programs remain the same. The difference lies in the task of knowing how accreditors can objectively look at a program and determining whether it meets those accreditation standards. Specifically, the accreditation evaluators must ensure that the standards are being met and that the institution provides the same institutional quality that has been evaluated and reported in previous accreditation processes for FTF programs at the

…[that] the electronically offered program is provided by or through an institution that is accredited by a nationally recognized accrediting body, the institution’s programs with specialized accreditation meet the same requirements when offered electronically and finally it should be the institution’s responsibility to review educational programs it provides via technology in terms of its own internally applied definitions of these principles. (n.p.)

Eaton (1999) noted, “Accreditation practice might then be viewed as an examination of key aspects of institutional quality: resources invested, process followed, results achieved.” Accreditation standards need to assess the process used to develop the DE curriculum, not just the outcomes. This should be done with an evaluation tool that closely examines the teaching and learning experiences to make sure that the accreditation standards are being met. It must include easily understood technology, minimum stated requirements for quantity, quality and frequency of interaction by students and faculty who are at least comparable to the FTF programs (Phipps, 1998). Although there is great emphasis on the development of clearly defined outcomes, their measurement, continuous review and implementation of changes based on their result, when evaluating a DE program, accreditation standards should be assess the process of DE learning at the institution to be accredited to ensure that there are adequate resources, faculty allocation, learner support, and institutional support (Kinslow, 1999).

According to Eaton (1999), there are three key aspects of institutional quality when accrediting DE: resources invested, process followed, and results achieved. When considering resources invested, the discussion should be about educational
modalities and policies consistent with institution’s mission. Policies must address administration curriculum and evaluation. There should be strong administrative support for the leaning design, content, processes and daily operating procedures. Accreditation should measure appropriate resource and faculty allocation. Learner support through technical services is imperative. Faculty must be trained in DE and their performance evaluated regularly. There should also be a well-developed plan that includes technological requirements and information security.

According to the Western Interstate Commission on Higher Education (WICHE) (2014), the following are the primary areas for review during accreditation of DE programs:

1. **Curriculum and instruction:** Including student/student and student/faculty interaction, guidelines, provision of appropriate technology, current and relevant materials, clearly understandable policies regarding copyright and faculty support and training.

2. **Evaluation and assessment:** Review of student success, learning outcomes, student retention and satisfaction and monitoring of the integrity of student work.

3. **Library and learning resources:** Student access to library resources, facilities, equipment, and laboratory experiences appropriate for the programs offered.

4. **Student services:** Student access to financial aid, advising, placement and counseling, training for the technology being used, a plan for resolving student complaints, and accurate advertising, recruiting and admissions information.
5. **Facilities and finances:** Institution’s equipment and technological expertise and support, a long-term plan for the maintenance and updating of current technology, appropriate budgeting, and policy development.

Accreditation evaluators need to be educated in the nuances of DE so that all aspects of the program’s compliance with accreditation standards can be fully evaluated to ensure that when the evaluators perform a site visit, the purpose of that visit is simply to assure that the program is actually doing everything that they say they are. The program being evaluated needs to demonstrate that it can effectively meet or exceed all accreditation standards for which they are being evaluated. This should include an established plan for meeting outcome criteria for DE and how student outcomes are improved or at least remain consistent with traditional FTF courses at the same institution (Hanna et al., 1998).

**Basic necessities for a successful DE program**

Keegan (1980) attempted to define distance education and outline the basic necessities of an effective DE program in one of the first research publications on DE. According to Keegan, six primary factors are necessary for distance education to be effective:

1. Defining a separation between the instructor and the learner;
2. The amount of influence and support from the educational institution;
3. The effective use of technology to create dialog and understanding between the instructor and the learner to ensure that learning occurred;
4. Consistent two-way communication;
5. The potential for there to occasionally be face-to-face meetings between the instructor and the student (for both academic and social interaction); and

6. Participation in an industrialized form of education.

These same primary factors are still of the highest importance in DE today.

The Council for Higher Education Accreditation, the parent organization of CAAHEP, noted that there are seven primary aspects of high quality DE programming that must be present when accrediting DE programs (Council for Higher Education Accreditation, 2002). These include:

- The organization is prepared to support the structure and financing of a DE program. Both of these are in alignment with Keegan’s factor number three.
- Faculty support, which is in alignment with Keegan’s number two factor.
- Sufficient student support, which is in alignment with Keegan’s number four and five factors.
- Curriculum and instruction consistent with quality DE programs, which is in alignment with Keegan’s (1980) number one and three factors.
- Student support, which is in alignment with Keegan’s number four and five factors.
- Ensuring that the DE program being offered supports the mission and vision of the organization and monitoring of student learning outcomes, which is in alignment with Keegan’s number six factor.

**Defining a separation between the instructor and the learner**

Many in higher education have failed to adapt their mindset of DE since their acceptance of these principles although the landscape and reality of DE has changed dramatically since 1980. When Keegan (1980) spoke of “Defining a separation between the instructor and the learner” (p.14), his intent was to give credence to the definition of the instructor and learner as being in different physical locations at the time that the instruction was occurring. These types of course delivery methods may allow for those students who were previously not able to
enroll in higher educational opportunities because of economical or geographical constraints to do so via this new method of instructional delivery. Although this fact remains a major contributor to the attractiveness and practicality of DE, it is also important to remember that, as technology has improved, so has the ability to provide increasingly better quality of instruction via DE. Bernard, Abrami, Lou, Borokhvsiki, Wade, Wozney, and Huang (2004) suggested that we are finally at a point where we no longer need to compare DE to traditional face-to-face methods of instruction. They argued that all forms of DE, including blended learning, online learning, and traditional face-to-face instruction, each have their own sets of strengths and weaknesses. As such, each delivery method also has its own natural place in the realm of higher education where they are best suited and should be held to those contexts.

**Amount of influence and support of the educational institution**

Perhaps one of the biggest misperceptions of DE is that it is a form of correspondence learning or independent study (Latchem, 2014). This has partly been due to the fact that each institution has its own definition of DE and parameters that qualify a course to considered DE. The terms open learning, flexible learning, blended learning, distributed learning, online learning, distance education, and e-learning have all been used, and each describes a slightly different type of DE. Although each has played its own important role in the development of DE, institutions must be cautious of the terms that they use to describe the educational delivery they offer so as to not confuse potential students (Paine, 1989).
Effective use of technology

When DE first began to be offered in the 1980s, computers were few and largely unavailable to private consumers. Therefore, original methods used in DE were limited to sending printed materials to students for them to complete, and then send back to the instructor for grading. Gradually, more technologically advanced methods, such as synchronous classroom experiences via teleconferencing, were introduced. Eventually affordable options for personal computer technology and internet use in the students’ homes were introduced. Along with the advent of the internet, these advances provided the basic foundation for today’s versions of DE. Keegan (1980) posited there needs to be a way to connect the learner and instructor. Although the meaning of this DE concept has changed dramatically over the past 35 years, the simple truth that Keegan implied is still relevant. The learner and instructor need to be in constant contact in order for learning to occur (Bernard et al., 2004).

Quinn and Barth (2014) suggested that the use of social media-like atmospheres imbedded within DE courses could enhance the satisfaction and participation of the students in the course. Currently, many learning management systems have discussion boards and other tools that mimic social media that students are not only familiar with, but also feel comfortable using to communicate with their classmates and even instructors. The synchronous and asynchronous methods of communication available in DE courses create a sense of community and connection between the students and instructors within a course, and can dramatically improve the level of interaction and participation, ultimately leading to
improved comprehension. As long as the instructors moderate these forums for professionalism and appropriate content, these types of forums can enhance communication within a course and provide improved outcomes and overall student satisfaction.

As suggested by Quinn and Barth (2014), one key to being a good participant in DE today is to fully understand the technology that is being presented and to be able to assist those involved to use it to its full potential. Students must understand from the beginning that, although the information is provided to them, they must take the initiative to devote time and effort to study the materials and stay in contact with their instructors, especially if they do not understand what is being taught.

It is also very important to consider how well a student is prepared to study in an online environment. Whether or not students have been properly equipped to take a DE course can have a significant impact on their overall performance in the course. Many schools, such as the University of North Carolina and the University of Georgia, utilize methods that enable students to determine their own personal learning style and provide an introduction to strategies to succeed in online courses based upon their own particular learning style (University System of Georgia, 2014; University of North Carolina, 2014).

Other factors, such as the validity of the assessment method used to measure learning outcomes and the quality of the technology used in DE courses, can also profoundly impact the achievement of course objectives (Hoeksel & Moore, 1994). As with courses for any delivery medium, student behaviors such as their participation in discussion forums, time management, and their overall opinion of DE
can also have a profound impact on achievement of learning objectives. The key to student/instructor and student/student interaction in DE courses is preventing problems due to miscommunication by providing crisp planning and a stout backup system for the course structure, including site-specific clinical instruction based on individual student assessment as well as providing close, frequent and consistent interaction between the student and instructor (Hoeksel & Moore, 1994).

**Consistent two-way communication**

When DE was first developed, the students and instructors were forced to depend on traditional mail service and phone conversations to communicate with their instructors (Downes, 2012; Naidu, 2013). Not only was this inefficient, but it also created significant barriers to learning for the students as the instructors were not always available when the students had questions. This is primarily where the terms “correspondence or mail-order” education were developed. Today’s students have a significant advantage above those who participated in the early forms of DE. Not only are there now platforms designed specifically for the delivery of DE, but the instructors are also able to communicate with their students at virtually any time, any place, and in a multitude of methods. Many instructors utilize not only email and voicemail to connect with their students, but they are also able to communicate by video conferencing to discuss topics and questions, and they may also provide virtual lessons that are live or recorded for the students to watch at their leisure. These enhanced methods of technology enable students to participate in real-time conversations with an instructor as the lesson is being taught from a remote location.
via the internet, allowing them to have voice and text conversations with the 
instructor, thus providing a constant flow of communication between the student, 
instructor, and their classmates.

Many instructors also provide virtual office hours where they are available 
online to have voice or text conversations with students at set times, when the 
students know that the instructor will be present, which mirror traditional office hours 
on a physical campus. Use of these tools has expanded the concept that knowledge 
is the result of good communication, discussion and debate; epitomized by the 
concept of connectivism and connecting knowledge between the learner, their 
classmates, and the instructor through massive, open, online communication 
(Downes, 2012; Naidu, 2013).

In order for there to be consistent two way communication that utilizes all 
forms of current technology, it is also essential that the instructor and particularly the 
students have the most current technology available to them in order to conduct 
such communication (Siemens & Downes, 2011). The technological necessities of 
the student to be able to participate at the highest level in the course are essential 
and should be made clear to the students before they begin coursework.

Distance education courses also provide a unique challenge in that students 
might inherently harbor distrust because they are not able to see their instructors 
and fellow classmates in person. In turn, the distrust might inhibit students’ 
participation and communication in the course because they may not feel safe in 
freely expressing their actual thoughts; consequently, they may choose, instead, to 
protect themselves by not contributing as much as they may in a traditional FTF
setting. Wan (2014) revealed that students were satisfied in DE classes in which they are presented with opportunities to visually see and interact with their instructors and classmates via video conferencing and have frequent candid, yet professional, conversations with those individuals in other places within the course. When later presented with like-opportunities elsewhere in the course, such as discussion boards and group projects, the students’ level of trust was dramatically increased. The study also revealed that course materials that mimicked interactive social media also helped to encourage the students’ trust in an online course.

**Potential FTF meetings**

When DE was first developed it was typically set up as more of a blended learning scenario, or one that would be considered more of a hybrid online learning system (Phipps, Wilman, & Mersater, 1998). In other words, the didactic portion, and possibly other portions of the course, were held via DE, while other portions of the course were held in a FTF manner. Typically this method would require students to travel to the site of the institution to complete their final exam, oral presentations, defense of their written work, or meet other course evaluation methods. In most cases, this was cost-prohibitive for students and created significant barriers for the students to be able to participate in many DE courses because they were not able to complete all of their work from their own geographical location.

Technological advances have made it possible for students to digitally participate in these types of activities that were once thought to be only possible FTF. The introduction of video conferencing, virtual presentation, and even online
course tools such as science labs, virtual anatomy labs and real-time participation in hands-on experimentation with other students in a course from around the world has made it possible for students to participate in any kind of educational activity at any time virtually in the same way that they would be if they were standing nearby their instructor and classmates (Lindsay, Naidu, & Good, 2007). Quinn and Barth (2014) suggested that programs should use synchronous technology to maintain face-to-face contact with their students and clinical preceptors at sites where students are performing hands-on components of their educational program. Students should be able to arrange virtual tours of their clinical facility. The technology can also facilitate meetings with clinical and programmatic faculty to further enhance contact and integration with instructors even though they may be at a significant physical distance from the student.

**Participation and distance education**

As discussed by Rosenbloom (2011), in traditional education instructors are required to develop, design, implement, engage, assess, provide feedback to the students, and still engage in their own scholarly research. This can be difficult when the instructor is typically not formally educated to be proficient in all of these subject areas. This is especially true in allied health education programs where the instructors are generally from clinical settings, and have received scant professional development in higher education teaching methodology. In this aspect, DE has a unique advantage as most of these functions are allocated to people within the institution who specialize in each of the areas and, thus, have teaching expertise. In
DE, these essential aspects of the course are assigned to many individuals who make up a team to present the final course offered to the students. While instructors may develop a general outline for their own courses, there may be a team of individuals involved in creating, building, reviewing, assessing, and providing support for the course itself. Many campuses are beginning to deconstruct the course components and reallocate resources in an effort to maximize the utilization of the instructor’s time and expertise, which provides positive results both financially and for overall outcomes, such as retention, meeting learning objectives, and student satisfaction (Gallagher & Garrett, 2013).

In the typical model of developing coursework for DE, instructor is given the unique opportunity to focus primarily on the student in order to provide greater interaction, communication and feedback in direct response according to their own field of expertise. Institutional administrations typically notice over time that student satisfaction ratings from those taking DE courses tend to be higher as a direct result of the instructor being able to focus more on the students and their work rather than to spend time on the logistics of delivering the course since it is handled by others within the institution who are specifically trained to do so (Rosenbloom, 2011). As a result, this may lead to a higher quality experience for the students as they receive more assistance with their work, and there is increased faculty satisfaction because they are allowed to focus on the areas of instruction where their expertise lies (Rosenbloom).
Student success in distance education

Key factors in student success are the technological experience of the course developer, instructor, and students. These factors contribute to the overall effectiveness and achievement of the learning objectives in DE courses. Providing a level of comfort with the technologies utilized in the instructional elements of the course can have a profound impact on the students' ability to learn. Findings of a study by Emerson and McKay (2011) revealed that, in a face-to-face course, as perceived work stress related to a lack of technological knowledge increased, there were no changes in the final grades of students. However, when students were taught the same lessons in an online format, as work stress increased, their scores decreased significantly. Furthermore, when working with less experienced online faculty and students, research has indicated that much of the focus is shifted to the development and learning of the technology rather than the actual course material (Gilbert & Moore, 1998; Kidney & Puckett, 2003).

An objective-structured clinical examination that has long been applied in the nursing field since 1975 was utilized to review nursing students who were preparing for their clinical examinations (Oranye, Che’an, Ahmad, & Bakar, 2012). This assessment examination was comprised of an exam for clinical skills assessment of student nurses who practice their skills in multi-station settings using standardized patients while faculty watch and evaluate their performance. There are many as 20 stations in which tasks are divided into components such as history taking, nursing diagnoses, performance of procedures, and interpretation of clinical data. The study was conducted to assess differences in student outcomes between those taking
their clinical by FTF vs. those completing the assessment via DE. Findings of the study revealed that, regardless of years of experience or delivery method of the educational program, there was no statistical difference in the scores of nurses in either group. The most influential factor in successful completion of the examination was most closely attributed to continuous monitoring of clinical skills competencies rather than relying entirely on method of instruction and course examinations. Thus, it may be assumed that implementation and consistent evaluation using clinical skills competencies was key in both traditional and distance education programs.

Studies by Kurtz, Mahoney, and Likicker (2009), and Annabel (2007) also concurred that clinical skills competencies should be sustained in both traditional and DE programs. There is a common misperception that, if preceptors have been working in their profession for a long time, they are very skilled in their tasks and, consequently, would be able to teach their skills to students in allied health programs. However, Annabel (2007) identified that years of experience did not inherently predispose preceptors to be good teachers, nor would it advisable to assume that they perform their clinical skills correctly or might pass along incorrectly performed skills to the students. It was suggested that preceptors should participate in ongoing education under an established professional development plan to develop or enhance (for those who are established instructors) their teaching experience and ensure they are following established methods of teaching/evaluating clinical skills performance.

The use of DE in educational programs was also explored by Robbins and Hoke (2002) who specifically investigated advanced practice psychiatric mental
health students. The study focused on ascertaining the validity, reliability and practicality of the educational program. It was determined that the type of assessment tools used to evaluate student performance in a program had a direct impact on overall student satisfaction in performance in the program. Students reported having a better experience and more positive student outcomes in the courses that provided consistent interaction and feedback from the instructors, and when assessments were performed in ways that necessitated this type of interaction. Assessments included discussion boards, essay questions on exams, group projects, and live-streamed discussions and student presentations.

Occupational therapy has also used DE to provide professional growth and advancement. Distance education provides access to education and continued practice updates to those in areas where such information was not previously accessible. Key elements of success in these courses included access to resources, opportunities for students to explore evidence-based clinical literature, consistent, and timely feedback on student work as well as opportunities to collaborate with peers (Reynolds, 2010).

Although traditionally perceived as being taught face-to-face (FTF), online laboratory sessions are becoming more common in even in general science fields such as biology and chemistry. Findings of a study conducted by Stuckey-Mickell and Stuckey-Danner (2007) that examined student responses to their perceptions of their experiences in online biology laboratory courses, the majority felt that their virtual laboratory experience was just as effective in contributing to their learning in the course as if they had participated in the FTF section.
Similar courses can be developed in a variety of ways to engage the students as effectively online, or exceed an FTF laboratory setting. An example is a biology course with a lab component that was developed by North Carolina State University in Raleigh by Mickle and Aune (2008) who studied student satisfaction with a general biology lab offered via DE. Completion of the biology lab required students to purchase a basic package of materials to conduct experiments at their residence. Previously, the lab would have been carried out traditionally in the class together. Findings indicated that not only were the students satisfied with their experience, but they also perceived that they understood the material better because they were forced to work on their own and follow the instructor virtually rather than rely on the instructor in a FTF session or follow what other students in the room were doing.

Chemistry lab courses are also being offered in DE format by some institutions. In a study conducted by Kennepohl (2001), a software simulation of the courses’ chemistry experiments was provided to students via a CD-ROM. Students performed just as well in the course when using the simulation program as the FTF students who were in a traditional laboratory setting. The students indicated they were also satisfied with their experience because it resulted in reduced overall lab time and offered them the ability to have the experiments in a more accessible and flexible manner for review before exams.

Technological advances continue to enable the creation of an increased number of varying methods of delivery in numerous locations. More institutions are providing educational opportunities anywhere and at any time via a cornucopia of technological delivery methods to bring instructors and students together (Gallagher
& Garrett, 2013). The National Council for State Authorization Reciprocity Agreements (2014) recently published a lengthy, yet not exhaustive, list of key elements that are necessary on the part of the institutions offering DE courses:

1. DE appropriately follows the institution’s mission, vision and values.

2. Continuous plans for development, sustenance and expansion of DE are part of the institution’s strategic planning and evaluation.

3. DE is incorporated as part of the institution’s governance and academic oversight.

4. DE curriculum is coherent, cohesive and comparable in quality and rigor to similar FTF programs at the same institution.

5. Continuous evaluations of effectiveness with results that are used to improve the evaluation of the goals of the courses.

6. Student success is evaluated by faculty that are delivering and evaluating the courses and those faculty are qualified and effectively supported.

7. Student and academic services are effectively provided by the institution.

8. Resources and support of DE courses are appropriately supported by the institution and expanded if needed.

9. The institution monitors and ensures integrity of its DE course offerings.

It is important to develop DE programs with a good balance of these aspects to ensure that accreditation standards, learning objectives are met, and that students and faculty are satisfied.
Instructor professional development

According to Desai, Hart, and Richards (2009), professional development for instructors in adapting teaching styles to meet the needs of their DE students are required for the courses to be successful. Making the change from FTF to DE requires that the instructor slightly shift their roles from mentor, coordinator and facilitator of a classroom to that of a conveyor of information and facilitator of conversation absent of social queues (Hardy & Bower, 2004). In order for the instructor to be effective in providing a meaningful learning experience for the students, they must participate in formal professional development to ensure that they are proficient in pedagogical issues involving student interactions, course content and deliver, multi-level communication, technologically advanced assignments and evaluation methods, and performance expectations (Moller, Foshay, & Huett, 2008). These skills can be very hard for instructors trained in traditional FTF classrooms that are seasoned in accomplishing all of these fundamental aspects of delivering higher education in a lecture setting (Desai, Hart, & Richards, 2009).

Specifically, Billings, Connors, and Skiba (2011) defined a list of the following principles of DE that every instructor should undergo professional development to learn how to effectively execute each in a DE environment:

- Interaction with faculty
- Collaboration among students
- Active learning
- Prompt feedback
• Time on task
• High expectations
• Respect for diverse talents and ways of learning

Although this list is not comprehensive, it is a general compilation of basic necessities for DE instructors to be successful.

**Objective alignment**

Though most of the research performed thus far to determine the quality of DE courses has focused on their outcomes as compared to comparable FTF courses (Miller & Miller, 2000; Zheng, 2004; Morrison & Anglin, 2006), many researchers have recognized that an evaluation of the structure and design of the DE courses is also very important to consider as a means to better outcomes. Regardless of the course delivery method, many researchers recognize the importance of developing objectives that are transparent and aligned with the desired learning outcomes (Fabry, 2009; Emerson & MacKay, 2011).

The American Distance Education Council, (ADEC) (n.d.) has come to a similar conclusion as illustrated in its statement in the *ADEC Guiding Principles for Distance Learning* that the majority of the guiding principles that have been used to creating high quality FTF courses can also serve as the basis for the development of good quality DE courses. The ADEC noted that one of the fundamentals of DE learning is that the experience should have a transparent purpose with extremely focused learning outcomes and objectives for achieving such outcomes (ADEC, n.d.). Morrison, Kemp, and Ross (1998) developed an instructional design model for
the successful development and implementation of learning objectives in DE courses (Figure 2.1).

**Quality Matters Rubric assessment tool**

The Quality Matters Rubric (QMR) tool was developed in an effort to evaluate the integrity of the design of DE courses. The QMR tool evaluates the effectiveness of the design of DE courses to optimize learning outcomes through effective use of learning objectives (Quality Matters, 2014). It is a peer-review process used in all levels of education throughout the U.S. for the development of high quality DE use of learning objectives (Quality Matters, 2014). It is a peer-review process used in all levels of education throughout the U.S. for the development of high quality DE courses that are reviewed and approved by faculty peer review both within and outside of the institution (Shattuk, 2007). The rubric itself uses 11 primary principles that evaluate the instructional design, student resources, communication, assessment, and objective alignment throughout an entire course. It is a process that requires insightful and consistent feedback and suggestions on the part of the reviewers, and is considered an ongoing review process by the course faculty to

1. Clearly define objectives for the students.
2. Present instructional information in a sequential format to enhance logical learning.
3. Utilize instructional methods that allow the students to master the objectives.
4. Allow appropriate time for preparation of instructional delivery and message.
5. Create assessments that accurately evaluate the objectives.
6. Utilize resources to verify validity of instructional design and learning activities.

Figure 2.1. Instructional design model (Morrison, Kemp, & Ross, 1998)
continuously improve their courses. The most common evaluation methods for the effectiveness of the QMR tool are student surveys and final grades of courses, which would indicate student mastery of the course learning objectives (Shattuk, 2007). \(^1\)

In most institutions faculty use the QMR as a guide to evaluate their course against the rubric. This gives the faculty member opportunity to strengthen areas of the course that may have problems, and identify potential deficiencies in order to improve their course. Once the initial changes are made, an institutional peer reviewer is assigned to the course. The institutional peer reviewer is someone who works at the same institution but generally teaches in a different content area. These reviewers become certified as such by taking a course offered by Quality Matters that instruct them how to navigate the rubric and provide appropriate feedback for course improvement.

After the initial institutional-level review has been completed, the faculty member has an opportunity to revise the course. It is at this point that the faculty member provides course access to a reviewer from Quality Matters to review the course. This reviewer offers feedback with suggestions for improvement as well as presents ideas regarding how to implement other strategies that have successful in other reviewed courses with a similar structure. Not every institution conducts their QMR reviews in as many steps or detail as the design of the review process is ultimately at the discretion of the institution.

\(^1\) Additional information about the Quality Matters Rubric can be found by visiting https://www.qualitymatters.org/rubric
The key to providing continuous professional development for instructors and development of educational delivery tools to enhance the quality and understanding of the course materials will be severely compromised and elitist if they tools such as the Quality Matters Rubric and those provided by the Kahn Academy remain cost prohibitive and inaccessible to those without the requisite tools and technologies. (Naidu, 2014).

**Outcome measurement**

Assessment and measurement of outcomes should be similar as that required for FTF programs. The focus is slightly different only in that, although new technologies are being used to administer the learning experience, the accreditor should take a close look to make sure that the technology helps the learner to achieve the desired outcomes (American Council on Education, 1996). A well-defined plan of desired outcomes, measurement of those outcomes, and testing for relevance of outcomes will establish quality assurance standards that are the hallmark purpose of all accreditation organizations. Distance Education should not be held to different and, certainly, not lower expectations than traditional FTF classrooms. Student services may not necessarily be exactly the same for DE students as what is offered for FTF students. However, DE students may not have the same needs as FTF students. The student services provided to DE students should be sufficient enough to meet the needs of all DE students in the sense that, if there is a service offered to FTF students that would be helpful to DE students, it
should be offered in some manageable way to the DE students as well (Kinslow, 1999).

**Summary**

The literature has suggested there are not only inconsistencies in the quality of different DE programs, but there may also be differences between DE and FTF programmatic quality and outcomes. Consequently, those reviewing DE programs should have some experience with DE to use as a reference when evaluating DE programs to ensure they are meeting the accreditation standards. Evidence has been provided that DE is generally as successful as traditional classroom instruction in many allied health and general science courses.

Although there is a lack of consensus as to the effectiveness of DE as compared to FTF courses, what is certain is that there are demonstrated factors that contribute to student success and satisfaction in DE courses (Keegan, 1980). Key components to successful DE course delivery were identified in the literature, such as institutional support, faculty professional development, effective use of technology, outcome alignment, consistent communication, and student preparation.

Because of the paucity of information currently available on the accreditation of clinical allied health education programs offered in a DE format, the use of grounded theory as the main structural framework is appropriate in the current study because it allows the data to develop the methodology and conceptual theory based on the analysis of the data.
The question remains: How does one implement suggestions presented in the literature to ensure that the accreditors have the necessary tools and knowledge to accurately assess DE programs to ensure that all accreditation standards are being met? The literature review identified tools that may be used within DE programs to evaluate their effectiveness and overall quality with instruments, such as the Quality Matters Rubric designed to examine the structure of the expected outcomes, professional development for the instructor, preparation of the students, and appears to ensure evaluative measures the program has in place to ensure the expectations of the standards are being met.

Chapter 3 explains the methodology used to conduct this study using Grounded Theory and data collection. This is followed by the analysis of the data collected in Chapter 4. Finally, Chapter 5 summarizes the results of the data analysis and offers recommendations for practice and future research.
CHAPTER 3. METHODOLOGY

This chapter describes the methodology that was used to conduct this study. The current challenges facing CoA programmatic evaluators when reviewing DE programs were examined as well as ascertaining what CAAHEP might do to standardize and prepare these evaluators to conduct successful evaluations. Grounded theory was applied as the theoretical framework to structure the collection of data via focus groups, surveys, and the review of accreditation reports of distance education (DE) allied health programs.

Theoretical Framework

Glaser and Strauss (1967) first coined the term grounded theory. Glaser’s background was in positivism, which is based on the principle that human behavior can be determined by external stimuli and collected for quantitative data to observe and measure social phenomena. Therefore, positivism is based on the analysis of facts gathered in an attempt to explain certain phenomena. Strauss’s background was symbolic internationalism, which relies more on the symbolic meaning that individuals place on their social interactions. The traditional Glaser and Strauss method of grounded theory is generally regarded as “true” grounded theory (Engward, 2013) which was used to frame this research.

Grounded theory was described by Curtis, Horton, and Smith (2012) as being based on symbolic interactionism. This concept was developed as a result of the review of their own data. The theoretical framework presents a way of using empirical data to explain social phenomena by exploring what people are thinking,
what they are experiencing, and how they propose to resolve those problems (Engward, 2013). Grounded theory requires the systematic collection of data that is analyzed to observe patterns and overarching themes within the data. Then the themes are used to eventually develop the main hypotheses of the research. Thus, unlike many theoretical frameworks that use the data to test an existing theory, grounded theory does the opposite by using robust development of a theory based on the data collected. The primary focus of this theoretical framework is to observe and gather data from a social construct that eventually illustrate developing patterns of behavior or shared ideas of the participants. This is common in research studies wherein a precedential area of study is available to use as the basis for the development of a theory prior to collecting the data (Engward, 1999).

Grounded theory is typically neutral because it avoids making assumptions, thereby describing a less biased view of human activity in a social context (Simmons, 2006). It also frees the researcher from having to adhere to a stringent predetermined methodology, but rather enables the researcher to adapt his or her own work to include a data collection methodology that best addresses the needs of the work at any given time (Engward, 2013).

According to Glaser and Strauss (1967), grounded theory begins with a general sense of where to begin the research work by defining neutral research questions, then developing a conceptual theory. The method for gathering the data must then be determined and executed by utilizing the most effective methods necessary to do so, based on the topic of the research to be conducted. Once the data have been collected, the researcher must then develop a theoretical sensitivity
by diligently ascertaining variables and relationships from the collected data and then using that data to ground the newly developed theory. Achieving this requires passive review of the data by the researcher, and using coding and continuous comparison of the data in order for patterns to emerge. To illustrate the framework used in the context of this study’s purpose, the researcher designed a flow chart displayed in Figure 3.1.

The first research question was used to frame the collection of information from the three sources of data for the study: focus groups, surveys and report reviews. The focus group was presented with the question, then their discussion was recorded and later transcribed by the researcher. Next, the transcriptions were coded for major emergent themes appearing in the data. The surveys were conducted similarly, with the research question presented within the context of the survey. The responses were then compiled and coded in a similar way as the discussion group transcriptions. The SSR and Site Visit Reports were reviewed in order to determine potential answers to the research question. Notes from those reviews were then compiled and coded for major themes in a manner similar to the procedure used for the other two sources. From the coding of all three data sources, the major themes from the collective data were determined.

The first step in performing research using grounded theory is to develop the research question. The question should be structured so that it is broad enough to enable the researcher to develop his or her own work without being constrained by too narrow a focus. Having a somewhat broad focus allows the actual resulting concepts to emerge from the data (Corbin & Strauss, 2008). Instead, the research
Figure 3.1. Study development, data collection, and analysis process
questions should develop the general scope of the study, while the analysis of the
data collected will eventually define the phenomena that are occurring (Watling &
Lingard, 2012).

Next, the researcher must certify that there is a methodological fit within the
study. When considering the methodology to be used to collect data for the study
the possibilities are endless. When using grounded theory as the framework,
however, it is important that the researcher weighs the pros and cons of [her] options
and chooses the method that best suits [her] needs and will lead to the best answers
of the developed research questions (Watling & Lingard, 2012). Because this study
largely depended on the experiences and opinions of allied health education
accreditation professionals, methods of collecting data from these individuals were
selected. The three sources of data for this study were: focus group conversations,
surveys of CoA evaluators that had recently completed review and site visits of DE
programs, and the review of the self-study reports and reviewer notes from other DE
site visits.

The actual analysis of the data when using grounded theory can be
somewhat cumbersome because of the continuous evolution of the data analysis
through method, collection and coding (Glaser & Strauss, 1967). Coding the data is
an essential and prominent part of data analysis when using grounded theory. It is
important that the researcher remains open to the emergence of new conceptual
and theoretical directions while coding, and even re-coding the data (Charmaz,
2006). From the codes, the researcher must then evolve the overall concepts that
are derived from the data to eventually facilitate the overall theory development. At
this point in the process, it is typically very helpful to develop diagrams to assist with the discovery and explanation of the derived theories (Watling & Lingard, 2012).

Grounded theory can be a valuable model when researching a subject where there a paucity of previous study, but where there appears to be a tangible research agenda and subsequently, relevant research questions. The flexibility of grounded theory enables the researcher to sift through their data to develop [her] own set of truths by using inspiration and creativity for the purpose of the study (Watling & Lingard, 2012). However, it should be noted that this process also leaves the researcher open to potential weakness. One of the most troublesome examples is when the researcher settles on a list of concepts rather than a more complete development of their data (Kennedy & Lindard, 2006). Another potential problem area is when the researcher makes unsupportable claims of explanation. To avoid this danger, Bryant (2002) recommended targeting a constructivist goal in order to fully understand the contexts and purposes of the study rather than using a traditionally positivist goal of uncovering truth or establishing general theories. The researcher should also strive to be purposefully reflective on the actual goals of [her] work and the limits of the determined theory’s explanatory power (Watling & Lindgard, 2012).

**Data Collection**

Three major forms of data collection were applied in this study: focus group discussions with key professional stake holders, surveys of CAAHEP DE site visitors, and review of DE Self Study Reports from schools that have accredited DE
programs. The primary focus for each of these data collection methods was discovering information that directly answered the research question for this study. All discussions, surveys, and reviews of information were evaluated using the research question for data collection.

**CAAHEP structure**

The focus group discussions were conducted as part of a workshop hosted by CAAHEP during their annual Summer Workshop held on August 1, 2014. The Summer Workshop provides an opportunity for leaders from the individual profession’s CoAs, members of the CAAHEP Board of Directors, and appointed liaisons from the CoAs’ sponsoring organizations to meet and listen to lectures on topics affecting accreditation as a whole. An organizational chart of CAAHEP is provided in Figure 3.2 to better explain the individuals who were part of these discussion groups and their interest in the topic.

**CAAHEP Board of Directors:** The CAAHEP Board of Directors is comprised of 16 members, who are elected by and from among the Commissioners. The Board is the accrediting body of CAAHEP that awards or denies accreditation after review of accreditation recommendations made by the Committees on Accreditation. It is also the primary governing body that oversees the business of CAAHEP and implements the mission and vision as adopted by the Commission (CAAHEP, 2015).

**CAAHEP Commissioners:** The CAAHEP Commission is comprised of representatives appointed to represent the organizations that belong to CAAHEP as
Figure 3.2. CAAHEP organizational structure
well as certain other “communities of interest.” These Commissioners are responsible for approving the bylaws, mission, and vision statements of CAAHEP, as well as determining which health sciences professions are to be recognized by CAAHEP.

Committee on Accreditation (CoA): A group that participates in the CAAHEP system of accreditation by managing the accreditation process for an allied health profession and then forwarding recommendations for accreditation to CAAHEP. They are all (21 healthcare professions) responsible for providing CAAHEP with the draft language for Standards and Guidelines for their specific profession.

CoA Executive Director: Each CoA has an Executive Director. This is typically the only person working with each committee that holds a paid position. These individuals may or may not have a background in the profession of the CoA for which they work, but are professionals in the way of administration of the daily tasks, management and organization of each CoA.

CoA Committee Members: These individuals are typically credentialed professionals from the fields of allied health represented by each individual CoA and hold appointed or elected seats on their CoA’s board as representatives selected by professionals in their own field. For example, a CoA Committee Member from the Committee on Accreditation for Education in Neurodiagnostic Technology (CoA-NDT) could be a Neurologist or an individual that holds a professional credential in Neurodiagnostic Technology such as the Registered Electroencephalographic Technologist (R EEG T) credential awarded by the American Board of Registered Electroencephalographic Technologists.
Each CoA has a group of national professional organizations that sponsor their CoA. To use the same CoA as an example, the CoA NDT has the following sponsors: the American Academy of Neurology, the American Clinical Neurophysiology Society, the American Society of Neurophysiological Monitoring, and the Neurodiagnostic Society of the American Society of Electroencephalographic Technologists. Some CoAs appoint members from their profession to their board, others request nominations from each of their sponsoring organizations and vote on the committee members, while still others rely on their sponsoring organizations to appoint a certain number of committee members per sponsoring organization to sit on the committee. Regardless of the method of selection of committee members, each CoA is carefully composed of individuals from each profession who are knowledgeable not only about their specific profession, but also the necessary educational needs for those entering their profession. Members of the CoA committees participate as volunteers for the betterment of their professions and are not monetarily compensated for their time.

Each CoA pays annual dues, submits an annual business summary report, and are responsible for appointing a Commissioner of their CoA to CAAHEP. In return, CAAHEP then provides each CoA with a Liaison and multiple business and guidance resources. Each professional organization is responsible for paying their own financial support responsibilities to CAAHEP (annually) and their own CoA (determined by each CoA). They are then given the ability to appoint a Commissioner to CAAHEP and appoint CoA Committee Members (the number and frequency are determined individually by each CoA). The CoAs are also able to
appoint their own Committee Members and provide their Professional Organizations with reports of their business meetings and action items. Figure 3.3 illustrates this cyclical financial and business relationships among all of constituents that contribute to the CAAHEP CoAs.

![Diagram of financial and business relationships between CAAHEP constituents]

**Figure 3.3.** Structure of financial and business relationships between CAAHEP constituents
Focus group discussions

This CAAHEP summer workshop also provides an opportunity for leaders from the CoAs to work in groups on solutions to topics and problems presented to CAAHEP by the CoAs. The Summer Workshop included two focus group sessions that provided participants the option of attending those that best suited the interests and needs of their own CoA. There were two, 45-minute focus group discussions held during the workshop. The researcher (listed as Abby Overton on the agenda in Appendix B) was asked to lead one focus group discussion choice during each of these two times as seen on Appendix B as Focus Group Option #4 at 3:00 PM and 4:00 PM. The discussions were attended voluntarily by members of each of the key stakeholders that were present at the workshop. The focus group discussions were attended by individuals from four distinct groups of attendees whose importance and roles related to the business of CAAHEP were described in the above; CoA Committee members, CoA Executive Directors, CAAHEP Commissioners, and members of the CAAHEP Board of Directors. The focus groups consisted of two group discussions of 17 people in the first group and 15 in the second. A more detailed breakdown of the composition of each of the groups can be seen in Table 3.1 and 3.2.

The first group was comprised of 12 CoA board members from various allied health CoA boards (3 of which have programs that currently offer DE and 1 that has members considering offering such programs), 2 CoA Executive Directors (1 of a CoA that currently accredits DE programs), 3 CAAHEP Board of Directors members, and no CAAHEP Commissioners.
Table 3.1. Representation of participants in focus group discussing questions regarding distance education accreditation, Group 1 (n=17)

<table>
<thead>
<tr>
<th>Group represented</th>
<th>Sub-group category</th>
<th>Number in attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>CoA Committee Members</td>
<td>Currently have accredited DE programs</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Currently have programs considering DE accreditation</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Currently have no programs accredited as DE or considering DE</td>
<td>8</td>
</tr>
<tr>
<td>CoA Executive Directors</td>
<td>Currently have accredited DE programs</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Currently have programs considering DE accreditation</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Currently have no programs accredited as DE or considering DE</td>
<td>1</td>
</tr>
<tr>
<td>CAAHEP Board of Directors Members</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>CAAHEP Commissioners</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

Total                                                               17
Table 3.2. Representation of participants in focus group discussing questions regarding distance education accreditation, Group 2 (n=15)

<table>
<thead>
<tr>
<th>Group represented</th>
<th>Sub-group category</th>
<th>Number in attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>CoA Committee Members</td>
<td>Currently have accredited DE programs</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Currently have programs considering DE accreditation</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Currently have no programs accredited as DE or considering DE</td>
<td>6</td>
</tr>
<tr>
<td>CoA Executive Directors</td>
<td>Currently have accredited DE programs</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Currently have programs considering DE accreditation</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Currently have no programs accredited as DE or considering DE</td>
<td>3</td>
</tr>
<tr>
<td>CAAHEP Board of Directors Members</td>
<td>Currently have accredited DE programs</td>
<td>2</td>
</tr>
<tr>
<td>CAAHEP Commissioners</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>15</td>
</tr>
</tbody>
</table>
The second focus group discussion was attended by 7 CoA board members from various allied health CoA boards (1 of which currently accredits DE programs and none that are currently considering DE accreditation), 3 CoA Executive Directors (none of these CoAs currently have DE programs or any currently considering DE accreditation), 2 CAAHEP Board of Directors members, and 3 CAAHEP Commissioners.

During these discussions, the participants were asked: (i) what challenges they have faced when asked to evaluate DE programs, (ii) how they feel CAAHEP could be helpful in providing more information and guidance for the accreditation of DE programs, and (iii) what suggestions they had for moving forward with implementing their ideas. Additional information about the workshop agenda and break-out sessions are provided in Appendix B.

One of the topics presented to CAAHEP for further discussion was that of the challenges faced by reviewers when performing accreditation reviews and site visits for DE programs. As a result, this became one of the discussion topics for the breakout sessions that were held as focus group discussions. This discussion was led by Auburne Deming, President of the Committee on Accreditation of Polysomnographic Technologists Education Programs (CoA PSG) and investigator for this research. These discussions were audio recorded and all participants in the groups were advised as such. This was so that the investigator could re-listen to the discussions at a later time to carefully collect all of the data that they yielded.

The discussions were moderated by the researcher and recorded using the investigator’s cell phone voice recorder then transferred to a computer file on a
secure server immediately after the discussions. The discussions were structured around the two main questions that were posed to each group:

a. What are the major challenges CoA evaluators experience when reviewing clinical DE programs for accreditation?

b. What professional development opportunities should be available for CoA evaluators of clinical DE programs to prepare them to overcome those identified challenges?

To prevent bias, the investigator to the focus groups upon introduction that she was working with CAAHEP to determine what challenges face CoA evaluators when evaluating DE programs for accreditation and that it was part of her Doctoral dissertation research. The members of the focus group were then asked to introduce themselves to the group by including their name, position on a CoA or CAAHEP committee, and purpose for participating in the focus group. After this introduction, the investigator verbally advised the participants that the discussions were being recorded for later analysis, and that they could opt out of the discussion if they desired.

To begin the discussions, the first question was posed to the groups for open discussion. By openly posing the question to the group, the participants were able to speak freely according to their own experiences as a result of their respective positions on their own CoAs or in the CAAHEP organization. The second question was then posed to the group, once again in an open format for free discussion of the question. The data collected from the audio recordings of the focus group
discussions was coded, analyzed and compared with the other data collected from the surveys and reviews of accreditation reports.

**Surveys**

Because the Committee on Accreditation of Polysomnographic Technologists Education Programs (CoA PSG) has the largest number (6) of programs designated as DE, surveys were given to the two Board members of the CoA PSG that were familiar with DE programs and had recently conducted an accreditation review and site visit to a DE program. This was the first time that either of these individuals had performed an accreditation Self Study Report (SSR) review and site visit of a complete DE program. Even though there were only two survey participants, surveys were used for this data collection rather than interviews to ensure the anonymity of the responses of these two participants. The survey provided a true reaction to the evaluators’ experiences while completing these tasks. At the time of the surveys, the site visit had been conducted and the reviewers had just presented their findings to the board for discussion along with their accreditation recommendations to CAAHEP. The two reviewers were asked the same question as presented to the focus group groups at the CAAHEP Summer Workshop.

The surveys were conducted via a confidential Survey Monkey that required password protection to enter the survey and protected the anonymity of the participants to collect their initial responses. After an initial review of their responses, specific details were then clarified via email correspondence. The information provided by these surveys were coded in the same way as the data
gathered from the focus group discussions and then combined with the rest of the data.

**Self Study Report (SSR) and site visit report reviews**

Self-study and site visit reports from recently conducted site visits for DE allied health education programs were provided anonymously to the researcher. These reports were from two different CoAs who had performed reviews and site visits of DE programs within the past three years. These CoA reports were not from the same site visits that the participants in the survey had completed on their DE site visits, therefore the data collected from this method had no cross-collection from any other method used in this study. These reports were reviewed for comments from the evaluators. All notes from the CoA evaluators were compiled and coded to determine any themes that may have emerged from the notes take while actually performing a site visit of such a program.

As mentioned in each of the data collection subsections, all of the data collected were organized and coded in an effort to determine patterns and emergent themes present in the data from each data set. For this study, In vivo coding, in particular, was used. In vivo coding is a method of reviewing collected qualitative data such as transcripts from interviews, surveys, documents and discussions that uses concepts, or coded themes, in the researcher’s own terms to capture key elements of what is presented in the data (Fereday, 2006). Because the researcher had experience with the subject being studied, in vivo coding was logical as the themes that were presented in the data were then coded in a way that utilized
terminology native to those that work with the CoAs and DE. Once the focus groups had met, the researcher used in vivo coding to determine overarching filters to apply to all of the data collected throughout the course of the study.

This coding process involved constant immersion in the data through continued collection and review, transcribing, coding, clarification of the surveys and the discussions of the focus groups, and review of the SSR and site visit reports. Once the initial review and coding of each data set was complete, the data was recoded and compared to determine concise themes presented by the data. The primary themes that emerged from this data are reported in Chapter 4.

**Data Quality**

Data collection was conducted in an ethical manner so as to protect the identity of the participants. All information collected and reported has had all identifying information removed so as to create complete anonymity for participants in each method of data collection and analysis. All data collected is authentic and of the best quality possible in order to produce a final report of the study of the highest standards of accuracy, credibility and transferability.

A formal application and successful award of an exemption was granted by the Institutional Review Board (IRB) in the Office for Responsible Research at Iowa State University. A copy of the IRB approval is provided in Appendix C.

**Summary**

The methodology used to conduct this research was structured using grounded theory due to the lack of research on this particular subject. By using
grounded theory, the researcher was able to use data collected via focus groups, surveys, and review of reports from professionals in allied health education accreditation with the most experience in DE program accreditation. This information then provided data that could be coded to determine major themes presented in the data that were then used to determine the answer to the research question and serve the purpose of the study. Further discussion of the emergent themes presented by the analysis of the data is reported in Chapter 4. This is followed by discussion of those results and recommendations based on the comparison of the results with the literature in Chapter 5.
CHAPTER 4. RESULTS

Accreditation evaluators of allied health education programs offered via DE need more information about how to assess the programs to ensure that the accreditation standards are being met. To determine the most challenging aspects of conducting DE site visits from the point of view of the accreditors, this study collected data from three sources: focus group discussions with key stakeholders from CAAHEP and CoA committees, surveys with CoA evaluators that had recently completed DE site visits, and a review of the field notes and final accreditation reports from site visits conducted on DE programs in allied health.

Results from Focus Groups

Some of the members of the focus groups were familiar with DE and had site visitors on their committees that had conducted evaluations of DE programs. Those individuals were most concerned with their site visitor not having any direction or professional development specific as to what to look for in a DE program as compared to the traditional FTF programs. This was especially true if those evaluators were not already familiar with DE. Those that had never had any direct experience with DE had concerns about how to know if the programs were meeting the accreditation standards and were panicked to think about what they would do if they received a request for accreditation from a DE program. Overall, the consensus of all members the two focus groups were that current evaluators are not prepared to fully evaluate clinical DE programs and know if those programs are meeting the standards of accreditation. This was so even for those with experience
in DE. The participants did not know what to tell their reviewers to look for or how to look for it.

**Results from Surveys and Evaluation Notes**

There was some general consensus between the surveys conducted with evaluators who had recently conducted evaluations of DE programs and the notes reviewed from recent DE accreditations. These data sources all indicated that, although apprehensive about how the evaluation would be conducted without traditional methods of evaluation (FTF meetings with all participants, looking through physical paper documents, etc…), all of the information that they needed in order to fully evaluate the program was available and it was even easier to locate information than with a traditional review. In all cases, the evaluators were provided with access to all necessary records and documents electronically, meetings were conducted virtually and FTF, and they were provided access to the actual online courses so that they could manipulate the teaching materials in the same way the students and faculty would. All of these tools provided a friendly environment for the evaluators to fully investigate the quality of the program and they felt confident in their accreditation decisions when it was completed. However, they did note that if additional professional development and information about conducting DE visits were available that they would definitely participate in them.

**Resulting Themes from all Data Sources**

The data collected were analyzed and coded to determine common themes and terms from the comments made in all three data sets. Primary themes were
from the data that led to the organization of the results of the data collection. These themes included:

1. Standards: The accreditation evaluators need to ensure that DE programs being reviewed are in compliance with the same standards as traditional face-to-face programs.

2. Professional development: This theme was categorized into four groups that were identified as being in need of some kind of professional development as to the preparation for, development, oversight, and evaluation of DE: (a) the accreditation evaluators, (b) DE faculty, (c) DE clinical preceptors, and (d) students.

3. Quality: This theme was sub-categorized into two areas of key development to ensure that the DE programs are truly meeting the standards of the accreditors: (a) resources, and (b) assessment.

Although each of these themes has specific subsets of discussion and key points to consider, there are three primary areas of emphasis that emerged as the results of this research included professional development, quality, and performing the accreditation review. The themes are presented in this chapter in the order of their frequency and, thus, significance, from the data collected.

In this section, applicable quotes collected from the research data are also presented to demonstrate validity of the results. These are referenced in the following way:

- FGP1 – 32: These quotes are from Focus Group Participants (FGP), numbered 1-32 for the 32 total participants in the two focus groups.
SP1 or SP2: These quotes are from either the Surveyed Participant (SP) 1 or 2 for the two people that participated in the survey.

**Standards**

The overarching consensus that emerged as the framework to define all of the rest of the results of this study was that, for each CoA, the standards remain the same and must be met regardless of the delivery method of the program. There was unanimous agreement from all participants in the focus groups, surveys, and accreditation report notes that this theme was the foundation of any discussion to be had regarding the accreditation of DE programs. As FGP1 stated, “the purpose of accreditation is to ensure that the program meets the standards. If the standards are met, the delivery method should not matter.” This was met with the simple, yet poignant reply of FGP4, “Yes, but the question then becomes: how does the evaluator know that those standards are being met if they are not familiar with DE?”

To define the answer to this question, the first set of results under the theme of professional development become important.

**Professional Development**

The theme of professional development was recurrent most frequently throughout the data. There was discussion about the need for professional development of the accreditation evaluators, professional development for faculty of DE programs, professional development for clinical preceptors working directly with students in remote locations, and professional development for the students to be able to thrive in a DE learning environment.
Accreditation evaluators

The data demonstrated a consensus that there is a significant need for the professional development of those actually performing the accreditation evaluations. Many of the individuals who are serving as evaluators have very little, or no experience at all in DE. FGP13 said, “I wouldn’t even know what to look for, where to look for it, or how to recognize if there is a problem.” This was in response to asking what they are telling their DE evaluators to specifically look for when reviewing a DE program as compared to a FTF program (see Appendix E) Typically, these evaluators are experienced in reviewing FTF programs with traditional classroom and laboratory time spent with programmatic faculty and students. These evaluators are also accustomed to performing site visits of FTF programs to verify that the programs are really meeting the accreditation standards as they report in their Self-Study Reports (SSR).

The problem arises when they are called upon to review a DE program and the nature of the review itself actually changes. SP2 said, “How do I know if the students are satisfied with their experiences if I never meet with them on campus?” During a traditional FTF site visit, the evaluator typically meets FTF with administrators, faculty, students, graduates, clinical sites, and other key stakeholders of the program to investigate the truth of what was reported in the SSR. A typical site visit schedule for an FTF program is shown in Table 4.1. The comment portrays a real concern for the evaluator. There are ways to meet with students virtually, but most evaluators are unaware of such resources.
Table 4.1. Typical site visit schedule for an FTF allied health program

| Time Assessed         | Topic of Discussion                      | Persons to attend*                                                                 |
|-----------------------|------------------------------------------|===================================================================================|
| 8:00am - 8:30am       | Opening Session                          | Program Director, Medical Director, Administrative Officer. Other survey participants are welcome. |
| 8:30am - 9:00am       | Medical Director                          | Medical Director                                                                  |
| 9:00am - 9:45am       | Students                                  | All current students if possible and representative graduates                       |
| 9:45am - 11:00am      | Tour Facilities (including clinical site) | Site staff                                                                        |
| 11:00am - 12:00pm     | Program Director                          | Program Director                                                                  |
| 12:00pm - 1:00pm      | Lunch with Advisory committee             | One or more members of the advisory committee who are not faculty, administrator, or student of the program. |
| 1:00pm - 1:30pm       | Administrative Officer or Dean            | Administrative Officer or Dean                                                     |
| 1:30pm - 2:00pm       | Primary faculty                           | One or more faculty members with responsibility for didactic course work.          |
| 2:00pm - 2:30pm       | Clinical Faculty                          | One or more faculty members with responsibility for supervision of clinical rotations. |
| 2:45pm – 3:30pm       | Program Director                          | Program Director                                                                  |
| 3:30pm - 4:15pm       | Site visitor working session              | Site Surveyors                                                                    |
| 4:15pm                | Closing session                           | Program Director, Medical Director, Administrative Officer. Other survey participants are welcome. |

*For each session, list the names and titles of the individuals who will meet with the site visit team.

Completion of all of these meetings during a site visit is not always possible with DE programs. For example, the clinical sites may all be in other states, which does not make it feasible for the site visitor to visit the clinical site while in the state of residence of the actual program itself. This is also true for student interviews, as there may not be any students within a reasonable distance of the physical site of the program that are available to meet with the site visitors in person. The site
visitors then need to be trained on ways that they can utilize other tools that would allow them to still complete the review and site visit with these limitations in place.

Similarly, on traditional FTF site visits, the evaluator is able to sit in on a class being taught or actually physically hold and review the curriculum, lessons, assessments, and results. Again, this may not be possible for DE programs. There are ways that each aspect of a site visit can be conducted for DE programs to ensure that standards are met just as with FTF programs. However, these evaluators need to be trained to know how to go about performing these reviews and site visits in ways that are friendly for reviewing DE programs.

Examples

SP1 was very concerned about not having any points of reference and replied, “I wish I had examples of what to look for when I review these (DE) programs. I can look at everything but I don’t always know if it is good or bad, if it really does meet the standards. Are there any exemplary programs out there that we could use as a guide?” It was clear that there was a strong desire from the evaluators to be shown examples of how the programs they evaluate are providing high quality courses, assessments, feedback and resources to their students. All of these things are required to be reported by the programs with they complete their SSR and then verified when the evaluators conduct their site visits. This is true for all programs, regardless of their method of instructional delivery. However, during a site visit in a traditional FTF atmosphere, the evaluator is able to see, touch, and evaluate copies of assessments given to students and review their results. In these
scenarios, the evaluators are able to hold physical pieces of paper in their hands that contain the students’ records and provide examples of the quality of work that the students do in each of the program’s courses.

*Usually when I go to a site visit, I am provided volumes of course papers in binders such as syllabi, exams, assignments, presentation notes, student records, course evaluations and course outcomes. I use those records to analyze if the program is really doing what they have reported in their Self Study.* –SP1

When evaluators are visiting a DE program, these physical copies of examples of materials used to teach in the program do not always exist. Instead, when evaluators conduct site visits for DE programs, they are typically provided access to the online learning management systems (LMS) so that they are immersed into the course just as an instructor would be. This provides the evaluator with full access to the programmatic and course content, student records and all of the same materials that they would typically have at a FTF program site visit. However, with this method of presentation, the evaluator is able to maneuver everything within a computer, rather than sift through volumes of paper.

*I was worried that when I reviewed the DE program that I would have trouble finding that information since there would be no paper in front of me. I actually found that it was easier to view everything electronically and now ask for that when I do site visits.* –SP1

Instead of the electronic records making individuals more apprehensive, this survey participant actually felt that the electronic versions of the materials made it much easier locate the information while performing the site visit. Evaluators should be prepared for these non-traditional mediums of programmatic review when professional development to conduct site visits for DE programs. For example, the
evaluators surveyed shared their experiences of actually being provided with complete faculty username and password access to the learning management platforms where they were able to manipulate and experience the courses in the same ways that the faculty and students see and experience as part of the DE program.

*When the Program Director actually opened up their course on the internet and walked me through what a typical week would be like if I were a student, I finally understood what they were doing. It was also helpful to see things from the faculty point of view as it allowed me to know if their reporting was accurate and if they were meeting accreditation standards.* –SP1

The survey participant was able to go to the resources that the students used, actually take the quizzes, access the discussion boards and faculty feedback, and even access student records, all through the same way that the DE faculty and administration does. These kinds of examples of the quality of all aspects of the program, though not conventional, were very complete and allowed the evaluators an opportunity to verify that the program was really providing the quality of coursework, resources, services and experiences to their students that they claimed in their SSR. SP2 stated, “*It was better than a traditional site visit because I was able to go into the entire course and see what had happened, the discussion, the exams, the results and more. It was like observing a live class!*” This is important because it actually demonstrates how the site visitors were able to evaluate the program. These are the types of examples that could be shared with other evaluators during professional development.
Survey results

FGP3 stated, “If there are problems with the way that the courses are being taught or how well students are doing, it should be apparent when the reviewer looks at employer and graduate surveys.” Comments such as this were common when discussing how an evaluator could identify potential areas of needed improvement when evaluating DE programs. All CAAHEP accredited programs are required to administer surveys each year to their graduates and the graduates’ employers to inquire as to both parties’ satisfaction with what was taught in the program and how well it conveyed to real world situations once employed. These and other surveys such as student satisfaction surveys and course evaluations from students while enrolled, are ways that most programs identify areas of potential concern with their curriculum and its delivery. Most CoAs also require that programs report the outcomes of at least the graduate and employer surveys on their annual accreditation reports in an effort to continuously monitor the effectiveness of the programs.

Student surveys are typically anonymously submitted either annually or at the end of each term of courses, or both, depending on the questions asked in the survey. This survey provides students with a way to give honest feedback about their experiences with their faculty, their program of study, clinical sites, and the institution as a whole. It may also be necessary, particularly in DE programs, to administer additional surveys to make sure that students have ample opportunity to share feedback about their satisfaction with the quality of the program since they are not on campus to provide traditional feedback such as discussions before and after
class. The reviewed SSR reports of DE programs reported many additional surveys that were administered by the DE programs. These included surveys of the students about their clinical sites and clinical preceptors, and surveys sent to the clinical sites and preceptors to ask about the students, faculty and program. Upon careful review by the investigator, she concluded that the data sets that these types of surveys conducted from many angles of review of the program could provide a very clear representation of the true quality and satisfaction with the program from everyone involved.

The data gathered from these surveys also provides important information to the accreditation evaluators as they can point out problem areas that the programs should be working to correct. If there is a problem reported on a survey that the program has not addressed with an action plan and timeline for re-evaluation of the problem, the evaluator should take careful note to discuss the issues with the programmatic administration and faculty. This is known by the researcher by her work as a member of a CoA committee for many years. From this same experience, it is known that eventually small problems presented surveys can lead to larger problems in overall quality of the program, or at least the perception of the program’s quality in the eyes of those filling out the surveys as unsatisfactory.

Faculty surveys are another tool that can be used to ensure that the program is meeting the standards. In particular, the satisfaction of the faculty will quickly illuminate an areas where resources are sparse as the faculty usually make this known in such survey results. “If I’m not getting enough money in my budget to cover the costs of the technology that I need to develop and teach my courses, the
safest place for me to do that is on my annual (faculty) survey. It is anonymous so I don’t have to worry about being fired for being honest in my opinion,” said FGP2.

Faculty surveys usually consist, but are not limited to, questions about the adequacy of professional development, budgets, resources, fair employment practices, and their satisfaction with the institution.

Faculty

The second major sub-theme under professional development was that of the faculty. The data revealed that accreditors are concerned first that the faculty in DE programs must receive professional development appropriate in both quantity and quality to be able to develop a truly effective DE program. As stated by FGP22, “How do the faculty know how to create and execute a good course in an online environment?” FGP25 added, “Should we be requiring DE faculty participate in some kind of continuing education specific to online learning?” FGP21 remarked, “And how do we know if what they learned was any good?” While conducting reviews of DE programs, evaluators wanted to see that the faculty had gone through a formal professional development process for the successful development and administration of a DE program, but that this professional development was also supported by the institutional administration and continued on a regular basis. It was of concern that most institutions no longer provide much in the way of monetary support for continuing education to their faculty. As FGP28 stated, “There is no money for these kinds of courses! We have to make sure, as accreditors, that we convey to the programs that they should add education money to their budgets.”
It was discussed that if a faculty member was correctly trained to develop DE courses with good practices that ensured that the standards were continuously met. Then that program would continuously meet or exceed those standards not only in the opinion of the accrediting body, but also of that of the graduates and future employers. SP2 noted,

*I felt like this instructor actually had better communication with her students through DE because there was constant interaction that could be recalled by the student at any time. That makes the messages clear to the student and ensure their engagement and success in the program.* –SP2

If faculty are not properly trained to be part of a DE program, it will be apparent in the student satisfaction surveys. As SP2 reported, “*One faculty member was not properly trained to teach a course delivered via DE. The students complained about the quality of the courses and felt the faculty were unprepared.*”

More distance education programs are being developed every day. More campuses are realizing the need to provide flexible and accessible education options to their students, while also offering flexible work arrangements to their faculty. With the continuous development of new technology and the ability to offer high quality educational programs via DE, it is not a trend that is going to go away. DE is now rooted as a viable and rapidly growing method of educational delivery that is here to stay. As such, educators and accreditors must determine how to do it best.

**Clinical preceptors**

Clinical preceptors are instructors that are charged with the oversight of students enrolled in allied health programs while they are working in a clinical setting to practice and perform the psychomotor and analytical skills necessary to work in
that profession. Because of the differences in the way that these collaborations can
be arranged, it was reported that there is incredible importance placed upon the
need for professional development of the clinical preceptors for any allied health
program, but even more-so for DE.

*I live in Florida and my student is in Washington State with a preceptor
at a clinical site. I have never met that person before. How do I know
what they are teaching my student? How do I really know that my the
person signing off on how that student is performing even has a clue
as to what they are doing themselves?* —FGP3.

In allied health DE programs, clinical preceptors are relied upon heavily for
instructional purposes because the primary programmatic faculty is not physically
there with the students as they would be in a traditional FTF course. As FGP3 said,
“If I can’t be there working beside the student, you bet I’m going to make sure that
the person who is knows what they are doing.” These preceptors are responsible for
the oversight and feedback while working directly with the students in their physical
presence. Because the clinical preceptors are not under constant supervision by
programmatic faculty while they are working with the students, it is important that
they are trained to know how to best instruct the students, provide meaningful
feedback, and report their assessments back to the programmatic faculty using the
DE instructional platform. It was also emphasized that just like the programmatic
faculty, that professional development of clinical preceptors should be continuous
and consistent. “*The clinical preceptors could be required to take part in an annual
information session that discussed best practices in online education,*” said FGP2.
Students

The last group of individuals that was discussed as requiring professional development to participate in DE were the students. It was reported that although many of the students that choose to enroll in DE programs are from younger generations and rather technologically savvy, there also must be recognition given to the fact that many still enroll in DE programs because it is more convenient for their lifestyles, or perhaps because they have no program geographically close to them in which to enroll. “There are people moving their whole family; spouse, kids, dog and all, to be able to go to school to get a job,” said FGP4. These are all realities of DE and points that must be considered, as they are some of the primary reasons that DE exists in the first place. It was reported that DE programs should be doing some kind of orientation and professional development for their students that helps prepare them for the DE environment.

*Students should be given a realistic introduction to what it means to be a DE student. This includes the time commitment and discipline required of their own doing to complete the coursework, and the expectation that the only way that the student will truly learn and be successful in the program is to remain continuously engaged in the course.* –FGP14

Quality

The third main theme to rise from the results of the data collected was that of quality. The quality theme had two major sub-themes that emerged; the quality and quantity of resources and assessment. Though there was slightly less data to support quality issues as compared to what was reported concerning professional development, the amount of times that it was mentioned emerged from the research
as a theme worthy of discussion. Perhaps FGP24 said it best with the comment, “How do we know if these programs are any good?” Though data was collected concerning many kinds of quality that should be given attention when reviewing a DE program, the majority of the discussion topics and comments were coded into these three main categories.

**Resources**

In order for any program in higher education to run effectively, it must have adequate resources. This is true for any program, whether it be FTF, DE, or any other blend of the two. FGP11 stated, “If an institution does not support the academic program with adequate resources, it will fail.” Perhaps the most important aspect of this result was most concisely stated by FGP5 when they said, “…resources for DE programs should not be any different for a DE student than one that is physically present on a campus. Although it may not be in the same manner of delivery, DE students should be offered the same type and amount of resources as anyone else.”

One of the major points of discussion about resources was to ensure that each of type of resource allocated to the programs is of adequate quality to meet the needs of the faculty and students. All resources should be evaluated on an annual basis using faculty and student surveys to determine if the allocated resources are meeting the needs of the program. If they are found to be lacking, there should be an action plan developed to ensure that those needs are addressed and met before the administration of the next evaluations. This is a common practice in both FTF
and DE programs but is a very important practice and notable for substantial consideration when reviewing DE programs to ensure that they have everything that is necessary to run the best program possible. As FGP23 said:

…unfortunately, it is common for institutions to think that DE programs will be cheaper to run because they do not require physical space resources, which are costly. However, the reality is that they can be just as costly as they require massive amounts of technical support and continuous management and updating of technological aspects of the courses.

Some of the most commonly reported resources from the data suggests that not only does there need to be adequate faculty resources, but that there also must be appropriate personnel to handle other student and faculty needs such as technical support, financial aid, admissions staff, librarians that can assist with DE research resources, and administrative oversight. As FGP 25 said, “Who answers the phone? Who is making sure that these students have all of their paperwork complete? They (the students) are going to fly in for new student orientation! What happens when they have computer problems?” The answer to most of these questions is that there are technical support staff available 24-hours a day to answer students’ questions. Instructors are also available via phone, video conferencing and email to answer questions and ensure that all student records are complete. Most DE programs have virtual orientation and class sessions which allow the flexibility of most students never having to travel to the school itself.

Although DE programs do not require physical classroom space for course offerings, there still must be resources allocated to allow for staff and faculty offices. Because the programs discussed were from allied health fields, there was also
discussion about the need for laboratory and clinical space for virtual classrooms, demonstrations, and hands-on experiences. These can be very costly and though the students are not always physically present on campus, that doesn't mean that those types of resources shouldn’t be taken into consideration when determining what must be provided to a program for it to be effective. SP1 noted, “This program is currently looking at adding simulation mannequins to their nursing lab and would like to find a way to use them for their sleep program. However, the cost of the systems may keep them from getting the mannequins.” There should also be adequate budgetary resources for everything that the program needs such as continued faculty professional development and course review, updating technology, providing continuously advanced electronic learning tools, extended hours of technical support, and other needs as they arise.

Assessment

FGP1 said, “DE does a great job of assessing students in the objective domains. However, I believe the biggest problem is figuring out ways to assess DE students in the affective and psychometric domains.” This was followed by FGP4’s comment, “These (students) are people we (the schools) are sending out to take care of sick people! They are literally playing with people’s lives! We’d (the schools) better make sure they know what they are doing!”

Some suggestions were made that advanced technology such as video conferencing during hands-on skills exams and the use of real-time video discussions with the students and clinical preceptors may be some ways to ensure
the quality of the assessments being administered. “Why can't we Skype when a student is working with a preceptor? Then we’d know if the preceptor and the faculty had the same assessment of the student's performance,” said FGP1. Most felt during this discussion that this would be particularly important for new clinical preceptors until the faculty knew for sure that they had been properly trained and were of the best quality to be working with students. FGP1 added, “I would continue to Skype with that preceptor until I knew that person and could trust them enough to not have to be virtually present every time.”

The next major topic of discussion surrounding assessments was the matter of cheating. “What keeps a student from giving their login to another?” said FGP4. “How do I know they’re not just sitting there with their book open, filling in the answers on the exams?” It was a great concern to some in the focus groups that students could easily have someone else log on to a learning management system with their username and password and complete their work for them. Focus group participants were concerned about the students’ ability to use the technology to suspend the exams while they looked up the answers to their exams and assignments in order to get better grades. Others in the groups felt that there were ways to ensure student identity such as with computer IP addresses and other technological tools to prevent such types of behaviors. FGP4 said, “I can look up what computer my student used when they took the exam from their IP address. It will tell me where and when it was accessed and I can see if that was the same IP that they normally use when they connect to the course.” Others still felt that the type of assessment used for DE could diminish the occurrence of cheating by using
more essay and discussion-type assignments so that consistency could be monitored in the students’ writing style and quality of their work. In the end, the consensus about cheating was laid to rest when FGP7 said:

*If a student is going to cheat, they are going to cheat. It doesn’t matter if they are sitting right in front of you or halfway across the world. It is not our job as accreditors to determine if students are too readily able to cheat in a program. However, it is our job as accreditors to ensure that the program is aware of ways that students could cheat in their courses, have taken measures to reduce the risk of cheating, and have a plan of action for when a student does get caught cheating.*

Both focus groups and surveyed evaluators were in consensus that the programs must be set up in a way that encourages student participation and ease of use for the students. To meet the accreditation standards, the students need to be able to find everything in the courses easily and know what is expected of them in terms of learning objectives and how they would be assessed to determine if they were meeting those objectives. “*There has to be tools out there to help assess if the students can navigate these courses and if they are set up in a way that is effective for learning,*” said FGP16. Similarly, FGP8 commented, “*A student is not in the classroom to get direction on what the objectives are for each lesson and how they will be assessed. How do we look for that in online courses?*” The Quality Matters Rubric was discussed as one tool that can be used to measure all of these concerns. The rubric not only assesses the course layout and usability by the students, but also addresses the transparency of the course objectives and their ties to assessments, basic course navigation and expectations, and overall course quality. Some in the focus groups had heard of Quality Matters but most were unaware of it and the potential uses as an evaluation tool of DE programs.
Summary

This chapter described the three primary themes that were evolved from the data collection. These included standards, professional development, and quality. Sub-categories of these overall themes were also reported with examples from participants in the methods of collecting the data.

Chapter 5 provides a discussion of these findings is presented along with a comparison to the literature for overall conclusions to this research. Recommendations for next steps and further study are also presented.
CHAPTER 5. DISCUSSION

Summary of the Study

The purpose of this study was to determine the best practices in DE that can be used to develop a standard guide for evaluating DE programs with clinical components for accreditation. This was accomplished by collecting data in three ways under the theoretical structure of grounded theory: focus groups, surveys, and document review. All of the collected data came from professionals in allied health accreditation through affiliations and various roles of service to the Commission on Accreditation of Allied Health Educational Programs (CAAHEP). Each of these sets of data was collected to answer the research question for this study: What indicators should CoA evaluators use to determine if DE allied health programs are meeting the standards of accreditation? The research question was divided into two sub-questions:

a. What are the major challenges CoA evaluators experience when reviewing clinical DE programs for accreditation?

b. What professional development opportunities should be available for CoA evaluators of clinical DE programs to prepare them to overcome those identified challenges?

The data were collected, analyzed, and reported in Chapter 1-4. In this chapter, the results of the data collected are compared to promising practices in DE that emerged from the literature to develop final conclusions for this study. This chapter also provides a discussion of how these conclusions might be put into action.
to be of use to allied health accreditation evaluators when reviewing DE programs and recommendations for work that could be performed in the future to continue to explore this topic and develop a better foundation for the accreditation of DE allied health education programs offered via DE, specifically those with clinical components.

Findings

Research Question 1

The first major question of this research was: What are the major challenges CoA evaluators experience when reviewing clinical DE programs for accreditation? Three primary themes emerged from the data collected for this study that are causing problems for evaluators when reviewing DE programs for accreditation: (a) standards, (b) professional development, and (c) quality. Each of these and their resulting sub-themes are discussed as follows.

Standards

There was an overwhelming consensus in the data that the standards of accreditation for the DE programs should not differ from those set for the FTF programs in any way. As FGP1 stated, “the purpose of accreditation is to ensure that the program meets the standards. If the standards are met, the delivery method should not matter.” Although there may be some differences in the delivery of the course materials and required resources of the students, there should be no difference in the standards of such programs to be accredited (Kinslow, 1999). Programs should be held to the same standards of accreditation, no matter the
mode of delivery of the programmatic content. The accreditation standards need to be used to assess the process used to develop, deliver and assess a DE program (Phipps, 1998). Although they may be met in different ways, the standards themselves do not change when evaluating FTF or DE programs.

**Professional development.** The most frequently identified theme in the data was that of professional development. The collected data were coded and organized into four main categories concerning professional development as it applies the accreditation of DE allied health programs. These categories include professional development for accreditation evaluators, faculty, clinical preceptors, and students.

**Accreditation evaluators.** The coding of the data demonstrated that there was a significant need for professional development of evaluators of DE programs seeking accreditation. Although most evaluators were experienced in reviewing FTF programs, there is a need for specific professional development for those reviewing programs offered via DE so that they are aware of the different ways that they can investigate the program to best assess if the program is meeting the accreditation standards.

The literature supports the needs for appropriate professional development of accreditation evaluators as well. Specifically, the need for professional development in the appropriate evaluation of curriculum, instruction, assessment, and programmatic resources are each essential (WICHE, 2014). Each of these can be set up to meet accreditation standards but possibly in different ways than what
traditional FTF programs may use. Evaluators need to be aware of not only the
nuances of how to investigate the DE programs to ensure that the standards are met
but also how to make necessary changes in the way that the evaluation itself is
conducted in order to fully evaluate the program using advanced technology to carry
out their accrediting actions.

**Adapted methods.** An essential element of ensuring the quality of any
aspect of a program undergoing accreditation is to examine examples of how they
are meeting any and all of the accreditation standards. There are times when
evaluating a DE program that this may need to be done in a modified format rather
than it would with a traditional FTF program to best accommodate the program and
the ability to fully evaluate it. For example, a DE program evaluator may not be able
to physically sit in a classroom to observe a lecture or hold the curriculum plan or
syllabus in their hands. They may not meet FTF with students and graduates of a
DE program because those things are not part of a program of that delivery method.
However, that does not mean that the program does not meet the standards of the
accrediting body. It may, however, mean that the evaluator must shift their methods
of evaluation to view examples of how the program meets the standards in their own
unique ways. Typically this will mean that there will be online orientations to the
learning management system and other tools that the faculty use to administer their
coursework to their students. There are also ways that the evaluators can meet with
key stakeholders in the program for interviews during site visits by meeting virtually
through video conferencing and other technological tools.
Assessment results. Perhaps one of the most effective ways to evaluate the quality of any program, regardless of the delivery method, is by reviewing the program’s assessment results. These typically consist of faculty, clinical preceptor, student, graduate, and employer surveys. Each of these surveys provide key pieces of information to assess how satisfied each of these groups are with the overall quality of the program, as well as with specific elements of the program. Survey results can be extremely helpful in identifying areas where there are program deficiencies. For example, if the employer surveys consistently report that the students are not able to perform a key skill upon completion of the program, the faculty need to go back to that section of the curriculum and make changes to the content and assessment to make sure that the skill in question is taught more thoroughly and assessed more carefully the next time the course is offered. Another example would be if the faculty is reporting that they are dissatisfied with the amount of time and budget they are provided for continuing education. The review of the site visit reports noted that one faculty member mentioned during the site visit that she was “unable to attend any (professional development) about distance education because I can’t afford the courses and the college doesn’t cover those expenses.” This would be a cause for alarm to the accreditation evaluator that perhaps the program and faculty are not receiving the resources that are necessary for them to function effectively.
Faculty

In most instances, the faculty are responsible for the development, design, implementation, engagement, assessment, and provision of feedback to students (Rosenbloom, 2011). If a faculty member is not constantly exploring new technologies and participating in professional development to fully understand how they can implement these new tools then they become useless. As FGP22 stated, “How do the faculty know how to create and execute a good course in an online environment?” The literature supports this by stating that participating in continuous professional development and striving to know about the results of implementing new technology, instructors are able to remain more current in the courses with the students to aid in their understanding of the course material rather than continuously struggling to understand the technical aspects of running the course (Kidney & Puckett, 2003).

In order for faculty to engage in continuous professional development for their DE courses, it is essential for their institution to recognize this need and provide funding and other necessary resources such as travel or technological support for such education. Based on the results of the surveys and focus groups, institutions need to recognize that this is a vital ongoing cost of the delivery of education via DE. Institutions must be willing to invest in the long-term preservation and development of their DE faculty and programs. It is the responsibility of the accreditation evaluator to ensure that this professional development is available to faculty to ensure that the program is of the highest quality in order to meet the standards of accreditation.
Clinical preceptors. Distance education program administrators must ensure that the clinical preceptors working with their students are not only professional and experienced in their profession, but that they also receive professional development on how to effectively work with students. As FGP3 said, “If I can’t be there working beside the student, you bet I’m going to make sure that the person who is knows what they are doing.” This can be done using current technologies such as video conferencing or recording a session and posting it for the faculty member to review for grading. Clinical preceptors should not only be screened carefully before being accepted to work with students, but also receive consistent professional development and be in constant communication with the faculty while students are performing work at their clinical sites.

One way that the students can be monitored while at the clinical sites is for the faculty to engage in video conferencing with the preceptor and student performing at the site. Video conferencing becomes of particular importance when faculty are evaluating student performance on final evaluations of skills assessments to ensure that the students really are performing at the level that is expected when performing those skills on real patients. These students will eventually be working with patients in healthcare settings and the assurance that they are well practiced in the proper technique and execution of their craft is of the utmost importance.

Students

Properly preparing students for learning in a DE environment can be very important. Although some students may be very comfortable in a technological
learning environment and have chosen this mode of delivery as a result of their experience, others may have chosen DE because of their geographical location and limitations and could benefit from some insightful initial professional development. According to Quinn & Barth (2014), it is important for students to fully understand the technology used to present the information so that they can use that what they are learning to the fullest potential. This could take the form of a simple orientation to possibly even offering practice courses to familiarize the students with the environment in which they will soon be immersed. Some schools have even developed tools for the students to evaluate their own natural learning styles and give them advice on how to adapt those styles to a DE environment to facilitate students to adapt more easily (University of Georgia, 2014; University of North Carolina, 2014). Just as the evaluators, faculty and clinical preceptors need professional development and continued support as they navigate the nuances of DE, students benefit from the same kinds of assistance.

**Quality**

Key aspects of institutional quality when accrediting DE are the resources invested, processes followed, and the results achieved (Eaton, 1999). One of the primary charges of the evaluators for any accrediting body is to ensure the overall quality of the educational program, regardless of the method of delivery utilized to administer the educational experience. By engaging in the process of becoming accredited, the program has already taken great strides to not only ensuring, but proclaiming their dedication to excellence in the education of students in their
profession. However, as with professional development, there are specific nuances of ensuring quality in a DE program that differ slightly from that of traditional programs.

**Resources.** Ensuring that program faculty have the necessary resources to properly administer their program and that students have the resources they need to be successful is also very important for the evaluator to recognize when reviewing a DE program. This is very clearly identified when FGP5 stated, “resources for DE programs should not be any different for a DE student than one that is physically present on a campus.” According to Keegan (1980), sufficient resources are a necessary factor for DE to be effective, support from the educational institution for students and faculty must be appropriate or there will be failure and dissatisfaction. The evaluators need to ensure that continuous funding and support for necessary resources for DE programs needs to be included in the institution’s strategic and long-term planning. Although DE does not usually require the same physical space and other costly resources of a FTF program, there are other resources for DE programs to be effective that can be cost prohibitive. The continuous monitoring of data security, technological updates for hard and software and staying current with technological advances can be very expensive. It is also important to allocate appropriate budgetary resources for the faculty and clinical staff continuous professional development as mentioned above.

It is also imperative that the resources available to DE students be at least of the same type and amount as those provided to FTF students of the same
institution. These include library resources, financial aid, advising, access to student academic help such as tutoring, and any other resources that they would have if they were taking courses in-person on that campus. Ensuring that students have equal and sufficient access to any and all resources they need to be successful in their educational endeavors is crucial.

**Assessment.** The quality of assessments administered in DE courses should be investigated by accreditation evaluators through the lens that they must evaluate the student fairly, accurately, and in a way that the students are being assessed on the skills and outcomes that are stated by the instructor. As discussed by Hoeksel and Moore (1994), the validity of assessment methods must be reviewed to determine if course objectives are being met. This supports the work of Morrison, Kemp, and Ross (1998) in regards to the development of an instructional design model for the successful development and implementation of learning objectives in DE course. There are many ways that assessments can be administered via DE that allow for good quality assessment to be conducted and provide just as high quality of evaluation and measurement of objectives as would be present in a FTF course. The key to assessments administered in DE courses is consistent and timely communication and the administration of assessments in a way that the student is very clear about what they will be assessed (Oranye et al., 2012).

The Quality Matters Rubric is one tool that could be covered in the evaluator professional development as a way to help the evaluators assess the quality of the online programs. It is a peer reviewed national standard of online education that not
only assesses the technical aspects of usability and navigation of the courses, but it also addresses the course content including objectives, transparency of learning and student assessment. Making evaluators aware of such tools existing and their value could help them look for these types of assessments being done in the programs they are reviewing but also offer them something that they could suggest to programs that are struggling with certain aspects of quality in their course design and execution.

There are ways that these domains can be assessed, but it must be done carefully and the faculty must be vigilant. This is where the quality of the clinical preceptors and their professional development comes into play once again. Faculty must ensure that not only are the clinical preceptors properly trained before they are allowed to work with the students, but also that they students are performing their skills to the highest quality standards while completing their work at the clinical sites. Because the faculty member is not standing right there with the students as they are completing their work, some accreditation evaluators fear that the quality of the assessments that the students are performing could be lacking. FGP4 stated, “...how do I know they’re not just sitting there with their book open, filling in the answers on the exams?” By utilizing technologies such as video conferencing, many of these concerns can be addressed. However, the accreditation evaluator needs to be aware that they need to look for such measures of integrity in the assessments administered in the programs.
Comparison of the data results and literature review

These results were also compared to the literature that was reviewed to develop the background and framework for this research. The results of the comparison of the information was relatively consistent with the majority of the literature supporting the findings of the study. The data revealed that the first major result was in consensus that the accreditation standards for DE programs are no different than those of the FTF programs. This result was supported overwhelmingly by the literature in which numerous previous studies came to the same conclusion (DelCorral, Guevara, Luquin, Pena, & Otero, 2006; Hughes, McLeod, Brown, Maeda & Choi, 2007; Rivera & Rice, 2002; Toth, Fougler, & Amrein-Beardsly, 2008; Western Interstate Commission for Higher Education, 1995). However, Emerson and McKay (2011) had determined that there is not yet enough information available to determine if the standards for DE and FTF delivery should actually be the same.

The expected and measured learning outcomes for the DE students should also be the same for DE programs as their FTF counterparts (Hanna, Wolford, & James, 1998).

The accreditation evaluators also need to be cognizant of the training provided to be undertaken by DE faculty. Clinical skills competencies must be maintained in order for faculty to be prepared to teach DE courses with clinical components (Annabell, 2007; Kurtz, Mahoney, Likicker, 2009). Technological advances have made it possible for faculty to work with their students synchronously and asynchronously, just as if they were standing beside them in a clinical setting (Lindsay, Naidu, & Good, 2007; Quinn & Barth, 2014). However, faculty with little
experience teaching in a DE delivery method should take advantage of professional development opportunities to learn how to use such technologies, just as traditional instructors participate in continuous development of their teaching development, engagement, design and implementation (Rosenbloom, 2011). Likewise, the DE faculty should be provided with the resources to participate in such training, just as a FTF faculty member would (Eaton, 1999). Unfortunately, one of the major problems facing most DE programs with clinical components is the reluctance of many in the medical community to embrace DE as a viable method of educational delivery for clinical skills performance (Reynolds, 2010; Robbins & Hoke, 2008).

The data results also revealed a need for appropriate preparation of the students for online learning environments as well as a need for establishing basic guiding principles for the overall quality of the DE learning experience. Although DE delivery offers students access despite potential geographic limitations and flexible scheduling of courses (Emerson & McKay, 2011; Stotzer, 2012; Quinn & Barth, 2014; Yu & Yang, 2006), the data provided strong evidence for this need for proper student preparation. One way this can be done is with preparation quizzes that assess learning styles of students and provide suggestions for adaptations of those styles to DE (University of North Carolina, 2014).

The quality indicators provided by the Council for Higher Education Accreditation (CHEA)(2006), and Keegan’s (1980) DE quality guidelines as well as other tools such as the Quality Matters Program (2012) could all be used as tools to ensure that DE programs are of the quality necessary to meet accreditation standards and the needs of the students. The literature also supports the findings
that creating connections with students to ensure that the learning objectives are achieved have also been shown to be essential (Downes, 2012; Naidu, 2013; Siemens & Downes, 2011), and the validity of the objectives must be reviewed during accreditation to ensure that they truly are being met (Hoeksel & Moore, 1994). Finally Institutional support and resources for a DE program were also shown to be of very high importance. (CHEA, 2012; Eaton, 1999; Keegan, 1980; Kinslow, 1999; Skorga, 2002). Table 5.1 provides a summary of comparison of the data results and the literature review.

**Research Question 2**

The second question to be answered by this research was, “What professional development opportunities should be available for CoA evaluators of clinical DE programs to prepare them to overcome those identified challenges?” The findings from the first question identified the challenges currently facing DE accreditation evaluators. The literature review and suggestions from the data collected revealed suggestions for the development of a professional development program to prepare DE evaluators.

One problem cited by the focus group participants is that many of the CoAs lack board members and site visitors that are well versed in DE, which creates a lack of qualified reviewers for DE programs. FGP12 even went so far as to say, “I don’t even know what to ask when visiting these programs; I wouldn’t even know what to look for.” This is a significant problem considering that most of the CoAs are now seeing at least some of their programs moving toward the DE model of instruction.
### Table 5.1. Comparison of data results, and supporting and conflicting findings in the literature review

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<tr>
<th>Data Results</th>
<th>Supporting Literature from Review</th>
<th>Conflicting Literature from Review</th>
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<tr>
<td><strong>Standards (Professional Development, Accreditation Evaluators, Adapted Methods, Assessment Results)</strong></td>
<td>• Ali, Hodson-Carlton, &amp; Ryan, 2004&lt;br&gt;• Atack &amp; Rankin, 2002&lt;br&gt;• Bernard, Abrami, Lou, Borokhovski, Wade, Wozney, and Huang, 2004&lt;br&gt;• CHEA, 2002&lt;br&gt;• Del Corral et al., 2006&lt;br&gt;• Downes, 2012&lt;br&gt;• Eaton, 1999&lt;br&gt;• Hanna, Wolford, &amp; James, 1998&lt;br&gt;• Keegan, 1980&lt;br&gt;• Mgutshini, 2013&lt;br&gt;• Mitchell, Ryan, Carson, &amp; McCann, 2007&lt;br&gt;• Western Interstate Commission for Higher Education, 1995</td>
<td>• Emerson &amp; McKay, 2011</td>
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<td><strong>Faculty (Clinical Preceptors)</strong></td>
<td>• Allen, Seaman, Lederman, &amp; Jaschik, 2012&lt;br&gt;• Annabel, 2007&lt;br&gt;• Kurtz, Mahoney &amp; Likicker, 2009&lt;br&gt;• Lindsay, Naidu, &amp; Good, 2007&lt;br&gt;• Phipps, 1998&lt;br&gt;• Rosenbloom, 2011</td>
<td>• Annabel, 2007&lt;br&gt;• Reynolds, 2010&lt;br&gt;• Robbins &amp; Hoke, 2008</td>
</tr>
<tr>
<td><strong>Students</strong></td>
<td>• CHEA, 2002&lt;br&gt;• Emerson &amp; McKay, 2011&lt;br&gt;• Keegan, 1980&lt;br&gt;• Naidu, 2014&lt;br&gt;• Quinn &amp; Barth, 2014&lt;br&gt;• Stotzer, 2012&lt;br&gt;• Yu &amp; Yang, 2006</td>
<td>• Mottarella, Fritzche, &amp; Parrish, 2004</td>
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<td><strong>Quality (Resources, Assessment)</strong></td>
<td>• CHEA, 2002&lt;br&gt;• Del Corral et al., 2006&lt;br&gt;• Eaton, 1999&lt;br&gt;• Hoeksel &amp; Moore, 1994&lt;br&gt;• Hughes, McLeod, Brown, Maeda, &amp; Choi, 2007&lt;br&gt;• Keegan, 1980&lt;br&gt;• Kinslow, 1999&lt;br&gt;• Rivera &amp; Rice, 2002&lt;br&gt;• Siemens &amp; Downes, 2011&lt;br&gt;• Skorga, 2002&lt;br&gt;• Toth, Fougluer, &amp; Amrein-Beardsly, 2008</td>
<td>• Latchem, 2014</td>
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The evaluators must be able to assure that programs are really meeting all of the Standards of Accreditation, however, there are currently very few evaluators with experience in DE, and some CoA’s with no experienced DE evaluators at all.

Because professional development was not only the most frequently reported topic in the data, it was also discovered that the literature strongly supports the need for continuous professional development of everyone involved in DE programs (Kidney & Puckett, 2003). Because this study was primarily focused on the accreditation needs in DE programs from the accreditation evaluator’s perspective, the first recommendation as a result of this study would be to develop professional development for those evaluators based on the best practices as determined from the review of the literature. The recommended method of delivery of this professional development is to develop a professional development seminar for accreditation CoAs and the evaluators that they intend to assign to their DE reviews and site visits. This could first be held during one of the annual CAAHEP meetings first to capture a large group with an immediate need. This session could either recorded or live-presented at later times to additional groups as webinar presentations, which could also provide additional professional development for the evaluators on the use of video conferencing participation that they might experience while reviewing DE programs. It is recommended that CAAHEP form a DE committee to determine the content of the seminars. A copy of this study and a suggested outline of topics to be covered in the evaluator professional development will be provided to CAAHEP and the task force to use as a guide to develop the professional development sessions. Appendix D provides a suggested evaluator
course outline. The committee should be comprised of representatives from CoA Committees (including Executive Directors), the CAAHEP Board of Directors, and CAAHEP Commissioners. It is recommended at least some, if not the majority of those selected for this committee have some background in DE and the accreditation of DE programs in accordance with their position on the committee.

**Task force**

The task force should focus on some primary areas for the professional development, based on the data collected in this study. The main purpose of the professional development would be to provide the evaluators information on what exactly should be explored when evaluating DE programs. Reviewers should also be provided with examples. Professional development would focus heavily on knowing: (a) how the programs are setting up their DE courses; (b) how to ensure that the faculty, clinical preceptors and students all receive adequate professional development for the tasks that each must perform as part of the program; and (c) what kind of quality measures are demonstrated by the program to ensure the quality of the program including evaluation of their resources, assessments and survey results.

Based on the data collected in this study the task force should focus on some primary areas for the professional development. The main purpose of the professional development would be to provide the evaluators information on what exactly should be explored when evaluating DE programs. Professional development should focus heavily on: (a) knowing how the programs are setting up
their DE courses; (b) knowing how to ensure that the faculty, clinical preceptors and students all receive adequate professional development for the tasks that each must perform as part of the program; and (c) determining what kind of quality measures are demonstrated by the program to ensure the quality of the program including evaluation of their resources, assessments and survey results. This professional development should include at least a general overview of tools such as the Quality Matters Rubric.

**Professional development**

Providing a general understanding of these types of quality assurance tools as a guide for what programs should be doing is essential for the evaluators and can also provide them with a reference to provide to programs that may be struggling by assisting them in improving their program to meet the accreditation standards. Reviewers participating in the professional development should also be provided with both positive and negative examples of what they may encounter while evaluating a DE program. If the evaluators are provided with real-life examples from programs that have gone through the accreditation process where there have been citations issued, then they will be better equipped to recognize a potential problem when they are performing the evaluation. To the contrary, if they are provided with positive examples of what other programs are doing compared to how they are delivering their DE curriculum, it can provide a standard of what kinds of things the evaluators should be looking for when evaluating a program. Positive examples in the professional development sessions could also provide the evaluators with
suggestions that they could offer programs on ways that they could improve their programs while they are conducting the accreditation evaluation.

The landscape of DE is continuously changing and, therefore, appropriate program development professional development for all faculty should be regularly evident to the accreditation evaluators reviewing the program. To support these efforts, the evaluators should also be looking to ensure that the program’s institutions is providing support for their employees to continuously develop both themselves and their programs to provide the best possible experience for their students.

Because CAAHEP accredits Allied Health programs, the majority of the CoAs require a clinical component to their educational programs. It is of critical importance for CoAs to be able to adequately assess the quality of clinical sites and preceptors because the programmatic faculty will not be physically present when the students are completing their clinical rotations at the affiliate sites. During the professional development, the evaluators should be provided information regarding how to evaluate DE programs to ensure that students are receiving proper oversight by qualified and credentialed preceptors to ensure the best possible outcomes for the students.

The professional development sessions should cover how the evaluators should investigate what the programs are doing to ensure that the students are properly prepared to undertake a program that is primarily DE. They must also ensure that the program is identifying and addressing the demands of hands-on clinical aspects of learning in a DE program. To accomplish this, evaluators must
determine what additional professional development and support the faculty in the DE programs are receiving to prepare them for these tasks.

The professional development should provide information on how to ensure that there is appropriate design and instruction provided in the DE courses. The Quality Matters Rubric is one example of how such a review could be conducted, but further investigation may provide information on additional tools that could be utilized by the programs and the reviewers to ensure quality in the courses. Once again, the evaluators would receive professional development and be given examples of what to look for to ensure appropriate interaction between the students and instructors in the courses as well as real examples of how the institution’s technological tools can be used to demonstrate that the standards are being met. This can be done by professional development the evaluators review the DE curriculum, assessments, evaluations, satisfaction surveys, student records, and all other materials virtually rather than sitting in live classrooms or holding student files and lesson plans in their hands. In addition, professional development could provide evaluators with examples of the tools they needs to be able to evaluate the resources made available to the DE students to ensure they are equal to those available to FTF students. At the same time it could also be discussed that not everything accomplished during a site visit of a DE program needs to be done on-site; and, in some cases, there may not be a need for the site visitors to physically visit the institution at all, depending on the ability to fully evaluate the program from a distance. The evaluators should be introduced to the availability and use of tools such as video conferencing and live chats with the clinical preceptors. They could
also utilize these methods to conduct meetings with students, graduates and others who may not be located within a reasonable driving distance to be present during the conduction of the site visit.

The standards of accreditation are the same for a given profession regardless of the delivery method. Therefore, the DE professional development could potentially be offered to all site visitors. However, at a minimum, professional development for those evaluating DE programs should be focused specifically on what they need to look for to ensure quality of the curriculum, resources, and meeting the accreditation standards both when performing the review and during the site visit. This could be done very effectively by providing real examples of what has been found during other DE site visits and even provide comparisons of what is typically seen during DE reviews as compared to what is seen during FTF visits and provide examples of both exemplary and poor demonstrations of meeting the standards or the presence deficiencies.

Recommendations for Future Research

This study was conducted using grounded theory due to the lack of research available on the specificity of the subject being examined. This was also because experienced professionals in the accreditation of higher education programs were used as the subjects from which the data for this study were collected in order to answer to the primary research questions. After the data were collected and analyzed, this researcher became able to theorize that education and professional development is essential for accreditors and evaluators of DE programs with clinical
components. My theoretical premise could be further explored in future studies by examining the effectiveness of the professional development through follow-up surveys after the participants have completed a DE accreditation. As DE becomes more widely studied and accepted in medical communities, additional research could also be conducted to incorporate the findings of these evaluators, with new additions to the literature by them and other researchers who conduct studies at new DE programs to replicate and validate each other’s work. This is certainly an area in great need of further research and development, and it has the potential to become a “hot topic” for study in coming years.

Distance education provides a wide forum for study that encompasses a variety of topics for further investigation due to its continuously progressing and morphing state of existence. Each time there is a new technology developed that could enhance educational experience, it could potentially generate a new line of research to determine its best uses and effectiveness via DE. From the results of this study, the recommended development of the DE committee within CAAHEP and the subsequent evaluator professional development sessions, the most direct suggestion for further investigation was to evaluate the effectiveness of the professional development sessions. This could be done many ways but it may be simplest to do this with surveys of the evaluators, after they have completed a DE site visit. It would be very helpful to solicit the participants’ feedback to determine if there should be changes or additions made to the professional development as there will likely be a need to offer the sessions for many years as DE continues to change with technology and more evaluators need the professional development.
Research has indicated that there is not much difference in the overall quality of education when comparing DE and FTF. However, there is very little research specifically related to the delivery and needs when developing DE courses for health professions. This is a very specialized topic but is one that not only affects those in higher education as they navigate the needs of providing education to students in remote geographical locations. It also becomes of incredible importance to anyone that could potentially be a patient in a location underserved by qualified medical personnel. Distance education offers opportunities not only for people to learn new skills and improve their own quality of life by engaging in a profession, but it can also train individuals to provide otherwise unavailable health care to populations that may not otherwise have a way to receive such care. As evaluators of the quality of education that the students in these programs receive, the accreditors have a very important task when reviewing DE programs with clinical components. Ensuring that a program is meeting the standards of the accreditor could literally be saving the lives of the patients for whom those graduates provide care. It is imperative that the evaluators reviewing these programs not only know what to look for to ensure that these standards are met, but that they are comfortable with the nuances of DE itself in order to properly perform the review and site visits of these programs. There is currently very little research that has been done to determine how to best evaluate DE clinical programs from an accreditation standpoint and more research is needed.
Final Thoughts

Through my more than eight-year tenure of working with CAAHEP, I have observed the trend of more professions moving toward accepting DE as a form of quality education that meets accreditation standards and well prepares students for the workforce. Many times when one program in a profession develops a DE program, it is typically not long before others follow suit. One primary reason for this is due to low enrollment threatening the elimination of some programs in certain areas of the country. By transitioning FTF programs to DE, some programs are able to increase their enrollment to acceptable levels. This is very enticing not only to the faculty who are able to sustain keep their jobs, but also for the administration that is charged with sustainability.

Nevertheless, there are still many people working with CAAHEP accreditation who staunchly refuse to accept that DE is a viable option for delivering clinical education. These nay-sayers are still of the belief that if you can’t touch something in real-life, in front of an instructor, that it you are not creating a learning environment of adequate quality. However, many of us who are experienced in DE must present the facts when these opinions are shared. Most of the students enrolled in these accredited DE programs are still working in hands-on clinical settings with patients, preceptors, and even instructors. The only difference is that these instructors may be present only via a video feed. This does not diminish the quality of education that the student is provided or the quality of care that the patient receives.

The simple fact is that, if a program meets the standards of the accreditation board, it also meets the standards regardless of the way that the program is
delivered. As accreditors we must work together to inform our boards and the evaluators of what is required for a program to be of acceptable quality to meet the accreditation standards. We must show them examples of both good and bad representations of programmatic attempts to meet those standards. Thus, we need to arm the evaluators with the knowledge, skills and experience to be able to confidently assess these DE programs and offer advice for improvement and expansion to the programs when needed.

Having the ability to offer allied health educational programs in DE format creates the opportunity to increase the numbers of graduates in areas that may be underserved by health care workers. The availability of these DE programs not only improves the lives of the graduates by creating a career for them in a profession they love, but it also creates improved access to healthcare for the patients that they serve.

Ultimately, the goal of an educational accreditor is to certify that educational programs are meeting a set list of standards to ensure high quality educational experiences to the students. For CAAHEP, this goes one step further due to the fact that the programs they are accrediting are graduating students who are working with the health and well-being of humans. The graduates of these programs are making potentially life-saving and life-threatening decisions and actions with their patients every single day. To ensure the quality of the educational experience of these students is not only of the integrity of the education, itself, but also the safety of the patients they will be responsible for in the future.
It is our responsibility as accreditors to ensure that the evaluators for our CoAs have sounded professional development for the evaluation of DE programs. As I have observed this phenomenon unfolding during my time serving on a CoA, I have come to the realization that it has been my personal responsibility to use my experience and education to conduct this research. My recommendation to develop professional development for our evaluators is something that I feel is a realistic option for CAAHEP. Although, at this time, it is not certain if CAAHEP will choose to take my suggestions into consideration, it is my opinion that valuable data were collected and plausible solutions were offered as the result of my research.

I will continue to serve on the CoA PSG until my current term ends in 2017, and plan to continue to teach in a DE program with clinical components. It is my hope that CAAHEP can use these results to their advantage and that I can continue to remain involved in educational accreditation for many years to come. The future of our health lies in the hands of the graduates of these programs. I can think of little that is more important than assisting in ensuring the quality of education for these individuals.
APPENDIX A. STEPS IN THE ACCREDITATION PROCESS

Steps in the Accreditation Process

1. **Submit Request for Accreditation Services (RAS)**
   The RAS can be accessed at http://www.caahep.org/Content.aspx?ID=11. The form may be printed and mailed, faxed or submitted electronically. Programs must submit an RAS for each award level. Upon successful processing of the RAS the CoA PSG will assign a Liaison to assist the program with completion of the Self-Study Report.

2. **Pay Registration Fee**
   A non-refundable registration fee of $750 is required with submission of the RAS (an additional fee of $250 may be required by programs that award separate certificate and associate degree). The Initial Accreditation Payment Form, found on the CoA PSG website, is to be completed and returned with the RAS submission. Checks can be mailed to the CoA PSG under separate cover should you choose to submit the RAS form online. The RAS will not be processed until the registration fee is received.

3. **Self-Study Report**
   Upon receipt of an RAS, the CoA PSG will send the program an accreditation packet that includes a Self-Study Report form (SSR) and instructions for completion. The SSR must be completed and submitted to the CoA PSG within 12 months of receipt by the program. A separate SSR must be submitted for each award level. Typical time for completion of the SSR is 3 months or less. If the SSR is not received within 12 months, a new RAS and Registration Fee must be submitted.
   
   A site visit fee of $1800 and an administrative fee of $750 are due with submission of the SSR. Once the site visit fee is received, tentative dates for a site-visit can be established.

4. **Liaison Review**
   The SSR will be reviewed by the Liaison and a reader to confirm that all required documentation is included and that evidence of substantial compliance with all standards is present. The Liaison may request clarification of information or additional documentation. When the Liaison determines that the SSR is sufficiently complete, a date for the site visit can be finalized.

5. **Site Visit**
   The CoA PSG will send site visitors to observe, verify, and clarify evidence that the program is substantially in compliance with all Standards. The site-visit is typically completed in one day and includes interviews with the program director, medical director, administrators, faculty, students, graduates, and the advisory committee. The site visitors will prepare a report which is reviewed by the Liaison and the program before it is finalized.

6. **CoA PSG Review**
   After the Liaison finalizes the site visit report, it is presented along with the SSR to the CoA PSG. Based on this material, the CoA PSG will forward a recommendation to either grant Initial Accreditation or Withhold Accreditation to the CAAHEP Board of Directors.

7. **CAAHEP Accreditation Action**
   CAAHEP is the agency that grants accreditation. Accreditation of the program is not final until their Board of Directors acts on the recommendation of the CoA PSG. The CAAHEP Board considers accreditation actions during the third week of each odd numbered month. CoA PSG recommendations must be submitted by the 15th of the prior month to be considered.
APPENDIX B. CAAHEP 2014 SUMMER WORKSHOP AGENDA

CAAHEP Summer Workshop  
August 1-2, 2014  
Charlotte Hilton Center City  
Charlotte, NC

Friday, August 1, 2014

7:30-8:30 am  Breakfast
8:30 – 9:00 am  Welcome and Introductions
9:00 – 10:00 am  Most Frequently Cited Standards – Theresa Sisneros
10:00-10:15  Break
10:15 – 11:30  Site Visitor Training – A look at how three CoAs are doing it:  
Sarah Marino – MAERB  
Abby Overton – CoA-PSG  
Keith Orloff & Betsy Slagle – ARC/STSA
11:30 – 12:00  A little fun before lunch!
12:15 – 1:15  Lunch
1:15 – 2:00  Customer Satisfaction Survey Results – What are Programs Telling Us and  
How are we Responding? Discussion led by Cameron Harris, Barry Eckert &  
Greg Ferenchak from the Performance Oversight Committee
2:00 – 2:45  What is YAM? And how can we make it even more useful to CoAs and  
Programs?  Lorna Frazier-Lindsey and Kathy Megivern
2:45-3:00  Break
3:00 – 3:45  Focus Groups on “hot topics”:  
1) International Accreditation - Where (and whether) to Begin-Cheryl Benn  
2) More Marketing Ideas for CoAs – Thom Skalko, Marian Fortmann  
3) Site Visitor Training – conversation continued – Sarah Marino, Keith Orloff  
and Betsy Slagle  
4) Assessing Online Learning – Lots of Questions, Looking for Answers –  
Abby Overton  
5) Strategic Planning for CoAs- Claire Chandler
3:45 – 4:00  Break
4:00 – 4:45  Focus Group Sessions repeat

Saturday, August 2, 2014

8:00 – 9:00 am  Breakfast
9:00 – 10:30 am  Transparency and Public Disclosure – new requirements, new policies and  
trends for the future – Elise Scanlon
10:30 – 10:45  Break
10:45 – 11:15 am  Reports on Focus Groups, Wrap up and Adjourn
APPENDIX C. INSTITUTIONAL REVIEW BOARD APPROVAL

IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

DATE: 9/29/2014
TO: Auburne Overton
1002 Yellow Bee Rd
Indian Trail, NC 28079
CC: Dr. Larry Ebbers
N256 Lagomarcino Hall
FROM: Office for Responsible Research
TITLE: Standards of Accreditation for Clinical Allied Health Distance Education Programs

IRB ID: 14-405

Study Review Date: 9/25/2014

The project referenced above has been declared exempt from the requirements of the human subject protections regulations as described in 45 CFR 46.101(b) because it meets the following federal requirements for exemption:

- (2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey or interview procedures with adults or observation of public behavior where
  - Information obtained is recorded in such a manner that human subjects cannot be identified directly or through identifiers linked to the subjects; or
  - Any disclosure of the human subjects' responses outside the research could not reasonably place the subject at risk of criminal or civil liability or be damaging to their financial standing, employability, or reputation.

The determination of exemption means that

- You do not need to submit an application for annual continuing review.
- You must carry out the research as described in the IRB application. Review by IRB staff is required prior to implementing modifications that may change the exempt status of the research. In general, review is required for any modifications to the research procedures (e.g., method of data collection, nature or scope of information to be collected, changes in confidentiality measures, etc.), modifications that result in the inclusion of participants from vulnerable populations, and/or any change that may increase the risk or discomfort to participants. Changes to key personnel must also be approved. The purpose of review is to determine if the project still meets the federal criteria for exemption.

Non-exempt research is subject to many regulatory requirements that must be addressed prior to implementation of the study. Conducting non-exempt research without IRB review and approval may constitute non-compliance with federal regulations and/or academic misconduct according to ISU policy.

Detailed information about requirements for submission of modifications can be found on the Exempt Study Modification Form. A Personnel Change Form may be submitted when the only modification involves changes in study staff. If it is determined that exemption is no longer warranted, then an Application for Approval of Research Involving Humans Form will need to be submitted and approved before proceeding with data collection.

Please note that you must submit all research involving human participants for review. Only the IRB or designees may make the determination of exemption, even if you conduct a study in the future that is exactly like this study.

Please be aware that approval from other entities may also be needed. For example, access to data from private records (e.g., student, medical, or employment records, etc.) that are protected by FERPA, HIPAA, or other confidentiality policies requires permission from the holders of those records. Similarly, for research conducted in institutions other than ISU (e.g., schools, other colleges or universities, medical facilities, companies, etc.), investigators must obtain permission from the institution(s) as required by their policies. An IRB determination of exemption in no way implies or guarantees that permission from these other entities will be granted.

Please don’t hesitate to contact us if you have questions or concerns at 515-294-4566 or IRB@iastate.edu.
APPENDIX D. SUGGESTED EVALUATOR COURSE OUTLINE

CoA PSG Distance Education Site Visitor Professional Development
Proposed Agenda

Objectives:
By the end of this professional development session, the participants should be able to:

1. State why the standards of accreditation are the same for programs regardless of the delivery model.
2. Discuss ways that DE programs can be evaluated in non-traditional ways to ensure they meet standards.
3. Evaluate programmatic professional development of faculty, clinical preceptors and students to ensure that it is appropriate for the program's delivery format.
4. Identify methods of evaluating the overall quality of a program based on their measurement of resources, objectives, assessments and survey results.

Program Outline

- Basic Overview of Traditional Vs. DE Delivery
  - Standards
- DE Courses
  - Access and Assessment
  - Examples from the Field
- Faculty, Clinical Preceptor and Student Professional development
  - Examples from the Field
- Identifying Quality Measures
  - Examples and Tools (Quality Matters Rubric)
  - Resources
  - Objectives
  - Assessments
  - Survey Results
APPENDIX E. SURVEY FOR EVALUATORS

Survey for Evaluators that had Recently Completed DE Site Visits
delivered via Survey Monkey

1. What are the major challenges you experienced when reviewing the clinical DE programs for accreditation?
   a. How did you address these challenges?
   b. What preconceived ideas did you have about DE before you conducted this visit?
   c. Were you told to look for anything specific when conducting this visit for the DE program as opposed to the traditional FTF programs?
   d. Did your opinion of DE change after this visit? How?
   e. Overall, did you think that this DE program was different, better or worse as a DE delivery as opposed to FTF? How?
   f. Were you able to assess the same things you would have if this had been a FTF site visit?

2. As someone that has conducted a DE site visit, what do you think can be used to develop guidelines for CoA evaluators of clinical DE programs?
   a. Are there any tools you wish you had to better prepare you for this site visit?
   b. Would a professional development session about accrediting DE programs have been helpful to you prior to conducting this site visit?
   c. What should be included in that professional development?

3. Do you have anything else you’d like to share about your experience?
REFERENCES


Fabry, D. (2009). Designing online and on-ground courses to ensure comparability and consistency in meeting learning outcomes. Quarterly Review of Distance Education, 10(3), 253-261.


