



OUTCOMES ASSESSMENT IN RC PROGRAMS: HOW FAR HAVE WE REALLY COME?

by Sandra McCleaster RRT

In the late 1980s, the then Joint Review Committee for Respiratory Therapy Education (JRCRTE) attempted to implement a comprehensive program of outcomes assessment for Respiratory Therapy educational programs. The initiative was well-intentioned and in fact, identified the respiratory therapy educational community as trailblazers in what was soon to become a national move to goal-oriented outcomes assessment across all disciplines in allied health education. As well intentioned as the concept was though, its implementation was very poorly conceived. Destructive in its methodology, it led to an insurrection of sorts by RC educators and to the ultimate death of the JRCRTE.

From the ashes of those first attempts at assessing the effectiveness of RC education, rose the Committee on Accreditation of Respiratory Care educational programs (CoARC) and a saner and more realistic approach to outcomes assessment emerged.

CoARC stands ready and willing to withdraw accreditation of programs that do not meet their "threshold levels of success"

The concept of Outcomes Assessment is organized around the extent to which stated goals are achieved. Performance standards are identified, various evaluation

tools are used and then the collected data are measured against identified standards to determine degree of success or failure. The stakes are high. CoARC stands ready and willing to withdraw accreditation of programs that do not meet their "threshold levels of success."

In theory at least, a program should identify its own goals based on its own institution and culture. RC programs are not all created equal or the same. Programs are as diverse as the institutions which house them, the people who run them, and the students they serve. Demographics, socio-economic factors, and physical resources all lead to any one program's individuality – and to the development of goals and measurement tools which are realistic and appropriate to that particular educational program and its local labor market. There's one thing, though, on which I think they would all agree: at commencement, graduates should possess the cognitive, psychomotor, and affective skills consistent with the role of a respiratory care practitioner.

But CoARC developed its own ideas as to what constitutes a successful program. In its attempt to get everyone "on board", CoARC developed its own uniform one-size-fits-all goals and measurement tools for defining program success. Programs had to

state the same goals, complete the same forms and report the same data all in the same way. I'm not sure that this was the original intent towards proving program effectiveness, but it got all programs "in line" and consistent in their reporting - which in fact at times, seemed to be of far more importance than the actual information being reported. Ironically, the advent of electronic reporting complicated, rather than simplified, the reporting of outcomes data. Through the years, the process has struggled through long and frustrating technical difficulties, electronic patches and changing deadlines.

Working in concert with the National Board for Respiratory Care (NBRC), CoARC instituted the requirement that graduates must earn the RRT credential in order for programs to meet a threshold level of success. Well, it's no secret that modern day respiratory therapists have all but stopped taking the exams that could earn them the title Registered Respiratory Therapist (RRT). It seems that once they earn the CRT credential, modern day practitioners no longer feel the need to become an RRT. This curious reality however, put respiratory therapy programs in jeopardy of losing their accreditation status with CoARC. In response, key program personnel acted fast and furious to locate long-gone graduates (persons over whom they no longer had any authority or control) and pressured them to take two enormously unpopular and expensive examinations.

Not surprisingly, it was a futile effort. Plus, the blatant injustice and unfairness of it all wasn't lost on the educators who soon began to rebel. Ever responsive, CoARC modified its requirement and now mandates that RC students, prior to graduation, must take and pass the written portion of a sample RRT exam in order for their program to meet the threshold level of success.

This is still a win for both CoARC and for the NBRC, who will succeed in getting people to buy its exams one way or the other. But educators are skeptical. It's raising some interesting, but bothersome questions. Note that students, prior to graduation and without any independent clinical experience, are being charged to pass what the National Board for Respiratory Care (NBRC) refers to as its "advanced practice" exam.

The irony of this, of course, is that if the RC profession were not a dual-credentialed profession, this issue wouldn't even exist to write about. (And if this topic sounds distressingly familiar to you, you're not alone. There's a huge groundswell of sentiment for a single credential in respiratory care, but that's another story for another day). Nonetheless, it's one more stum-

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bling block along what continues, to this day, to be the rocky road to effective program assessment. My twenty-year retrospective of outcomes assessment in Respiratory Care brings me to wonder just how far we've actually come.

Where and how students "end up" does matter a lot. We have a responsibility to them and to our public. In concept, outcomes assessment is, without a doubt, the "right" thing to do. And we all do it. Not, I hope, just because of the external mandate of CoARC, but because we are accountable to all of our stakeholders and because we want to effect overall programmatic improvement.

Yes, educators will always grumble about busy work and bureaucratic intrusion, but the educators I know really do believe in the concept of goal-oriented outcomes assessment. None are unwilling to do any productive work involved. Nor do they resist being held accountable. On the contrary, they actually welcome the opportunity for meaningful program information that can be applied in their particular community of interest. They all willingly invest extensive time and energy, precious resources which many educators feel might be better spent doing rather than assessing and reporting. Sometimes, what is meant to improve the quality of our efforts may be standing in the way of real effectiveness.

What gets lost in the sauce is the fact that outcomes assessment is not an end in itself, but rather a means to an end. So why not more emphasis on curricula, teaching, learning, or the kinds of student activities that lead to better outcomes?

The road to effective and useful outcomes assessment in RC education has been lined with stepping stones and stumbling blocks. I'm not sure where the road is actually taking the profession, but I believe we'll know it when we arrive. We're not there yet.

Sandra McCleaster, MA, RRT is a veteran therapist, author, lecturer and educator. She is an adjunct faculty member at Bergen Community College in Paramus, NJ.

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as sickle cell disease, Hb F or S, and other conditions, are not suitable for this test. An alternative fructosamine test may be used in these circumstances and it similarly reflects an average of blood glucose levels over the preceding 2-3 weeks.

It is interesting to take a short look at how this glycosylation process works in the hemoglobin molecule. A glycosylated hemoglobin is formed spontaneously in red blood cells by the combination of the NH₂-terminal amino groups of the hemoglobin beta chain and glucose. The aldehyde group of the glucose first forms a Schiff base with the NH₂-terminal amino group, which then rearranges to a more stable amino ketone linkage by a spontaneous (nonenzymatic) reaction known as the Amadori rearrangement. The higher the blood concentration of glucose and the longer the duration of the hyperglycemia, the more HbA_{1c} will be formed (greater percent of glucose that becomes bound to hemoglobin).

The utility of this laboratory test to the respiratory therapist? Diabetic patients can be problematic very quickly if there is a sudden change in glucose level. If your patient has an HbA_{1c} result on their chart, and if it is elevated above 6%, it will be worth your while to take extra precaution. Your patient has a recent (last 2 weeks to three months or so) history of elevated blood glucose levels.

Don Steinert is an Associate Professor in the Department of Nursing and a faculty member in the Respiratory Therapy Program at the University of the District of Columbia.

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