CCE®
THE COUNCIL ON CHIROPRACTIC EDUCATION

Accreditation Manual

Designed for

Programs

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Foreword

The Council on Chiropractic Education (CCE) is an autonomous, specialized programmatic accrediting agency. The Council administers the process of accreditation, renders accreditation decisions and establishes bylaws, policies, procedures and accreditation requirements. CCE maintains recognition by the United States Department of Education and the Council for Higher Education Accreditation (CHEA). CCE is also a member of the Association of Specialized and Professional Accreditors (ASPA).

Accreditation requirements focus on student and resident learning outcomes within Doctor of Chiropractic Degree Programs (DCP) and Chiropractic Residency Programs (residency) to prepare graduates to serve as competent, caring, patient-centered and ethical primary health care professionals.

CCE awards and continues accreditation through a dynamic process of review and evaluation for compliance with the "Principles, Processes & Requirements for Accreditation" as reflected in the current edition of the *CCE Standards*. This review process addresses the ability of a program to achieve its stated mission, goals and objectives.

Familiarity with the CCE *Standards, CCE Manual of Policies (Policies), CCE Bylaws* (*Bylaws*), and this *Accreditation Manual* is essential to the development and operation of CCE accredited Doctor of Chiropractic Degree and Chiropractic Residency Programs. This manual contains information about the Council, the CCE accreditation process and responsibilities of the participants in these processes. Any questions regarding the manual itself should be directed to the CCE administrative office.

Throughout the document the notation of "*Standards"* reflect either the, 1) *CCE Accreditation Standards*, which outline the requirements for the Doctor of Chiropractic Degree Program (DCP), or, 2) the *Residency Program Accreditation Standards*, which outline the requirements for chiropractic residency programs, whichever is applicable.

Section I Council

A. Vision, Mission, and Values Statements

The Council on Chiropractic Education (CCE) serves the interests of the public, the profession, students, and residents in general in alignment with its vision, mission, and values statements. These statements are contained in the CCE Accreditation Standards (*Standards*) and published on the official CCE website (www.cce-usa.org).

B. Purpose

The Council conducts evaluation processes leading to the accreditation of programs that comply with the requirements for accreditation as outlined in the *Standards*. Council activities associated with program evaluation and accreditation includes:

1. Implementation of policies and procedures set forth in the *Standards* and related accreditation documents *(Manual of Policies, Bylaws, Accreditation Manual* and *Academy of Site Team Visitors Manual*).
2. Maintenance of communication with and conducting reviews of programs to address routine and special circumstances.
3. Evaluation of a program's adherence to stated mission and goals, assessment and planning processes, program outcomes, support services and other elements within the Requirements for Accreditation.
4. Granting or denying initial accreditation, and granting, deferring or revoking reaffirmation of accreditation, along with other defined actions and decisions.
5. Encouragement of program improvement through continuous self-study and review.
6. Provision of advice and assistance to established and developing programs.

C. Organization

The Council is composed of no fewer than thirteen (13) and no more than eighteen (18) Councilors: ten (10) who are full-time employees of the accredited programs (Category 1 and 4), four (4) practicing doctors of chiropractic (Category 2 and 5), and two (2) public members (Category 3). Detailed information regarding the composition of the Council appears in Article VI of the CCE *Bylaws*. The Council Chair, or designee, serves as the official Council spokesperson. The Council annual meeting is held in January, and the semi-annual meeting is held in July of each year unless otherwise noted. Special meetings may be called by the Council Chair or upon the written request of a majority of Councilors.

1. Council Officers

The Council officers (Bylaws, Article VIII) are the Council Chair, Associate Chair, Treasurer and the CCE President. These officers, along with the Councilor At Large, comprise the Council Executive Committee (CEC), a standing committee of the Council. The CEC addresses Council matters that may arise between Council meetings using a participative decision-making model. The CEC normally consults with the entire Council on major issues before taking action while never taking accreditation actions without the entire Council. The volunteer members of the CEC may be appointed to serve no more than two (2) consecutive two-year terms in their respective positions.

2. Council Chair

a. Communicates regularly with the CCE President, CCE Vice President for Accreditation & Operations and the CEC, regarding decisions to be made by the CEC and Council.

b. Serves as the chair and voting representative on the CEC.
c. Develops the agenda for CEC and Council meetings.
d. Reviews, finalizes and directs distribution of all Council-related business and accreditation correspondence through the CCE administrative office.
e. Conducts Council meetings, adhering to CCE Bylaws, policies and procedures and Robert's Rules of Order.
f. Issues reports and requests for information through the CCE administrative office and shares received information with the CEC and Council.

D. Council Meetings

1. Attendance and Quorum

Councilors are expected to attend all scheduled meetings and any special meetings called by the Council Chair. Unexcused absence may be grounds for dismissal. The majority of Councilors entitled to vote, constitutes a quorum, and must be present for Council business to be transacted.

2. Confidentiality Agreements

Upon appointment to the Council and before each Council Meeting, each Councilor must sign/date the "Councilor Confidentiality Agreement" and guests attending a Council meeting must sign/date the "Guest Confidentiality Agreement". These documents are maintained on file in the CCE administrative office in accordance with the Records Management and File Plan. Violations of the CCE confidentiality policy by a Councilor, agent or employee are addressed in CCE Policy 4 and also in the CCE Bylaws, Article VI.

3. Conflict of Interest

Prior to regularly scheduled Council Meetings, councilors must declare to the Council Chair if they have an actual or potential conflict of interest regarding any program by completion of Council Form 9 and must leave the room during any discussion, deliberation or decision-making with regard to that program. CCE Policy 18, *Conflict of Interest*, and CCE Bylaws, Article VI, address these areas. The CCE administrative office maintains declarations of conflicts of interest and appropriate updates in accordance with the Records Management and File Plan.

4. Status and Progress Review

The Council Chair conducts status review and progress review meetings unless he/she has a conflict of interest. In such cases, the Associate Chair or other appointed Councilor will conduct the review. If conflict factors apply to both the Council Chair and Associate Chair, another Councilor appointed by the Council present will conduct the meeting.

E. Other Processes and Information

1. Public Statements

The Council verifies the accuracy of program's public statements, especially with regard to the accreditation status of the program. In all instances, the program should contact the Council for review and approval of any questionable statements not specific to CCE policies and procedures prior to publishing such statements. These requirements are outlined in CCE Policy 22, *Program Integrity & Representation of Accreditation Status*, where requirements for disclosure of information by the program to the Council are also referenced regarding the processes of accreditation.

2. Revision to the CCE Bylaws, Policies and Standards

The process for revisions to the CCE Bylaws and CCE Manual of Policies are outlined in CCE Policy 24 & 25, respectively. The process and revisions to the *Standards* are conducted on an eight-year cycle, by the Standards Review Task Force appointed by the Council. Proposed revisions regarding the *Standards* can be submitted by all stakeholders, to include the public at large, and the opportunity for public comment is allowed throughout the eight-year process as indicated in the policy. Policy procedures for the *Standards* are outlined in CCE Policy 23.

3. Complaints

CCE Policy 64, *Complaints*, outlines the processes to follow in addressing complaints against CCE Councilors, Academy of Site Team Visitors, Administrative Office Staff, Member Representatives, other agents of the organization, *Standards* or *Policies* and CCE Accredited programs.

Section II CCE Administrative Office

The activities of the CCE administrative office and responsibilities of the staff are primarily directed by the CCE President. In relation to accreditation matters, the President and other CCE staff operate at the direction of the Council Chair and in coordination with the Council Executive Committee (between annual/semi-annual meetings) and the Council.

A. Council Support

The CCE administrative office administers technical and procedural aspects of the accreditation process by maintaining confidential accreditation files for each program, agendas, minutes, support materials for each Council meeting, and conducting a variety of communication activities on an ongoing basis.

B. Accreditation Process Support

The CCE administrative office maintains the CCE Schedule for Accreditation Activities, which outlines the routine accreditation cycles and reporting for each program, which includes; comprehensive site visits, interim site visits and monitoring reports. The CCE administrative office coordinates all site visit and monitoring report activities, and related communications between the programs, site teams, and the Council. The office also ensures implementation of all accreditation processes, and provides procedural details, information, recommendations, and services related to accreditation.

C. Directory of CCE Accredited Programs

The CCE administrative office maintains the Council on Chiropractic Education's directory of accredited programs. This list is posted on the CCE web page at www.cce-usa.org and includes the program name, contact information, dates of the next scheduled Council status review meeting, address and identifies the college president or program director. Listed programs must inform the CCE administrative office immediately regarding updates to contact information on this list.

D. CCE Information Documents

The CCE administrative office updates and maintains official CCE documents and also makes them available to the public via the CCE website (with the exception of the Articles of Incorporation) in accordance with CCE policies and procedures and includes the following**:**

1. *Articles of Incorporation/Domestication:* Provide the legal basis for CCE.
2. *CCE Bylaws:* Define the governance, operations, and role of the CCE and its basic components, including its member representatives, councilors, and officers.

3. *CCE Accreditation Standards:* Document the criteria the doctor of chiropractic degree programs must meet in order to achieve and maintain CCE accreditation.
4. *CCE Residency Program Standards:* Document the criteria the chiropractic residency programs must meet in order to achieve and maintain CCE accreditation.
5. *CCE Manual of Policies*: Contains guidance and procedural documents consistent with the rules, regulations, and procedures in other CCE publications.
6. *Accreditation Manual:* Designed to assist programs in understanding the concepts, processes, procedures, and roles of CCE and the Council.
7. *Academy of Site Team Visitors Manual:* Designed to assist site team chairs, team members and observers of the processes and procedures of pre-visit, visit and post-visit activities.

Section III Requirements for Initial & Reaffirmation of Accreditation

A. Letter of Intent

1. Initial Accreditation

Since accreditation is a volunteer peer-review process, the program must send a letter of intent from its governing body to the CCE administrative office stating its intention to pursue accredited status. For programs seeking initial accreditation or development of an additional location (in accordance with CCE Policy 1, *Substantive Change*), the Council establishes the self-study report and site visit requirements for those programs not already accredited by the Council after a formal application and the required initial eligibility documentation has been submitted and approved by the Council.

After review and approval of the application and eligibility documentation, the Council will determine when the first cohort is scheduled to graduate based on the information provided by the program in its application. Once the graduation date has been established, the Council will then notify the program when its self-study report is due and when it can anticipate its first comprehensive site visit to take place. In this instance, the Council affords the program the right to have two Status Review Meetings with the Council at its regularly scheduled Council Meetings prior to its first cohort graduation.

2. Reaffirmation of Accreditation

The Council submits a notice to the program approximately 18 months prior to the scheduled comprehensive site visit and 12 months prior to the submission of the self-study, requesting a letter of intent from the program's president/director regarding their intentions of reaffirming their accreditation status with the Council. Once the program acknowledges their intent to reaffirm, the Council informs the program of the requirements for submission of their self-study and site visit preparation.

B. Eligibility Documentation

For reaffirmation of accreditation, the program need not submit evidence of eligibility documents required for initial accreditation unless eligibility requirements have changed from the last reaffirmation visit. However, the program must maintain documentation that it complies with the eligibility requirements outlined in the *Standards*, Section 1. This information must be available for review by the site team during their visit and also the Council, as required.

C. Self-Study Process

The self-study report is a comprehensive document addressing all aspects of the requirements for accreditation as outlined in the *Standards*. The program is required to submit one (1) electronic version

(flash drive or email) to the CCE administrative office for review and distribution.

Following submission of the letter of intent from the program, CCE officially notifies the program in a letter with specific detail regarding the process, to include the date the self-study is due to the CCE administrative office. The program forwards the completed self-study for review by the CCE administrative office staff six months prior to the scheduled site visit. If the report form and content are determined to be unsatisfactory, the program may be required to submit a revised report before further review is conducted. After the review, an Executive Summary Report (ESR) is sent to the program notifying the program of any additional information requirements, whether a self-study update is optional or required, and also to provide feedback to the program regarding the format and content of the self-study. The program reviews the ESR, takes the appropriate action(s) and prepares for the site visit.

It is important to note that, by accepting the self-study, the Council does not imply that all statements in the document satisfy the requirements for accreditation in the *Standards*.

If a self-study update is warranted, the program submits a self-study update report describing any important changes that have occurred since the original report was submitted. Any new or updated ancillary documents are also resubmitted with the report to the CCE administrative office for distribution to all team members (no later than 30 days prior to the site visit).

The CCE administrative office then sends the self-study and the Executive Summary Report (ESR) to the assigned site team in preparation for the site visit.

The Council also completes a review of the self-study report no later than 30 days prior to the scheduled annual or semi-annual Council Meeting in preparation for the Status Review Meeting with the program.

D. Self-Study Content

Development of the self-study report is a major step in the application for initial or reaffirmation of accreditation. It is an honest self-analysis of the educational program's effectiveness, including program strengths and areas in need of improvement, prepared with input from its own people—board members or governing official, staff, faculty, administrators, and students or residents.

The self-study report must:

1. Provide clear evidence that the program complies with the CCE requirements for accreditation.
2. Provide an objective appraisal of program strength, weaknesses, and challenges, based on the requirements of the Standards.
3. Illustrate how the various activities of the program meet the Standards.
4. Focus attention on the ongoing assessment of outcomes to demonstrate individual student achievement of meta-competencies and for the continuing improvement of academic quality.
5. Demonstrate that the program has processes in place to ensure that it will continue to comply with the CCE requirements for accreditation.

The report should include, at minimum, the following:

Cover/Introduction

Cover page design may include logo, photos and/or graphics (but not required), followed by a completed Accreditation Status form (Council Form 15 or 16, Appendix I and II), which can be obtained by contacting

the CCE administrative office.

The program should provide a brief summary of the reason for the report (i.e. seeking initial or reaffirmation of accreditation). The introduction should provide a brief narrative on the current state of the program, including a description of efforts undertaken to obtain information to produce the report, as well as the names of key individuals involved in the self-study process.

Requirements of Accreditation – CCE *Standards*
The program should identify each area of the *Standards* and provide the necessary narrative and supporting documentation to evidence compliance. Areas that show weakness or are not evidenced to be in compliance with the *Standards* should be identified by reporting the current status and also future planning processes the program will implement to achieve compliance with the *Standards*.

NOTE: It is important to report in all areas of the *Standards* and not to omit any area. Appendices and/or exhibits should be attached appropriately. Regarding appendices/exhibits, excerpts from large documents are preferred rather than attaching an entire document. Care should be taken to provide the Council with the program's best supporting evidence rather than a preponderance of evidence in consideration of reviewers focusing on and interpreting meaningful information that may be missed by wading through voluminous documents.

Supporting Documentation
In providing supporting documentation and/or evidence for the requirements of each standard, reference the *Onsite Documents Requirements* as a guide, (see Appendix VI and VII). Note, this is not an all-inclusive list of items to be included in the self-study report, supporting evidence and documentation should be tailored to the self-study narrative regarding each standard as the program deems appropriate.

Section IV Site Team Selection, Observers & Staff

A. Academy of Site Team Visitors
The Council Site Team Academy Committee collaborates with the CCE staff to maintain and, as necessary, supplement membership to the Academy of Site Team Visitors (*Academy*). Policy and procedures regarding the Academy appears in CCE Policy 10, *Academy of Site Team Visitors*. The Council organizes and implements training and workshop activities for site team candidates and current Academy members on an annual basis or as needed based on categories of expertise requirements and/or major revisions to CCE publications.

B. Site Team Composition
The CCE staff establish the site team composition based on availability, absence of conflicts of interest, categories needed to conduct the visit, and experience/training.

C. Team Agreement Form
The team agreement form, listing the proposed team members with position titles, affiliation, and contact information, is submitted to the president/program director, who may accept the list as presented or provides reasons why any proposed team member should not serve for the site visit. The decision of the program will not be based on personal reasons, but rather, if any of the team members have a conflict of interest with the program that is unknown to the Council, e.g., has been a paid consultant at the program in the past 8 years or a candidate for position of hire at the program in the past year.

The program is encouraged to discuss any concerns about proposed team members with the Council Chair and/or CCE President before submitting a request for removal due to the time constraints involved in the entire process. Any request for removal of a proposed team member must be submitted in writing to the Council Chair and must clearly explain why service by the individual could be unfair or deleterious to the accreditation process. Such a written request must be submitted to the Council Chair within seven (7) business days of the programs receipt of the list of proposed team members.

NOTE: All Academy members are bound by the confidentiality conditions set forth by the Council. In addition, each site team member signs conflict of interest declarations prior to site visit activities.

D. Site Team Agreement to Serve

Upon the program's agreement on team composition, the CCE staff issues a written letter, the Team Agreement to Serve form, and applicable materials to team members. The CCE staff then contacts team members regarding site visit details and travel arrangements.

E. Guest Observers

With the approval of the CCE President and notification to the president/program director, a guest may be invited to observe the site visit. An observer may be a representative of the Council, another accrediting organization, the Commission on Higher Education Accreditation (CHEA), or the U.S. Secretary of Education (or USDE designee). New member(s) of the Site Team Academy often attend as guest observer(s) to supplement training prior to being assigned to a site visit team.

In the case of an approved observer, generally a site team academy member in training or a new councilor, the observer shall comply with the following procedures when accompanying a visit:

1. Will adhere to the same confidentiality requirements as site visit team members;
2. Will not participate in the decision-making or consensus process of the team;
3. Will not offer critiques or analytical reviews of the program, documents or team functions,
4. May not actively solicit input or data from program personnel or students;
5. May observe the process and procedures of team activities and functions, accompany team members to on-campus visits and attend team meetings;
6. May view any materials made available to team members;
7. May discuss with team members facts and information about which they may become aware, and will convey any relevant information to the team; and
8. If identified as intrusive or interfering with the site team process by either the program or the site team chair, the individual may be required to leave or be limited in their scope.

F. CCE Administrative Office Staff

A CCE administrative office staff member is assigned to comprehensive (initial and reaffirmation) site visits to assist and provide support to the site team and the program. Staff members provide guidance to the site team chair and team members regarding their assigned responsibilities on the visit, assist in clarification and consistent application of the requirements for accreditation as listed in the *Standards*, monitor and guide consistency of processes, provide draft report compilation, and explain Council policies and procedures to team members and program personnel, as needed. CCE staff attend meetings between the team and program personnel, assist the team in obtaining and reviewing information, participate in

team discussions, but do not evaluate the program. CCE administrative office staff are also present at interim or focused site visits, at the discretion of the CCE President or Council Chair.

Section V Type of Site Visits

Various types of site visits are part of the peer-review evaluation process and are a very important component of the accreditation processes. Additional information regarding site visits and evaluators may be found in the CCE Manual of Policies, within CCE Policy 10, *Academy of Site Team Visitors* and CCE Policy 11, *CCE Site Visit Teams*.

A. Comprehensive Site Visit (Initial or Reaffirmation of Accreditation)

A comprehensive site visit is a full review of a program applying for initial accreditation or reaffirmation of accredited status, and is scheduled for the spring or fall following submission of the self-study report. The length of the visit is normally four days for a DCP. For residency programs, the length of the visit varies depending on the size and structure of the program. The team verifies and validates the information presented in the self-study document. The team report identifies the program's strengths and any concerns regarding minor to major deficiencies in meeting the requirements of the *Standards*.

B. Interim Site Visit

The interim site visit is normally scheduled midway through the routine accreditation cycle. The Council may address issues identified in the most recent status review, in the DCP's Program Characteristic Report (PCR), in other reports required by the Council, or information from other sources. If no concerns or areas of weakness/deficiency are identified, the Council may choose to forgo the interim site visit, but in most cases a visit will occur to promote communication, monitor compliance and ensure continuous quality improvement with the DCP. The length of this visit varies based on the review needed by the Council, but generally, two to three days is appropriate with the exit briefing on the last day of the visit. (Note, interim site visits do not apply to chiropractic residency programs.)

C. Focused Site Visit

A focused site visit is normally conducted in follow-up to address a concern or area of weakness/deficiency needing attention regarding the CCE Standards or policy requirements following a progress report, or as follow-up to a substantive change, etc. The length of this visit varies based on the review needed by the Council, but generally, two to three days is required with the exit briefing on the last day of the visit. A focused site team normally consists of a team member(s) from the previous visit along with a team member(s) not involved in the previous visit.

Section VI On-Site Evaluation (Site Visit)

A. Self-Study Review by Team Members

Prior to beginning the visit, team members thoroughly review the program's self-study report, with updates (if applicable), and all related documents. The self-study report and the *Standards* are the guiding documents for the site visit. The analysis of this report and related documents, especially those sections relevant to areas assigned, enables team members to develop an important overview of the program and supporting evidence regarding the requirements of each Standard. During the visit, the team will verify and validate the content of the self-study report and additional information gathered during the site visit, as related to the Standards.

The self-study report is intended to demonstrate and evidence that the program is complying with Section 2, CCE Requirements for Accreditation, in the *Standards*.

B. On Campus/On-Site

The site team chair and CCE staff coordinates and facilitates the team visit, including leadership of team discussions by the site team chair. Site visit teams usually remain on campus/site from 8:00 a.m. to 4:30 p.m. daily. At the discretion of the site team chair, these times may be adjusted to accommodate the program, or to meet special team needs for extended hours.

C. Initial Team Chair Meeting & Precautions

An initial team chair meeting is conducted the day prior to the scheduled first day of the site visit and is mandatory for all team members to attend. The team chair and staff brief the team regarding the logistics, responsibilities, documentation, etc. and provide updates or additional information to the team as necessary.

One of the important topics discussed during this meeting is the review of precautions. These items are of particular importance to the Council as they give general guidance for some of the "what to do" and "what not to do" issues during the site visit process. Many of these items are outlined in relevant CCE policies and procedures and/or identified in the Site Team Agreement form signed by all team members prior to the site visit. They are listed below for reference and information.

Precautions

1. All matters associated with a site team visit are confidential as individual team members participate in the service of the Council. All communication between the program and team must occur through the site team chair and/or CCE staff. Team members and individuals from the program will not correspond or communicate on matters other than the status of the program and self-study materials. Should a team member receive unsolicited correspondence or documents from the program being evaluated, the communication will be referred to the site team chair and CCE staff.
2. Team members do not discuss their evaluations outside of team meetings.
3. Team members will respect the confidentiality of self-study reports and any other internal program documents, including the team report.
4. Team members will abide by all relevant CCE policies, specifically CCE Policy 18, *Conflicts of Interest*; CCE Policy 19, *Official Documents & CCE Spokespersons* and HIPAA requirements.
5. Team members will not recruit faculty or staff for service elsewhere or suggest their own availability as a consultant or employee.
6. Team members will not accept gifts, favors or services from the program. Souvenir gifts, restricted to inexpensive items representative of the program or its geographic location, are permissible.
7. Team members will not side with interest groups or individuals in the program, or allow them to be drawn into debate on program issues.
8. Refrain from libel or slander statements (written or spoken, respectively); accordingly, site team members must be sure that all statements about a program, its resources, programs and personnel are accurate, fair, and reasonable professional judgments based on factual information and careful observation.
9. Team members place primacy on evidence and data that support compliance with Standards.
10. Team members must not let personal biases influence fact-finding and evaluation.
11. Team findings will be supported by reference to documents and to interviews with as many program personnel as necessary.
12. Team members should verify, cross check and validate data that is reviewed.

13. Team members are responsible to identify areas of concern where evidenced.
14. Teams will focus their attention on identification of significant issues that pertain to the program's ability to demonstrate compliance with the Standards, and not waste time on minor matters that are outside the purview of the Standards.
15. Team members are required to identify concerns, when applicable, and the Council will determine the nature, degree, and disposition of these concerns. As Council representatives, team members must be clear with program personnel so that the site team does not prescribe specific actions.
16. Notations of strengths or concerns must be factually representative of the program; there must be no attempt to balance the number of strengths with any number of concerns.

D. Introduction Meeting with Program

The site team chair provides an orientation briefing regarding the specifics, purpose and function of the site visit to the president/program director, his/her designated representatives, site team members, and any observers and staff present to begin the on-site evaluation process. The briefing includes, but is not limited to the following:

1. Site team chair introduces the team and explains role of each member, observer, and staff, etc.;
2. Site team chair describes purpose of visit (comprehensive, interim or focused site visit)*;*
3. Site team chair describes function of team;
   a. Eyes and ears of the Council,
   b. Verify/validate the information and evidence provided in the self-study, and to obtain additional evidence, as needed, in relation to the requirements of the Standards.

4. Site team chair describes the process;
   a. Evaluation based on the *Standards,*
   b. Snapshot in time,
   c. Quality improvement,
   d. Communication both ways – open dialogue,
   e. Exit interview on last day of visit,
   f. Draft report; opportunity to correct factual errors; final report; program response report; meeting with the Council; Council decision.

Site team chair invites the president/program director to introduce program representatives and provide brief introductory comments, and then site team chair closes session by reviewing initial meetings in accordance with the Schedule of Events. NOTE: The opening session is generally designed to last approximately 15 minutes.

E. Schedule of Events and Meetings/Interviews with Program Personnel

The CCE staff, working with the team chair and program accreditation liaison, prepares a Schedule of Events (SOE) for the visit activities prior to the visit. The schedule will consist of, as appropriate, various meetings and/or interviews with program personnel. Team members will be provided the schedule prior to the visit and may provide the staff and team chair with additional meetings they deem necessary. The program accreditation liaison will also be provided a copy of the SOE (prior to the team's arrival) for distribution to program personnel as they deem appropriate. During the visit, team members may add or delete meetings/interviews, in coordination with the team chair and staff. The staff will maintain the master schedule and utilize it as the record of all persons/groups interviewed (names, titles, etc.), facilities visited, and activities directly observed.

The interactions of team members with members of the governing board, administration, faculty, staff, and student or resident body are vital components of the visit. The on-site visit allows for team members to validate findings through personal observations, meetings with personnel and students/residents, and other direct interactions. The following information provides team member guidance for interviews and meetings with program individuals and groups, and discussion topics for each Standard. One or more team members may meet with selected individuals or groups; the type of site visit conducted will determine which of these meetings will be most appropriate. Topics are organized by the DCP Standards or the Residency Standards.

NOTE: This is not intended to be a complete list as team chairs and team members may require additional meetings/interviews at their discretion depending on the size and structure of the program. The content of interviews is often dependent upon the information and evidence provided in the self-study. Interviews should be structured to answer key questions the site team must address, rather than follow a set format.

The following topics/questions are appropriate for interactions with all program personnel, and applicable to both DCPs and Residency Programs.

1. How were you involved in the self-study process?
2. Do you have sufficient resources (facilities, personnel, finances) to support the activities and plans in your area?
3. Are policies and procedures made available to appropriate groups (students and faculty), and clearly defined?

1. CCE Accreditation Standards (DCP): Example Topics for Interviews/Meetings

Self-Study and Site Visit Questions:
Interviewee(s): Self-Study Committee, DCP administration, program director

- Questions the DCP might have about the processes and logistics regarding the site visit;
- Discussion about the strengths and achievements of the DCP, as included in the self-study;
- Involvement of faculty, students, and staff in the self-study process;
- Progress on addressing deficiencies noted by the program in the self-study.

A. Mission, Planning and Program Effectiveness

Interviewee(s): DCP administration, institutional/program effectiveness committees and/or personnel, and faculty

- How does the program support the mission, goals and objectives of the DCP;
- Program planning and planning processes;
- Processes for data collections and reviews to inform planning priorities and budget allocations;
- Sufficient resources (facilities, personnel, finances) to support the DCP's plans/activities;
- How are departments and faculty involved in planning and budgeting processes;
- Processes for conducting program effectiveness/program evaluation; cycles of data collections and reviews;
- Measures, thresholds, and data used to evaluate program effectiveness, including NBCE and DCP completion rates, and program learning outcomes and/or aggregate meta-competency outcomes;
- How are meta-competency outcomes and other assessment data used to inform curricular improvements (also see Standard H);
- How are program effectiveness data and processes used to inform planning, program improvement activities, and tied to budgeting processes?

B. Ethics and Integrity

Interviewee(s): DCP administrators, Dean of DCP/Academics/Clinics, Student Services personnel, faculty, and students

- Academic, clinic, patient care and student policies, applicable to the DCP;
- Conflict of interest policies (BOT and DCP employees);
- Policies regarding ethical and professional care of patients;
- Policies or procedures regarding research;
- Policies or commitment to Academic Freedom;
- Policies and process to adjudicate violations of academic and ethical standards (Note, also covered under Standard F.);
- Evidence of investigation and disciplinary actions for violations of ethics or integrity, if present;
- Policies and procedures are available to DCP constituents.

C. Governance and Administration

Interviewee(s): BOT, President/CEO, DCP administrators

- BOT's knowledge, support and involvement in the DCP plan/strategic plan;
- How does the BOT fulfill its fiduciary responsibilities; review of institutional and/or DCP mission, planning, budgets, and policies, as applicable to the DCP?
- Organizational structure and communication between the DCP, institutional administration and the BOT;
- Clear lines of responsibility and communication between the DCP administration and the DCP's faculty and staff;
- Effectiveness of the organizational structure; appropriate DCP committee structures;
- Regular evaluations of DCP administrator(s) performance.

D. Resources

Interviewee(s): CFO, President/CEO, director/dean of DCP, director of technology/IT, director of library/learning resources

- Current annual budget, revenues and expenditures for the DCP;
- Policies defining accounting system and internal financial controls, as applicable to the DCP;
- Institutional financial indicator score and ratio performance (i.e. CFI), and DCP budgets demonstrate adequate and stable resources to support the DCP;
- Development of realistic, long-term DCP budget projections (multi-year); analysis of increases/decreases;
- Processes that link budgets to planning, (also covered under A.2);
- Department–level budgeting processes; procedure for deans/directors to request allocations for their department, (may also be covered under A.2, A.3 or H.2);
- Management of facilities; infrastructure master plan/maintenance plans, as applicable to the DCP;
- Appropriate affiliation agreements, contracts, and/or leases, as applicable to the DCP;
- Adequate instructional support/resources (e.g., facilities, clinics, classrooms, laboratories, technology, internet access, learning resource center/library, etc.) to support program;
- Budgeting and planning for DCP instructional technology needs.

E. Faculty

Interviewee(s): director/dean of DCP, faculty

- Faculty evaluation policies/process; systematically followed;
- Policies and process for hiring, promoting, reviewing, and dismissing faculty;
- DCP personnel files; academic credentials, licensure (if applicable), expertise and experience;
- Faculty contracts or faculty bargaining unit agreements;
- Faculty workload assignments, classroom and clinics; time allotted for research/scholarship and service;
- Faculty is of sufficient size/student-faculty ratio;

- Instructional support/resources, classroom technology (also covered under D.2);
- Faculty development programs, including funding, availability, and utilization by faculty;
- Expectations for faculty research/scholarship and service (policies, faculty handbook) (also covered under I and J);
- Faculty involvement in academic policies, program effectiveness and DCP planning (also covered under A.2-A.3);
- Faculty involvement in assessment of courses, student learning, meta-competencies (also covered under H.2);
- Faculty access to and use of student learning and program assessment data (also covered under H.2);
- Faculty involvement in curricular change (also covered under H.1 and H.2);
- Faculty development requirements, opportunities and outcomes.

F. Student Support Services:

Interviewee(s): dean/director of student services, registrar, director of learning resources (librarian, instructional technologist/personnel), academic services, etc., and DCP students

- Policies and process to adjudicate violations of academic and ethical standards, applicable to the DCP;
- Academic standing policies and reviews;
- Evidence of investigation and disciplinary actions for violations of academic and ethical standards;
- Tracking and analysis of DCP student complaints and grievances; trends;
- Types of support services provided to the DCP students;
- Measures and thresholds for student support services; utilization of data to inform improvements;
- Tutorial programs or other methods of student academic support, applicable to the DCP;
- The extent of academic, disability, and other services provided to students; methods used to promote and track utilization of those services;
- DCP student utilization and satisfaction with academic support services;
- The student handbook and student policies;
- Opportunities for, and oversight of, co-curricular activities, student clubs and organizations;
- Student retention data (may also be covered under A.3 or A.4));
- Financial aid services and counseling; financial aid policies;
- Career services/counseling, applicable to the DCP.

G. Student Admissions

Interviewee(s): dean/director admissions, registrar, director of marketing, and DCP students

- DCP admission policies/requirements;
- Review of DCP admissions records; compliance with DCP's policies;
- AATP and non-AATP student data, review of most recent PEAR report;
- Review compliance with CCE Policy 7 requirements;
- DCP Orientation program/activities;
- DCP informs applicants that educational and licensure requirements and scope of practice parameters are specific for each regulatory jurisdiction and provides applicants with access to such available information;
- Policies related to prior academic credit and transfer of credit;
- Policies and procedures for admission of international students;

H. Curriculum, Competencies and Outcomes Assessment

Interviewee(s): Chief Academic Officer (CAO), Dean of DCP/Academics/Clinics, clinic director/dean, curriculum committee, assessment committee, department chairs, faculty and students

- Curriculum structure; incorporation of the meta-competency curricular objectives into the academic program; review of the curriculum map or similar representation that identifies where topics related to the meta-competency curricular objectives are addressed;
- Assessment of the meta-competency outcomes meets best practices, such as appropriate methods/tools to measure the meta-competency outcomes, use of multiple assessment methods, identifies frequency or required number/timelines for assessments, established thresholds or performance targets, rubrics define competency-levels and communicate the expectations for each level, assessments provide feedback to students, and assessment processes identify the need for remediation, when needed;
- Meta-competencies assessment methods, tools and data, (clinical entrance/exit exams, direct observation, student clinical worksheets, assignments/projects, etc.);
- Review of evidence/data that each student meets meta-competency outcomes prior to graduation; Processes used by the program to verify individual student meta-competency outcomes data prior to graduation; remediation processes;
- Processes to regularly review aggregate student learning assessment and MCO data, and how data is used to inform curricular improvements, evaluate program effectiveness and inform planning, (also see Standard A.3);
- Dissemination and analysis of meta-competency assessment data to committees, faculty and admin for curricular improvement, program effectiveness, and planning processes (also see Standard A.2-A.3);
- Processes, committees, and faculty involvement in modifying the curriculum, learning objectives, and assessment methods (also see Standard E.2);
- Identified program strengths and weaknesses via program assessment/program effectiveness processes; monitoring and/or corrective actions for weaknesses; examples of closing the loop (also see Standard A.3);
- Procedures related to student intern and supervising clinician duties, responsibilities, and conduct in clinic environments; Review clinic manual;
- Evaluation of student interns at external sites are comparable/consistent with those that exist in the DCP setting, based on identified student learning outcomes; assessment procedures for auxiliary clinical intern experiences, i.e., CBIs, VA, DoD, Clinic Abroad, etc.;
- Patient quality assurance program; Review of patient health record audit system and processes, including measures/audit criteria/indicators (e.g. History Taking, Examination, Diagnostic Testing, Diagnosis, Management Plans, etc.), thresholds, and data; Results are shared with faculty-clinicians and appropriate clinic personnel to inform improvements to patient care and student learning;
- Delivery of patient care complies with state and federal laws/regulations, and industry standards; compliance tracking/monitoring may be included in the patient health record audit indicators and/or included in clinic operation guidelines, manuals and policies, such as patient safety procedures, informed consent, regular HIPAA training/certification, etc.

I. Research and Scholarship

Interviewee(s): Chief Academic Officer (CAO), Dean of DCP, Dean/Director of Research, Faculty Development Committee, Director for Teaching and Learning, and faculty

- Expectations for research and scholarship, as identified in the DCP goals & objectives, program effectiveness measures, or other program documents;
- Measures and thresholds for research and scholarship are established and tracked; results tied to program effectiveness, planning, and budgeting processes;
- Research and scholarship inform DCP instructional objectives/content, and patient care;
- Opportunities and support for faculty and student research and scholarly activities;
- Policies and procedures of research activities and related committees (e.g., institutional review board, human subject's committee, research committee, etc.);
- Portfolio of faculty research and scholarship performed since the last PCR; current research projects;

- Research budget, internal funding for research, and external grants.

J. Service

Interviewee(s): Chief Academic Officer (CAO), Dean of DCP/Clinics, appropriate faculty committee(s), Director Student Services, faculty and students

- Scope of service activities, e.g. 1) program/institutional, 2) professional, 3) public/community;
- Portfolio/list of faculty and student service activities (for most recent 1-2 yrs.);
- Measures and thresholds for service are established and tracked by the DCP;
- Scope/type of service activities aligns with DCP's mission, goals and objectives;
- Policies and procedures, where necessary, regarding provision of services provided by students and faculty.

K. Distance or Correspondence Education

Interviewee(s): Chief Academic Officer (CAO), Dean of DCP, faculty for distance/correspondence courses faculty, director of technology/IT

- Policies and processes to verify identity of students enrolled in distance and correspondence courses;
- Policies and processes that protect student privacy and notifies students of additional student charges associated with the verification of student identity at the time of registration or enrollment;
- Processes for proctored examinations.
- Review sampling of distance education courses via LMS and/or course syllabi; distance education is defined as courses *with regular and substantive interaction between students and the instructor, delivered either synchronously or asynchronously via employed technologies, such as internet and/or audio conferencing*

2. Residency Program Accreditation Standards: Example Topics for Interviews/Meetings

A. Mission/Purpose and Program Effectiveness

Interviewee(s): Residency director, sponsoring organization's administrator, faculty

- The mission/purpose articulates the specific clinical training focus of the program and is made available to stakeholders;
- The residency program's goals/ objectives and program learning outcomes are congruent with the mission/purpose;
- The mission/purpose is periodically evaluated and revisions are supported by evidence for needed change;
- Process(es) for conducting program effectiveness evaluation; including established measures, thresholds, and cycles of data collections and reviews/analysis;
- Program effectiveness processes includes an analysis of resident competency assessment data; competency assessments have established thresholds, and inform program or curricular improvements;
- Program effectiveness/evaluation results are used to inform program improvements;
- Sponsoring organization's knowledge, support and involvement in the program effectiveness processes/plan;
- Involvement of faculty in program effectiveness processes.

B. Ethics and Integrity

Interviewee(s): Residency director, faculty, residents

- Academic, clinic, patient care and resident policies, as applicable to the program;
- Conflict of interest policies;
- Polices regarding ethical and professional care of patients;
- Policies or procedures regarding selection of residents;
- Policies or commitment to Academic Freedom;

- Policies and process to adjudicate violations of ethical standards, including academic, clinical and behavioral concerns;
- Evidence of investigation and disciplinary actions for violations of ethics or integrity, if present.

C. Governance and Administration

Interviewee(s): Residency director, governing official/sponsoring organization administrator(s), faculty, residents

- Lines of authority (org chart) between the residency director and sponsoring organization official/administrator(s).
- Residency program administrative structure provides clear lines of authority and responsibility between the residency director and faculty. How does the administrative structure facilitate the achievement of the goals of the program?
- Periodic evaluations of the program director.

D. Facilities and Resources

Interviewee(s): Residency director, sponsoring organization's administrator(s)

- The sponsoring organization and the academic affiliate support the mission/purpose of the program through provision of appropriate facilities and resources;
- Adequate support/resources, e.g., facilities, clinics, equipment, technology, internet access, access to learning resources/library (internally operated or externally provided), to support program.

E. Faculty

Interviewee(s): Residency director, faculty, residents

- Faculty evaluation policies and process; faculty/employee handbook or similar;
- Faculty credentials, licensure, expertise and experience;
- Number of faculty per resident; Faculty FTE;
- Faculty development opportunities; faculty engagement in research & scholarship;
- Faculty's involvement in the development, assessment and refinement of the curriculum; Process for curricular change; assessment of resident competencies;

F. Resident Support Services:

Interviewee(s): Residency director, resident services administrator, sponsoring organization or academic affiliate personnel, faculty, and residents

- Types of support services provided to the residents; provided by the residency program, sponsoring organization and/or academic affiliate;
- Resident orientation, training, advising, resident-employee benefits, disability accommodations, etc.;
- Resident handbook and/or policies;
- Sponsoring org or program policies/ procedures for resident grievances and due process; tracking and analysis of resident complaints or grievances.

G. Resident Selection

Interviewee(s): Residency director, resident selection committee, faculty, residents

- Selection criteria, policies and procedures for the residency program;
- Statistics on applications, acceptance, rejection.

H. Curriculum, Clinical Training and Competencies

Interviewee(s): Residency director, clinic director/dean, faculty-clinicians, residents

- Residency program identifies specific outcomes for each competency, which align to the program's specific advanced clinical training focus;
- What assessment methods and/or tools are used to measure and track that each resident has attained all the competency outcomes prior to program completion/graduation? What are the frequencies and thresholds for the assessments of the competency outcomes?
- Processes for remediation of residents' deficiencies;
- Auxiliary clinical experiences, i.e., external or additional clinic rotations, including how residents are assessed;
- Procedures related to resident and supervising faculty-clinician duties, responsibilities, and conduct in clinic environments; Review clinic manual (or similar document);
- Success rates of residents achieving competency outcomes and any clinical quantitative requirements, if applicable;
- Assessment of resident performance, includes processes for how aggregate/trend outcomes data are generated, tracked, analyzed, reported and used to improve the program (also see Standard A);
- Strengths and weaknesses of the clinical training program and/or competency outcomes assessments;
- Clinical/specialization training (including adequacy of patient volume and diversity, adequate faculty/clinician supervision,);
- Level on involvement of residency director, faculty and/or the curriculum committee in curriculum design and curriculum change;
- Curriculum map or similar representation demonstrating a curriculum that provides a coherent, integrated and progressive educational program with appropriate experiences and progressive responsibility for the residents, aligned with the competency outcomes, as identified by the program;
- Utilization of a quality assurance system(s) for patient care that includes performance measures/criteria and establish performance thresholds; data is tracked and used to inform improvements; involvement of faculty, involvement of residents; example of improvements;
- Delivery of patient care complies with state/federal laws/regulations, as applicable and industry standards;

I. Duty Hours

Interviewee(s): Residency director, dean(s), faculty-clinicians, residents

- Residency program's minimum required duty hours for all clinical and academic activities and weekly workload expectations, as provided in a residency handbook or similar document;
- Policies regarding moonlighting and on-call;
- Tracking of resident schedules.

J. Completion Designation

Interviewee(s): Residency director, dean(s), sponsoring organization administrator(s)

- Title and type of certificate or degree conferred to resident upon completion of the residency program;
- Records of certificate awarded, tracked/managed by residency program and/or sponsoring organization.

3. Off-Campus/Sites (if needed)

Many programs operate clinics at remote (off-campus) sites. The CCE staff contacts the program accreditation liaison to obtain information for each clinic site, (e.g. required or optional site, number or percentage of student-interns and faculty-clinicians, operational times, distance from campus, etc.), to determine if/which of the clinic sites should be visited during the site visit, in accordance with the site visit schedule. Prior to the arrival of the team and CCE staff and the DCP personnel coordinates and arranges the logistics of the clinic visits. Sufficient time is provided to visit with students/residents at the clinic, meet with the director, and review of patient records, (if applicable, if not electronic). Because of time limitations, it may be necessary to omit visiting small clinics and instead concentrate on visiting only the

larger clinical operations. In particular, if a program relies upon a specific clinic location to accomplish clinical competency assessments, that site should be visited.

4. Group/Committee Meetings

Self-Study Steering Committee

This committee is assigned responsibility for the preparation of the self-study report. Team members meet with this group briefly at the beginning of the site visit (usually immediately following the introduction meeting if scheduling permits). Potential topics for discussion at meetings with the self-study steering committee:

- Committee composition (particularly, representation of major groups and constituencies of the program);
- Involvement of faculty, staff, students or residents;
- Distribution of responsibilities among committee members;
- Methods used to collect and compile information;
- Process for writing and editing the self-study report

Faculty

Most often, at least two team members will be present and an open meeting in which program faculty are invited to attend is scheduled. Potential topics for discussion at this meeting with the faculty include:

- Involvement of faculty in the self-study process;
- Involvement of faculty in the development, assessment and refinement of the curriculum;
- Faculty workload (adequate FTE's,);
- Involvement of faculty in program and/or institutional decision making and faculty related policies;
- Effective channels of communication and data sharing, e.g. committees, in-services, etc.;
- Opportunities and support for professional development;
- Expectations regarding research, community service, and professional service;
- Accomplishments of the faculty and its governing body;
- Academic freedom;
- Mechanism(s) to convey faculty concerns to the administration;
- Knowledge and involvement in assessment of student learning and program effectiveness;
- Quality of instructional support/resources.

Students or Residents

Most often, at least two team members will be present and an open meeting in which program students (or residents) are invited to attend is scheduled. Potential topics for discussion at meetings with the students include:

- Involvement of students (or residents) in the self-study process;
- Effectiveness of program communication;
- Program strengths and weaknesses;
- Quality of instructional support/resources (e.g., classrooms, laboratories, internet access, learning resource center/library, etc.);
- Opportunities for community involvement/service activities;
- Quality and effectiveness of clinical training and MCO assessment (e.g. faculty feedback on assessment performance, adequate of patient experiences/opportunities, adequate faculty supervision, availability of external training opportunities such as preceptorships, ability of students (or residents) to meet meta-competency and clinical requirements, if applicable);
- Mechanism(s) to convey student (or residents) concerns to the administration (i.e. policies/processes).

Curriculum and Assessment Committee (or similar committees or groups)

This is the body assigned the responsibility of ongoing review, modification, and implementation of the program curriculum, program improvements, as well as the assessment of student/resident learning and meta-competency achievement. Depending on the program, these duties may be distributed to more than one committee and may include a program effectiveness or planning committee. Potential topics for discussion at meetings with the curriculum and assessment committee(s):

- Designated responsibility for curriculum changes and/or program improvements;
- Methods/sources for assessment data, including both internal (student learning/MCO assessments, clinical entrance/exit exams, program completion and retention rates, etc.) and external (NBCE exams, Canadian board scores, state licensing exam boards, alumni surveys, etc.);
- Feedback loops/mechanisms (i.e., methods used to implement needed curriculum change following analysis of assessment data);
- Interaction with other committees (e.g., student/resident progress/review committee, faculty governing body, program and/or institutional effectiveness, and planning etc.);
- The extent to which faculty are knowledgeable of, and supportive of, the program's formal assessment plan and program effectiveness processes.

Institutional Governing Board (e.g. Board of Trustees, Directors, Regents, etc.)

This is the body with the ultimate responsibility for the college/university and the DCP. It typically sets the mission for the institution and possibly the DCP's mission, establishes the overall goals for the institution and/or the DCP, approves the institutional/long range plan, hires and oversees the CEO, and approves the final budget. One or more team members will meet with available trustees/directors. One or two members of the governing board may meet with the team; because this often involves travel of that person, the time for the meeting is established in advance of the team's arrival on campus or may occur remotely. Potential topics for discussion at meetings with the institutional governing board representatives:

- General board functions, policies and responsibilities;
- Institutional financial stability;
- Conflict of interest policies and processes;
- Involvement in the self-study process or review, if applicable;
- Involvement of the board in planning and budgeting for the DCP, if applicable;
- Org structure, interaction of the board with the DCP's administration, if applicable;
- Board review of program-level data; DCP's program effectiveness data, if applicable;

Sponsoring Organization's Governing or Administrative Authority/Official of the Residency Program

The structure of the sponsoring organization of a residency program may defer from program to program. However, the sponsoring organization's governing or administrative authority/official(s) has ultimate responsibility for resources, policies, and quality of education/training provide by the residency program. This could be the senior administrator of the sponsoring organization that oversees the residency director and/or has responsibility for the residency program's resources, policies, and educational/training program. This body or administrator, typically approves the residency program's mission/purpose, and budget. Additionally, they may hire, oversee, and evaluate the residency director. One or more team members will meet with the residency program's sponsoring organization's governing or administrative authority/official(s). Potential topics for discussion at meetings with the Sponsoring Organization's Governing or Administrative Authority/Official:

- Level of involvement in operation/administration of the residency program, as applicable;
- Involvement/awareness of processes for program effectiveness/evaluation and data/results, as applicable;
- Involvement in budgeting for the residency program;
- Org structure, interaction with the residency director;
- Resources and facilities that support the residency program;
- Involvement in the self-study process/review/awareness;
- Evaluation of residency director.

Affiliate Organization or Academic Affiliate of the Residency Program

An affiliated organization or academic affiliate to the chiropractic residency program is an institution or organization that operates independently of the residency program but is directly or indirectly involved with residency program. The academic affiliate or organization may provide guidance to the residency program and/or formal services such as instruction, resident support services, library and information technology to support research and scholarship, etc. One or more team members may meet with representatives of the academic affiliate organization.

- Discussion topics are dependent on the type and scope of services provided to the residency program;
- Formal services provided by the academic affiliate organization are outlined in a contractual agreement.

5. Team Room, Team Meetings and "Open Meeting Room"

Closed team meetings are held regularly to review progress, share findings and general observations about the requirements for accreditation within the *Standards*, develop understanding of potential gaps, identify strengths, and to discuss have follow-up in specific areas. These meetings normally include brief team member reports on individual areas, discussion by the entire team and general review of progress on the draft team report, in assigned areas. This exchange enables team members to pool experiences and resources, stimulate thoughts, question one another, confirm impressions, determine additional areas for examination and discuss issues toward consensus, which is the preferred method for reaching decisions.

Prior to the site visit and in accordance with the Schedule of Events the program is informed of their requirement to notify all constituencies of the program when the CCE site visit team is scheduled to be on campus, the location of the team room and the "open meeting" times available. The "open meeting" time is typically scheduled at the end of the day during each day of the visit (with the exception of the last day) to allow for informal confidential meetings with students or faculty that were unable to attend the open student-faculty meetings or to speak privately with the team. Team members make themselves available for these meetings and they occur under the direction of the site team chair or his/her designee.

The program should provide the team with appropriate meeting room space and logistical requirements while on campus conducting the site visit. The CCE staff and program accreditation liaison will coordination these efforts prior to the visit. Appendix VIII, Team Room Setup Requirements, provides guidance for this process.

F. Document Review and Availability

The documents required during the site visit normally are available in the team room devoted to team use during the visit. These documents should include items listed in the Onsite Document Requirements (Appendix VI and VII), items requested by the team, and also those identified by the program that supplement their self-study report. Program documents should be provided in electronic format (e.g. thumb drive) and include a list and/or table of contents identifying the file name and file location.

The program is also required to maintain on site, and update as necessary, all eligibility documents as outlined in Section 1 of the *Standards*. If these documents are not located in the team room, the program should provide a list identifying their location as well. CCE staff or the site team must verify the program's eligibility documentation.

NOTE: In submitting materials for initial accreditation or reaffirmation of accreditation, or other reporting procedures, the program agrees to comply with CCE requirements, policies, guidelines, decisions and requests. During the processes of accreditation, the program must evidence full and candid disclosure,

and shall make readily available all relevant information. The program shall provide the CCE with unrestricted access to all parts and facets of its operations, with full and accurate information about program affairs, including evidence of institutional accreditation status and state authorization/licensure, as requested.

G. Site Team Chair meetings with President/Program Director (during the visit)

The site team chair meets with the president/program director to update and share information in an open dialogue. These briefings begin on the second day of the visit, first meeting in the AM, after the team chair has the opportunity to meet with the team following the first day's activities and discuss findings and/or observations. The CCE staff is also in attendance at these briefings to answer questions with regard to the accreditation process or CCE policies and procedures. During the meeting with the president/program director, communication may include; requests for assistance or advice in obtaining information/documents required for site team review; or questions from the president/program director.

Also, during these meetings with the president/program director, both parties will discuss and determine what type of exit meeting the team chair will provide at the end of the visit. In all instances, the team chair and president/program director will agree to the format of the exit briefing following the below examples:

1. Open forum; oral presentation of concerns/recommendation and strengths, and open discussion about process only (no questions relating to findings); or
2. Open forum; oral presentation of concerns/recommendations and strengths only; or
3. Limited session (site team and selected program reps), oral presentation of concerns/recommendations and strengths only.

H. Site Team Chair Briefing with President/Program Director (last day of visit)

The site team chair also meets with the president/program director on the last day of the visit, immediately preceding the exit briefing, to discuss the final findings of the team in an open dialogue. The CCE staff also attend this meeting to answer questions with regard to the accreditation process or CCE policies and procedures. During the briefing, items discussed include:

1. Provide president/program director with opportunity for clarification/discussion;
2. Provide collegial advice to president/program director from site team chair (if applicable);
3. Explanation of concerns/recommendations to provide context for the concern;
4. Questions regarding CCE accreditation processes and timelines; and
5. Provide president/program director with oral summary of commendations and concerns with recommendations.

I. Exit Briefing with Program

The format of the exit briefing will be determined as outlined in Section G above, at the discretion of the president/program director and site team chair. The team and site team chair will then meet with program personnel and the site team chair conducts the exit briefing following the below guidelines:

1. Provides opportunity for president/program director to address attendees;
2. Briefs attendees on type and scope/format of exit briefing (in accordance with Section G);
3. Restates and explains the purpose of accreditation and visit;
4. Explains terminology of report (i.e., concerns/no context, suggestions/optional, etc.) as outlined in the Accreditation Manual;
5. Reviews the timetable for producing the draft team report, correcting errors-in-fact, producing the final team report, and obtaining the program response prior to the status review meeting involving the program and the Council;

6. Presents, without further review, oral statements regarding any concerns/recommendations and strengths/commendations that will appear in the draft site team report; and
7. (If applicable) begins the open forum discussion regarding process only; and
8. Closes exit briefing by thanking the program for hosting the site visit and along with entire site team exits the campus/site.

J. DCP - Summary of Daily Schedule

The following summary depicts a typical daily schedule during a comprehensive site visit to a DCP. With interim and focused site visits, adjustments are made accordingly, but follow similar procedures.

Day One

1. Arrive on campus; acquaint team with team room, facility and document locations (normally 8:00 AM);
2. Complete a campus orientation tour (if necessary; limited to 15-20 minutes);
3. Conduct introductory meeting;
4. Conduct individual and group interviews/meetings;
5. Review documents provided in team room and others as requested;
6. Conduct informal confidential "open meeting" (if applicable); and
7. Hold evening team meeting (closed meeting; in team room or at hotel).

Day Two

1. Arrive on campus (approximately 8:00 AM);
2. Site team chair meeting with president/program director (first meeting of day for chair, usually at 8:30 AM);
3. Continue conducting interviews/meetings;
4. Verify evidence, data and documentation, as applicable to the requirements of the *Standards*;
5. Conduct informal confidential "open meeting" (if applicable); and
6. Hold evening team meeting (closed meeting; in team room or at hotel).

Day Three

1. Arrive on campus (approximately 8:00 AM).
2. Site team chair meeting with president/program director (first meeting of day for chair, usually at 8:30 AM);
3. Conclude interviews/meetings and scheduled follow-up(s) as necessary;
4. Continue verification and validation of data, information, documentation;
5. Finalize data collection and source documentation;
6. Conduct informal confidential "open meeting" (if applicable); and
7. Hold evening team meeting (closed meeting; in team room or at hotel).

Day Four

1. Arrive on campus (approximately 8:00 AM);
2. Site team chair briefing with president/program director (immediately preceding the exit interview); and
3. Exit interview (typically at 9:00 AM; earlier at the discretion of the team chair and president/program director).

K. Residency - Summary of Daily Schedule

Residency program site visits may vary in length and the number of site team members depending on the size and structure of the residency program. The following summary illustrates the daily schedule for a 1.5-day site visit, as an example.

Day One

1. Arrive on site; acquaint team with team room, facility and document locations (approximately 8 am);
2. Complete a site orientation tour (if necessary; limited to 15-20 minutes);
3. Conduct introductory meeting;
4. Conduct individual and group interviews/meetings;
5. Review documents provided in team room and others as requested; and,
6. Hold evening team meeting (closed meeting; in team room or at hotel).

Day Two

1. Arrive on site (approximately 8 am).
2. Site team chair meeting with residency program CEO (first meeting of day for chair, usually 8:30 am);
3. Conclude interviews/meetings and scheduled follow-up(s) as necessary;
4. Continue verification and validation of data;
5. Finalize data collection and source documentation;
6. Hold 10:00 AM team meeting (closed meeting; in team room to discuss concerns/recommendations and commendations).
7. Site team chair briefing with residency program at 11:30 AM (immediately preceding the exit interview); and
8. Exit briefing (approximately at 12:00 PM).

Section VII Site Team Report and Program Response

A. Site Team Report

The site team chair is responsible for ensuring that individual team member contributions appear in proper sequence in the team report according to the *Standards*, Section 2. In preparing the team report, the site team chair may seek advice from the CCE staff about report organization, formatting and content.

The site team chair ensures the clarity of the composite report, and the accuracy of the summary listing of any strengths and concerns with/recommendations. The report is a qualitative assessment of the entire program, but it need not be lengthy. The report addresses how the program meets the *Standards*, noting any unique characteristics and/or strengths. Validated and verified gaps in the meeting the *Standards* are addressed as concerns, and program strengths as commendations. The report is to be clear and constructive in order to help the program. The evidence used to arrive at such conclusions must support any evaluative statements.

The report clearly describes any concerns and recommends a plan and potential for overcoming such challenges. The report must *not* contain critical material not supported by findings or outside of the scope of the *Standards*.

The site team does not stipulate whether or not the program is in compliance with the *Standards* as this is the prerogative of the Council. However, the team must describe in narrative the activities and

supporting data to determine how the program is addressing and fulfilling each requirement of the *Standards*, including any subsequent concerns/recommendations and commendations.

B. Site Team Report Review & Distribution Process

1. Draft Report & Corrections of Errors in Fact

The draft report is distributed to each team member either by the site team chair or the CCE administrative office within 5 days of the last day of the visit.

a. Within six days of receipt of the draft report, team members review the report and provide narrative clarifications and/or edits to the site team chair.
b. Within four days of the team members' response, the site team chair, with the assistance from the staff assembles the final version of the draft report, and the CCE administrative office sends it to the president/program director with a Corrections of Errors in Fact letter/email.
c. Within seven days of receipt of the letter/email, the president/program director responds to the CCE administrative office and site team chair with correction of errors in fact. Other than factual errors, i.e., title/name designation, number corrections, etc. the context of the draft site team report is not open to editing by the president/program director at this time. (Note: As the program will be granted an opportunity at a later date to provide feedback on the entire process, this is not the time for the program to respond with its own concerns or recommendations. See Section VIII.A, Site Visit Team Process Evaluation.)
d. If such substantiation is extensive, the site team chair may need to communicate with team members before completing the final report.

2. Final Report

Once any indicated errors of fact have been verified and corrected by the site team chair, an electronic version of the final report is sent to the CCE administrative office.

a. Within five days of receipt of the corrections of errors in fact, the CCE administrative office sends a cover letter/email and an electronic version (email) of the final report to the president/program director and Accreditation Liaison. An electronic version of the report is also sent to the site team. This normally occurs within four weeks of the conclusion of the site visit.
b. The CCE administrative office also sends a copy of the cover letter/email to the DCP governing board chair or residency governing/administrative official, as an FYI notice of the scheduled status review meeting with the Council.

3. Program Response

Upon receipt of the final report, the program must submit a formal written response to the content, if the report contains any ***concerns***. This response is normally submitted 55 days following the conclusion of the site visit, and must be received in the CCE administrative office no later than 30 days prior to the Council Status/Progress Review Meeting.

a. The program response must include the entire site team report text with response text in larger, bold type or blue font at the appropriate places within the report narrative. The program *must* respond to any team concerns accompanied by *recommendations*.
b. Proper documentation and/or attachments must support and clarify the program response.
c. Team *suggestions* may also be addressed, but the program is not required to do so.

d. The narrative of any response to the Site Team Report must also describe any major program changes made since the site team visit. If the program has identified current or potential major issues or concerns since the team visit, explanation of these must be provided in the narrative of the program response to the team report.
e. The program must send one (1) electronic version (flash drive/email) of its response to the CCE administrative office in accordance with the cover letter and Team Report Timetable.
f. The Council is provided a copy of the program's *Response to the Final Site Team Report*, approximately 30 days prior to the scheduled Council meeting.
g. The team report then becomes the property of the program.
h. In the event that the site team report is released to any third party, *the team report must be published only in its entirety, never in an excerpt format;* as such unsupported excerpts might distort the intent of the report and compromise the process of accreditation.

4. Review of Program Response to Final Report

Program Response to Final Site Team Reports are coordinated with the CCE staff and reviewed at the Annual and Semi-Annual Meetings by the Council for discussion and required action. Prior to each meeting, the Council Chair assigns primary and secondary review responsibilities to councilors regarding Program Response Reports. Following the meeting, the Council provides correspondence to the program regarding the action of the Council.

Section VIII Post Visit Activities and Review

A. Site Visit Team Evaluations

To improve the site visit team process and refine team member training, program representatives, team members and the site team chair are asked to evaluate the process. The CCE staff will distribute site visit evaluations requesting completion and return following the conclusion of the site visit. The site team evaluations enable the site team chair to evaluate the performance of each team member, make recommendations about future site team service, and provides comments regarding the overall process. Additionally, each site team member evaluates the site team chair, the CCE administrative office, and have the opportunity to provide feedback on the site visit process. Finally, once the final report has been distributed or after the Council Status/Progress Review Meeting, the CCE staff provides the *Site Visit Questionnaire* form (Council Form 13) to the president/program director (through the Accreditation Liaison) for feedback regarding the pre-visit, visit and post-visit activities, allowing for comments/suggestions concerning the overall process. All such comments are confidential to the Council and CCE staff.

B. Disposition of Documents

Except in the case of an adverse accrediting decision, the CCE staff notifies the site team chair and team members to destroy all materials and electronic files pertaining to the visit following the status decision by the Council. If an adverse accrediting decision is made, the site team chair and team members are notified to maintain and/or submit all documentation to the CCE administrative office for reference and information in the case of an appeal, and in accordance with the CCE Records Management and File Plans.

Section IX Review of Monitoring Reports

A. Progress Reports

Progress reports address previously identified areas of weakness/deficiencies or non-compliance with a

Standard/Policy that require monitoring. Progress Reports must be submitted to the Council, on a date established by the Council (reference Appendix III, DCP Reporting Requirements). CCE staff will notify the program if the report is not in the proper format and/or missing elements, as established in the Council letter to the program, and may request additional information prior to submission to the Council. The Council will notify the program if an appearance by program representatives will be required at the next Council meeting.

The progress report is not as detailed or in-depth as a self-study report. The program is required to address the following areas as delineated in the Council letter:

a. Reference the appropriate Standard(s)/Policy(ies) (non-compliance or area of weakness/deficiency) requiring monitoring.
b. Provide a narrative describing actions taken by the program to resolve the concern or improve the area of weakness/deficiency.
c. Provide the evidence and outcomes data to demonstrate the concern or area of weakness/deficiency is resolved, or evidence outcomes data to demonstrate significant progress, including the date by which those results should be realized.
d. Major variances between planned and actual data must be explained.
e. Provide specific supporting documentation and/or data to evidence resolution of the concern or area of weakness/deficiency.

B. DCP - Program Characteristic Reports (PCRs)

Periodic Program Characteristic Reports (PCRs) are submitted to the Council in accordance with the CCE policies and procedures. The CCE staff provides notification letters and report templates to the DCP in the spring and fall, approximately 60 days prior to the PCR submission date, in accordance with the CCE Schedule of Accreditation Activities. PCRs are required as one of the reporting requirements the Council utilizes to continue its monitoring and reevaluation of its accredited programs, at regularly established intervals, to ensure the programs remain in compliance with the CCE *Standards* and policies.

PCRs are coordinated with the CCE staff and reviewed at the Annual and Semi-Annual Meetings by the Council for discussion and required action. Prior to each meeting, the Council Chair assigns primary and secondary review responsibilities to Councilors regarding PCRs. Following the meeting, the Council provides correspondence to the DCP regarding the action of the Council.

C. DCP - Program Enrollment & Admissions Reports (PEARs)

Annual Program Enrollment & Admissions Reports (PEARs) are submitted to the Council in accordance with the CCE policies and procedures. The CCE staff provides notification letters and report templates to the DCP in the fall, approximately 60 days prior to the PEAR submission date. PEARs are required as one of the reporting requirements the Council utilizes to continue its monitoring and reevaluation of its accredited programs, at regularly established intervals, to ensure the programs remain in compliance with the *Standards*, policies, and also in accordance with the annual enrollment reporting requirements established by the U.S. Department of Education.

PEARs are coordinated with the CCE staff and reviewed at the Annual Meetings by the Council for discussion and required action. Prior to each meeting, the Council Chair may assign review responsibilities to Councilors regarding PEARs. Following the meeting, the Council provides correspondence to the DCP regarding the action of the Council.

D. DCP - Interim Site Visit Reports

CCE staff provides the program with a notification letter approximately nine (9) months prior to an interim site visit, in accordance with the CCE Schedule of Accreditation Activities. The notification letter also addresses potential dates for the site visit.

Following receipt of the interim site visit date(s), the program is provided with instructions regarding the specific areas of the *Standards* to address in the Interim Report, format requirements and the due date for reporting. The Council utilizes interim site visits to monitor and re-evaluate accredited programs, at regularly established intervals, to ensure programs remain in compliance with CCE *Standards* and policies.

Interim Site Visit Reports are initially forwarded to the site visit team for review, no later than 30 days prior to the date of the site visit to the program. The Interim Site Visit Report, along with the Program Response to the Site Team Report, are then coordinated with the CCE staff and reviewed at the Annual or Semi-Annual Meetings by the Council for discussion and required action. Prior to each meeting, the Council Chair assigns primary and secondary review responsibilities to Councilors regarding interim site visits. Following the meeting, the Council provides written notification to the program regarding the accreditation decision and Council action.

E. Special Reports

In extenuating circumstances, the Council may request special reports from the program outside of the normal Council Meeting schedule in preparation for a Special Meeting of the Council to discuss and deliberate regarding the information provided in the report. In these instances, the Council usually convenes these meetings for the benefit of the program to provide expeditious action for various reasons. In other instances, the Council may convene these meetings due to matters requiring emergent action as determined by the Council.

NOTE: The progress and special report formatting guide is located in Appendix IV, *Response Report Format*. Formatting for PCRs, PEARs, and Interim Site Visit Reports are specific to those reports and provided to DCPs in advance of scheduled submission dates.

Section X Program Appearance before the Council

A. Review of Application Documentation

In preparation for the status review meeting, Councilors review and evaluate the documents comprising the application for initial accreditation or reaffirmation. Reviews include the self-study report, the site team report, the program's response to the site team report and any other documents relevant to the accreditation process. Councilors focus on specific areas as assigned by the Council Chair in preparation for the entire Council to discuss and ask questions of the program representatives.

B. Meetings with Program Representatives

1. The Pre-Status and/or Pre-Progress Review

a. The Council Chair (or designee);
   (1) Excuses Councilors with previously identified conflicts of interest and requests the remaining Councilors inform the Council Chair if any other known or perceived conflicts of interest may exist regarding the program;
   (2) Determines eligibility of Councilors to participate in the evaluation of the program based

on any disclosure of conflicts of interest (that had not been previously identified) and in accordance with CCE Policy 18, *Conflicts of Interest*;

(3) Introduces primary and secondary reviewers of the program to provide a briefing; and,

(4) Assigns Councilors to ask questions of the program representatives during the appearance (if applicable).

b. Primary and secondary reviewers (assigned Councilors by the Council Chair) provide a brief analysis of their findings and recommendations to the Council.

c. CCE staff provide the Council with a summary of each program with required reporting, which includes, history/background for the current report, list of outstanding concerns from any Council accreditation letter in the current accreditation cycle and the next routine accreditation activity for the program. Furthermore, CCE staff provide an analysis of applications for eligibility (Initial Accreditation), Substantive Change and/or Progress Reports when deemed appropriate by the CCE President.

2. Welcome/Appearance

The Council Chair (or designee):

a. Introduces/recognizes the Council, CCE staff and any other representatives/observers;

b. Requests the president/program director introduce his or her delegation;

c. States the purpose of the meeting (e.g., status review, progress review or initial accreditation) and identifies the program report(s) under review by the Council; and,

d. Reiterates meeting time limits, and discloses policies and procedures regarding meeting proceedings, i.e., documents for handout must be approved by Council Chair; documents not related to the accreditation process are not permitted. In most instances, a one-hour time limit is recognized for the appearance, however, the Council Chair reserves the right to adjust the time accordingly.

3. Meeting Protocol – Interaction and Communication

a. The Council Chair invites the president/program director to make an opening statement;

b. Questions are posed to any of the program representatives by the Councilors. The program representatives may refer questions to other members of their delegation, if appropriate;

c. During the appearance session with the program, the meeting is under the direction and guidance of the Council Chair (or designee); and,

d. The Council Chair invites concluding remarks by the president/program director.

4. Close of Meeting

The Council Chair thanks the program representatives and informs them that the Council will deliberate and provide a written decision to the program regarding any accreditation actions (typically within 30 days following the meeting).

5. Post-Meeting Session

Following the status or progress review meeting with program representatives, the Council Chair then facilitates discussion among the Council until a consensus decision is made regarding any deficiency(ies). Finally, the Council considers all documentation and oral presentations and makes a consensus decision regarding all accreditation actions for the program.

6. Outcomes

The various options for Council accreditation decisions and actions are described and outlined in the CCE *Standards, Residency Standards,* and/or *Manual of Policies*, as applicable. In all cases the

Council provides a written decision regarding the accreditation status of the program. Questions regarding decisions and actions should be directed to the Council Chair and/or CCE President.

Appendix I – Council Form 15, Accreditation Status Form - DCP

Accreditation Status

Prepared for *The Council on Chiropractic Education*,
10105 E. Via Linda, Suite 103 - 3642, Scottsdale, AZ 85258-4321. Tel: 480-443-8877. Email: cce@cce-usa.org.

Program Name:_____

Address _____

City_____State _____ ZIP_____

Program Telephone Number (_____)_____

Prepared for the _____ (Month/Yr) meeting of the Council, based on the July 2020 *CCE Accreditation Standards, Principles, Processes & Requirements for Accreditation*

DCP Summary

Type of accreditation status currently held: Programmatic

Date accreditation with CCE began (Mo/Yr): _____

Date of last status review meeting with Council (Mo/Yr):_____

Date of next self-study report due to Council (May/Oct Yr):_____

Date of next comprehensive site visit review (Spring/Fall Yr): _____

Date of next status review meeting with the Council (Jan/Jul Yr):_____

Date of next PCR due to Council: _____

Date of next Progress Report due to Council (if applicable): _____

_____( )_____
Name of Chief Executive Officer Telephone Number

_____
Name of Governing Board Chair

_____
Board Chair Email Address

_____
Board Chair Address

_____
City State ZIP

_____ _____/_____/_____
Chief Executive Officer Signature Date

Appendix II – Council Form 16, Accreditation Status Form - Residency

Accreditation Status - Residency

Prepared for the Council on Chiropractic Education (CCE),
10105 E. Via Linda, Suite 103 - 3642, Scottsdale, AZ, 85258-4321 - Phone: 480-443-8877

Program Name:_____

Address _____

City_____State _____ZIP_____

Telephone Number (_____)_____

Prepared for the _____ (Month/Year) Meeting of the Council based on the July 2017 *CCE Residency Program Accreditation Standards; Principles, Processes and Requirements for Accreditation.*

Residency Summary Verification

Date accreditation with CCE began (Mo/Yr): _____

Date of last reaffirmation of accreditation with Council (Mo/Yr):_____

Date of next self-study report due to Council (May/Oct Yr):_____

Date of next comprehensive site visit review (Spring/Fall Yr): _____

Date of next status review meeting with the Council (Jan/Jul Yr):_____

Date of next Monitoring Report due to Council (if applicable): _____

_____(____)_____
Name of Residency Program CEO (or equivalent) Telephone Number

_____
Name of Governing/Administrative Official Title of Governing/Administrative Official

_____
Governing/Administrative Official Email Address

_____
Governing/Administrative Official Address

_____
City State ZIP

_____ _____/_____/_____
Residency Program CEO Signature Date

Appendix III – Program Reporting Requirements

Deadline Dates for Reports Submitted to the Council

Accuracy and completeness of reports submitted to the Council are essential factors in the accreditation process. Descriptions, analyses and assessments provided in such reports must be clearly and succinctly stated, and organized in a manner conducive to the work of all the individuals and groups involved in the accreditation process. The following due dates are intended to guide successful completion of reports and assist Programs in preparation and planning; in many cases correspondence and/or instructions to the Program will provide exact dates for submission.

Report	Date Due *
Application for Initial Accreditation	by May 1 (for review at July meeting) by November 1 (for review at January meeting)
Self-Study	April 1 or October 1
Self-Study Update	No later than 30 days prior to the site visit
Interim Site Visit Reports**	February 1 or August 1
Progress Report (No site visit)	June 1 or December 1
Progress Report (Site Visit required)	February 1 or August 1
Response to Requests for Information	Determined by Council
Response to Site Team Reports	Reference Team Report Timetable (Appendix V)
Program Characteristic Report**	April 30 or October 31
Program Enrollment & Admissions Report**	December 1
Substantive Change Application	See CCE Policy 1, Substantive Change
Special Report Requested by Council	Determined by Council

* **Due dates that fall on a weekend or holiday are extended to the next business day**
** **Reports not applicable to Residency Program's**

All reports: Send one (1) electronic version (flash drive/Email) to the CCE administrative office for review. Following review and notification, the Program may be required to make revisions and submit final copies (electronic) to the CCE administrative office. The CCE administrative office will, in turn, distribute the report to each site team member and/or Councilor as directed by policies and procedures or the Council Chair. If a conflict of interest has been noted or declared, the report is not provided to those individuals.

NOTE: Requests for extension of submittal dates must be made in writing to the Council Chair by the president/program director). Documents distributed and prepared by the Council may not be altered by the Programs.

Appendix IV – Response Report Format

In preparing responses to site team reports, progress report and/or update/special reports, please keep in mind that Councilors are responsible for reading the reports of several other programs prior to the Council meeting. For that reason, it is vital that the responses or reports are concise, complete, straightforward and well documented. It is also important that the reports are not cumbersome or unwieldy. Note: This report format is not intended for use when preparing a self-study or PCR.

Order of Report

1. **Cover** (cover design may include logo, photos and/or graphics)

Must include:

a. Name of the program
b. Indicate the type of report (see below for examples):
   - Response to Report of **(Date)** Comprehensive Site Visit
   - Response to Report of **(Date)** Focused or Interim Site Visit
   - Progress Report in Response to Council Letter of **(Date)**
   - Special Report in Response to Council Letter of **(Date)**
   - Update Report in Response to Council Letter of **(Date)**
c. Date of Report
d. Prepared by: Name/Title of person(s) preparing the response
   Phone
   Email address

2. **Accreditation Status form** (Contact CCE administrative office for the form. Note, this form is not applicable for a Response Report of an Initial Accreditation Site Visit.)

3. **Current Organizational Chart**

4. **Council Letter**
   Applicable if this is a progress, special or update report, include copies of the most recent **signed** Council letter or letters to which the program is responding. Do not use a print out of the electronic version without the affixed signature for this section of the report.

   If this is a response to a site visit report, a Council letter is not necessary.

5. **The Report**

   a. Content Requirements
   All reports must contain a table of contents identifying the narrative, attachments and/or exhibits. Attachments and/or exhibits should be specific and limited to the necessary evidence to illustrate a specific point in the report (see example in item 6 below).

   Provide clear, complete, yet concise responses to the concerns (or issues noted in the letter if not a concern), and provide evidence that may help to resolve each concern/issue. Specify actions that have been taken and provide documentation that they have been completed. The reviewers are looking for documentation that actions **have been completed** and may request a follow-up report on any actions that have not been completed. Avoid vague responses indicating the program "plans" to

address a concern in the future. If any actions remain to be accomplished, the program must provide the following:

1) An action plan;
2) A schedule for accomplishing the plan; and
3) Evidence of commitment of resources for accomplishing the plan.

Responsible planning accompanied by official commitments of necessary resources is essential.

Do not reflect a defensive posture. The program should communicate through its responses, a desire to demonstrate that the program has made a substantial effort to comply with the Standard in question rather than a desire to "refute" the site team or Council evaluation and subsequent recommendation.

b. Responses to Site Team Reports

Programs are required to respond to all concerns contained in a site team report **directly within the body of the report in the order in which they appear** in the site team report. The program will receive an electronic version of the final site team report to use for this purpose.

Following each concern and recommendation, insert:

DCP Response:
Detail the DCP response using a single-spaced, slightly larger font that is not bolded.

The team reports are typically in Calibri 11 font; the DCP may choose any other type of font or present its response in a different color that is clearly legible for its response. For example, the response may be blue in color and/or in Times New Roman 12.

c. Response to Progress, Special and Update Reports

Programs are required to respond to all Council concerns contained within the Council letter(s) **directly within the body of the Council letter in the order in which they appear** in the letter(s). The program will receive an electronic version of the Council letter to use for this purpose.

First, delete the salutation and introductory paragraphs up to the first standard listed in the letter and then, following the Council's required action paragraph(s) under each standard listed in the letter, insert your response(s) as in the example below:

Section 2.D Resources

The DCP provides and maintains financial, learning, human, and physical resources that support the DCP mission, goals, objectives, and strategic plan.

The DCP must provide a report on the financial stability of the program and demonstrate its support of the mission, goals and objectives of the program.

DCP Response:
Detail the DCP response using a single-spaced, slightly larger font that is not bolded.

The Council letter is typically in Calibri 11 font; the DCP may choose any other type of font or present its response in a different color that is clearly legible for its response. For example, the

response may be blue in color and/or in Times New Roman 12.

6. Attachments/Exhibits

Provide appropriate documentation or evidence to support the response. For example, if the response indicates that a faculty member has completed coursework toward the completion of graduate semester hours in a particular field, include transcripts documenting courses completed.

Supporting documentation might include data, assessment forms, policies, committee minutes, etc. **listed as labeled/numbered attachments**. The attachments should be clearly noted within the body of the response report, e.g., "(**A01 Mission Statement**)." Refer to the *Instructional Guide for Attachments and PDF*, as provided on the CCE website for additional requirements, http://www.cce-usa.org/publications.html.

Please remember to keep attachments brief, when possible. Include only excerpts of larger documents or publications and highlight the related areas for easy review, i.e., if a document is 20 pages in length but you are only referencing two (2) pages in your report, only the two (2) pages need to be included. **Clearly, highlight, mark or underline the related paragraphs or items from document excerpts for fast reference for the reader. Additionally, excerpts should identify the title of the larger document in a cover page, header or footer, e.g. Clinic Manual.**

Submitting Your Report

Please submit one (1) electronic version of the entire report, including attachments, on a flash drive or via email no later than the date indicated in the letter. **The report must be in Adobe Acrobat format (.pdf) with links to attachments, which open in a separate document window.** While not required, it is recommended to use Acrobat Pro or a similar product to convert the document into pdf. Do not submit scanned reports or documents.

For mailing (flash drive), please send the report to:
Council on Chiropractic Education
Attn: Jeannette Danner, Director of Accreditation Services
10105 E. Via Linda, Suite 103 - 3642
Scottsdale, AZ 85258-4321

For email, please send the report to: danner@cce-usa.org

Appendix V – Example Team Report Timetable

TEAM REPORT TIMETABLE

(Program)
(Dates of Visit)

(Date)
Exit Interview (Last Day of Visit)
Site team chair and team members meet with the president/program director and any administrative staff or others the president/program director wishes to have present, at which time the site team chair provides an oral presentation regarding any strengths and/or concerns with recommendations.

(Date)
Draft Report Assembled (Last Day + 5 days)
Site team chair and CCE administrative office staff assembles the draft site team report and distributes to all team members for their review.

(Date)
Team Members Respond (Last Day + 11 days)
Team members review draft site team report and provide edits to site team chair and CCE administrative office staff. Site team chair approves draft site team report for distribution.

(Date)
Draft Report (Last Day + 15 days)
CCE administrative office staff sends draft site team report to president/program director for review of Corrections of Errors in Fact.

(Date)
Corrections of Errors in Fact (Last Day + 22 days)
Corrections of Errors in Fact are sent from the DCP to the site team chair and CCE administrative office. Site team chair approves final site team report for distribution.

(Date)
Final Report (Last Day + 27 days)
CCE administrative office staff sends final site team report to president/program director, accreditation liaison, DCP governing board chair, site team members and Council Chair.

(Date)
DCP Response (Last Day + 55 days)
Response to the final site team report is sent from the DCP to the CCE administrative office for distribution to the Council.

NOTE: *Due dates that fall on a national holiday/weekend are adjusted accordingly. The DCP Response to the final site team report must be at least 30 days prior to the Council Status Review Meeting in accordance with CCE policies and procedures.

Appendix VI – Onsite Document Requirements - DCP

The DCP must make the following documents available on site for review by the team (Column B). Provide a listing and/or table of contents of all documents (paper copies or electronic) in the team room, with the location of each document clearly identified. Additionally, at the time of the site visit please provide the most current data/reporting for items indicated in the table below.

		A	B
	Documents:	**Provided in the SS Report:**	**Provide in the Team Room:**
A.1.	Publication of the Mission Statement. Appropriate approval of the mission statement.		
A.2.	Materials pertaining to the program planning; planning goals and objectives including processes, timelines, performance results, data and analysis, and ties to resource allocation and or budgeting.		
A.3.	Program effectiveness processes and reports; including metrics for academic and non-academic operations, established thresholds, and data and analysis, and ties program improvement and planning processes.		
A.4.	Current posting of NBCE scores in accordance with Policy 56. The site team will verify the calculation of the NBCE performance.	[insert DCP website link]	-Complete the *NBCE Verification* Form.
A.4.	Current posting of the DCP completion rate in accordance with Policy 56. The site team will verify the DCP completion rate.		-Complete the *DCP Completion Verification* Form.
B.1-2.	Institutional/DCP policies and governing board bylaws Institutional/DCP policies and governing board bylaws		
B.2.	Board of Trustees' signed Conflict of Interest Disclosures forms		
C.1.	Governing board meeting minutes with regard to BOT approval and/or review of the mission, budgets, planning, academic program assessments, etc., for the two (2) most recent years.		
C.1-2	Organizational charts		
D.1.	Current financial audits (last two years and management letters).		
D.1.	Current Fiscal Year budget document and other materials pertaining to the budgeting process.		
E.1.	Faculty manual or collective bargaining agreement; faculty policies and procedures (re. workload, evaluations, rank and promotion, professional development, committees, etc.)		
E.1.	Faculty Cohort Attributes Listing of faculty members with associated titles and credentials, current courses taught, and associated credit hours taught in the DCP.		

E.2.	Faculty involvement in curriculum		
E.3.	Faculty Professional Development and Evaluations		
F.	Catalog (electronic or hard copy)		
F.1	Student Handbook and Student Services Student Conduct Policies		
F.2	Student Services Effectiveness		
F.3.	Student complaint policies/procedures. Record of student complaints.		
G.1.	Published admissions requirements and policies, e.g. transfer of credit, international students, AATP, financial aid, scholarships, refunds, etc. policies.		
G.1.	List of DCP matriculants for the most recent two years, for each of the following categories: - standard admissions & AATP - international - transfer-in Completed examples of admission/transcript evaluation worksheets, (i.e. 90 semester hrs., GPA, life & physical science credit hrs., etc.) for traditional (non-AATP) admissions, AATP, international, and transfer matriculants, if applicable.		-Complete the *Matriculants Listing* form. -Provide examples of completed admissions / transcript evaluation worksheets.
G. & Policy 7	If the DCP admits AATP students, evidence of monitoring academic performance and providing appropriate academic support, when needed, (see CCE Policy 7 requirements).		
G. & Policy 7	Most recent Program Enrollment Admissions Report (PEAR), including an analysis of academic performance of AATP students.		-Provide copy of most recent PEAR
H.	Clinic handbook/manual		
H.1.	Documents that demonstrate the topics corresponding to the meta-competency curricular objectives are addressed in the curriculum; and the course syllabi to verify the meta-competency curricular objectives are addressed in the curriculum.		
H.2.	An assessment plan to measure student learning and achievement of the meta-competency outcomes, including assessment methods and tools, thresholds, data and analysis. Copies of the clinical assessment forms (electronic forms). Utilization of assessment data/results.		
H.2.	Data/evidence that demonstrates individual student achievement of the meta-competency outcomes prior to graduation.		
H.3.	Evidence that the program utilizes a system of quality assurance		-Listing of New Pts and

	for patient care, such as a patient chart audit system, that includes performance measures/criteria and established performance thresholds. Subsequent QA data and analysis, and examples, demonstrate that the results are used to inform improvements.		Existing Pts for QA-Chart Audit, see *Chart Audit Instructions*.
I.	DCP requirements or expectations/measures & thresholds for research & scholarship; definitions of research & scholarship; tracking of research & scholarship; and support for research & scholarship.		
J.	Scope/types of service activities; requirements/ measures & thresholds for service; tracking of service activities; and support for service.		
K.	ID verification for distance or correspondence courses. Definitions - Type of courses offered: distance or correspondence.		
Section 1 II. B.2.	Eligibility documents as evidence of compliance with the requirements for accreditation, in accordance with CCE Standards, Section 1.II.B.2 and as listed in Section 1.II.A.2, items a thru i, including the most recent regional accrediting agency actions letter, which provides the current accreditation status of the institution.		-Provide evidence for items identified in the *Eligibility Requirements* Form.

Appendix VII - Onsite Document Requirements - Residency

The residency program must make the following documents available on site for review by the team (Column B). Provide a listing and/or table of contents of all documents (paper copies or electronic) in the team room, with the location of each document clearly identified. Additionally, at the time of the site visit please provide the most current data/reporting for items indicated in the table below.

		A	B
	Documents:	**Provided in the SS Report: (Ref Attachment)**	**To provide in the Team Room:**
	Program self-study report and exhibits/attachments		
A.	Residency program's goals and objectives, and program outcomes.		
A.	Program effectiveness documents, including measures, data, thresholds, analysis and evidence/example of how these are used to inform curricular improvements. The program effectiveness/evaluation processes include an analysis of resident competency assessment data.		
A.	Residency program committee meeting minutes for the most recent year		
C.	Organizational charts and related documents		
C.	Residency program and/or sponsoring organizational policies.		
E.	Residency program's faculty-clinician manual/handbook, if applicable,		
E.	Listing of faculty members with associated titles, job description		
F.	Resident handbook or catalog (or similar document)		
G.	Published resident selection requirements, policies and procedures		
H.	Residency program and/or clinic handbook(s)		
H.	The residency program's specific outcomes for each competency, which align to the program's specific advance training focus		
H.	An assessment plan to measure the resident's achievement of the competency outcomes, including assessment methods and tools, thresholds, data and analysis. Provide copies of the assessment methods/tools.		
H.	Evidence that demonstrates each resident's achievement of all the clinical competency outcome, prior to graduation/completion of the program.		
H.	Evidence that the program utilizes a formal system of quality assurance for patient care, such as a patient chart audit system that includes performance measures/criteria and establish performance thresholds; subsequent QA data and analysis and examples that demonstrate the results are used to inform improvements.		
	Eligibility documents as evidence of compliance with the requirements for accreditation, in accordance with CCE Residency Standards, Section 1.II.B.2 and as listed in Section 1.II.A.2.a-h.		

Appendix VIII – Team Room Setup Requirements

Site Team Visit - Team Room Setup Requirements

The following items/systems should be available in the team room (on-campus/site):
Note: Adjust according to the number of site team members

1. Keys to the Team Room
   - one (1) for **each** team member and CCE staff

2. One or two (1-2) computers (PC and/or laptop) set-up in the team room with:
   - printer capabilities (in the team room)
   - internet access
   - college intranet access (if applicable)
   - Microsoft Word, Excel and Acrobat programs loaded

3. Power cord/surge protector capabilities for CCE site team's and staff's personal laptops (6-8) on team room table

4. Internet access for all personal laptops (wireless, if applicable;
   - provide log-in and password information and instructions

5. Copier (easy access for team members, not required in team room)

6. Telephone and with college directory

7. pens and pencils, post-it notes, and pads of paper

8. Nametag for each team member (preferably with lanyard)

   Name Tag Example: Dr. Chris Smith
   CCE Site Team

Typically, the college provides snacks and beverages in the AM and PM in the Site Team Room, e.g. coffee, tea, water, juice, pastries, chips, nuts, etc.