September 29, 2022

Dear Dr. Olehausen and members of the CNME,

The Council of Chief Academic and Clinical Officers (CCACO) of the Association of Accredited Naturopathic Medical Colleges (AANMC) appreciates the opportunity to provide feedback to the CNME as you undertake a planned review of the naturopathic accreditation standards. The members of CCACO have reviewed the standards and your specific questions, and wish to provide this feedback as a collective. Individual schools may submit additional responses specific to their programs. CCACO is very open to providing any continued feedback, support, or clarification the CNME needs with regard to this submission and is thankful for the opportunity to provide collegial feedback.
Thank you for your consideration of our suggestions and feedback.

Respectfully,

AANMC Board of Directors
AANMC Council of Chief Academic and Clinical Officers

CNME General Questions

1. Are there any elements or criteria in any of the standards that should be removed? If so, what are they and why is this necessary?

   Standard VI

   A2 - States that the program is primarily residential and that the clinical training is *entirely* residential.

   - The CNME standards now allow for telemedicine, so this section should reflect the agreed upon recent changes.
   - The schools would like a definition of the word ‘residential’ and additional clarity regarding how it is applied to telemedicine and affiliate clinical sites.

   B5e – Basic acupuncture and Oriental medicine – recommend removing

   - Some programs do not teach acupuncture and *basic* acupuncture is not defined.
   - If not removed, the schools recommend changing ‘Oriental’ to ‘Chinese’ or ‘East Asian’ as the term is out of favor and considered pejorative.

   C5 - 1,200 hours must be in residential clinical settings.

   - Please define residential and how this applies to telemedicine and affiliate site training programs.

C5f – training that can't count towards the 1,200-hour clinical requirement

- Please consider allowing a small amount (i.e. 20 hours) of clinic hours to be obtained from non-patient care hours such as supporting the lab, dispensary, etc. These opportunities provide students valuable, non-patient, clinical experience that is useful in their futures as clinicians.

2. Are there any important elements that have been left out of any of the standards? If so, what are they and why is this necessary?

   Guidelines on the Use of Information and Communication Technology states that the majority of the curriculum is residential.

   - Please define residential and how this aligns with affiliate sites and telemedicine.

3. Do some of the current standards contain elements or criteria that should be shifted to different standards? If so, please outline the specific changes you suggest and why they would be helpful.

Standard VI

A2 - The program is primarily residential.

- The pandemic demonstrated that some courses can successfully be delivered virtually. We suggest removing this language and allowing the program to have autonomy regarding material delivery. The program must be able to demonstrate the quality of the learning environment to the CNME.

4. Are there redundancies or duplications in the current standards that should be eliminated? If so, please outline what they are.

   No feedback regarding redundancies or duplications in the current standards were collected at this time.

5. Are there any unclear wordings, ambiguities, contradictions, or inconsistencies in specific sections that should be addressed? If so, please outline.

Standard VI

C5: Define 'residential more precisely and consistently with the Guidelines on the Use of Technology.

Guidelines on the use of technology

- The schools have been evaluated on these as if they are standards, not merely guidelines. If they are meant to be followed as standards, they should be incorporated into the standards.

Standard VI

5ab and D8 – these are confusing to the schools for application of how many hours of the 850 can take place at affiliate sites. The schools need to be able to demonstrate the quality of the learning experience regardless of location. It is our respectful request that there not be a limit on hours; quality, not location should be the emphasis for clinical education.

6. Do we need to add any new standards? If so, what are they and why are they needed?

    a) A standard requiring schools to incorporate Diversity, Equity, Inclusion and Belonging should be considered. Consideration should be made to ensure this is incorporated throughout the program and institution, including, but not limited to admissions, human resources, academics and clinical education.

    b) AANMC is proposing a new standard regarding recognition of one centralized application to represent residency:

        By definition, a centralized residency application and match service implies that there is one service. Centralization affords a unified message regarding the professional stature of a health profession, aids in the ease of application, and minimizes administrative burden and costs borne by the applicants. It also assists residency sites in having one location to seek out applicants for their positions. Precedent exists in podiatric medicine to recognize one centralized application and match for podiatric residency, and reads as follows:

        Centralized Application Service for Podiatric Residencies (CASPR) CASPR is a service of the American Association of Colleges of Podiatric Medicine (AACPM) and its Council of Teaching Hospitals (COTH). CASPR enables graduates of colleges and schools of podiatric medicine to apply simultaneously to podiatric residency programs approved by the Council. The goal of CASPR is to facilitate residency selection by centralizing and streamlining the application process.

        p. 5 https://www.cpme.org/files/CPME/2022-4_CPME_320.pdf

        Sample language for the CNME could read as follows.

        The Centralized Application for Naturopathic Residency (CANR) is a service of the Association of Accredited Naturopathic Medical Colleges (AANMC). This application enables graduates of accredited naturopathic programs to apply simultaneously to naturopathic residency programs recognized by the Council. The goal of the centralized residency application is to streamline and facilitate naturopathic residency application and placement.

7. Do you have any general observations about the current accreditation standards? What do you like or dislike about the current CNME standards?

    Standard VI

    - C5a - the 850 hours greatly limits the ability for students to preceptor with doctors in the field. Affiliate sites are much better simulations of the post-graduate experience than

academic medical centers/teaching clinics. Increased use of affiliate sites should increase post graduate opportunities, student understanding of best business practices, and diversify both learning and patient experiences. Schools should be allowed to increase the use of affiliate sites if they can demonstrate the quality of the learning experience.

Specific Questions

1. Have you observed any widespread weaknesses in regard to skills and/or knowledge among recent ND graduates that the CNME should address in the ND curriculum standard (i.e., Standard VI, "Program of Study")? If so, please list.

    - Professionalism and professional communication have become more challenging, although this is vaguely and non-specifically written into the standards.

2. Given the various scopes of ND practice currently found in the U.S. and Canadian jurisdictions that license/regulate NDs—and how these scopes may evolve—what aspects of academic or clinical ND education, if any, need further development?

    - No feedback was collected in response to this question.

3. Given trends in healthcare insurance coverage for ND services, are there any aspects of the academic or clinical ND educational standards that need further development? If so, please list.

    - Students need to be trained in correct and best practices in jurisdictionally relevant diagnostic coding. We would like to request that the standard ensures the teaching of, but no expected live clinical application of coding, given different scopes of practice across the AANMC member jurisdictions.

4. The CNME educational standards reference the goal of graduating "primary care/general practice physicians/doctors": Is this still appropriate as a fundamental goal of ND education and training? If not, what, if anything, should be specified as the fundamental goal?

    - More tightly define 'primary care'. Per the American Association of Family Practitioners -the definition is the first interaction with an undifferentiated complaint or patient. This definition is centered around diagnosis and treatment, regardless of insurance, scope of practice or type of therapeutic intervention used.

    - General practice is not a commonly defined term. We suggest replacing it with the term primary care.

5. The CNME has recently revised its accreditation standards to allow for the use of telemedicine and simulations to fulfill a portion of the clinical training requirements, including a limit of 25% for telemedicine contacts and 20% for simulations: What further revisions, if any, might be needed to clarify and/or strengthen these aspects of clinical training?

- The guideline states 20% of the training, however we do not see a definition regarding what part of the training this refers to. Clarity is requested regarding if this relates to patient contacts or hours, or both.

6. Given that there are some ND programs where ND students share classes with students enrolled in a different healthcare program—or who are getting an ND degree jointly with another degree—are any revisions/additions needed in the CNME standards to address these situations? If so, please outline your suggestions.

    - No feedback was collected in response to this question.

7. Assessment continues to be a challenging area for some ND programs: Are any revisions needed in Standard VII, "Assessment of Student Learning and Program Evaluation"? If so, please outline your suggestions.

    - No feedback was collected in response to this question.

8. The CNME is considering implementing a hybrid format for conducting comprehensive evaluation visits for reaccreditation of ND programs—i.e., handling some of the meetings via videoconferencing prior to the onsite campus portion of the visit so that the onsite portion is less rushed and/or of shorter duration. Would utilizing a hybrid evaluation visit format be potentially helpful to schools? If so, which parts of a visit could be handled virtually instead on campus?

    - During recent site visits, the meetings held virtually were those with alumni, students, and faculty. The videoconferencing option potentially allows for greater participation, especially for alumni that no longer reside near the school location. However, schools personally preferred to have all meetings held within the 3-day site visit period. While these are three full days, consolidating meetings during this time results in the least amount of disruption to normal daily operations. Other than allowing for the student, faculty and alumni forums to be held in a teleconferencing format, we would recommend the remaining aspects occur in-person and within the normal site visit timeframe.

    - It would be very useful for the team to let the schools know what additional materials they would like access to prior to the visit. Additionally, avoidable confusion has been created when a visitor asks for information during the visit that is not in a format the school uses.

RESIDENCY STANDARDS

<u>Standard 2.3 - Administrative Oversight</u>

- c) Fix grammatical error
    - Agreement on how the recognized sponsor will monitor training site compliance with policies and ~~the~~ its success in meeting educational goals;

<u>2.5 Site-vetting</u>

- Does the standard ensure potential conflicts of interest include resources? If collaborating with a sponsor, do sites need to request any potential conflicts of interests and document a conflict-of-interest policy?

Standard 3.1 and 3.13

Background: There have been circumstances where a resident was unable to complete their residency in a consecutive time frame. Some scenarios include a health issue of the resident, the resident having to care for a family member, the residency site no longer being able to host a resident, or other reasons rendering the resident site/resident unable to continue the contractual obligation. Gaps in residency do pose logistical issues for sites, and can lead to sites not participating in a subsequent year if they are still completing their contractual obligation to a prior resident.

- AANMC would like guidance regarding what is an acceptable gap (3 months, 6 months, 9 months) to be able to resume a residency, either at the same clinic or in a different clinic.
- Standard 3.13 states "…a problem arises that prevents a resident from completing 48 weeks of a one-year residency within a 12-month period, a residency site may choose—at its discretion—to extend the length of the residency beyond the 12-month period to accommodate the resident…" Suggestion to include "when the resident is able to resume full-time work in the program"

Standard 3.13

- a) ii. – revise to "10-day PTO" to "80 hours PTO". Some residents work four 10hr/day workweek. The 10 days PTO was initially written for a resident working a five 8hr/day workweek. If revised to 80 hours PTO, a resident on 4/10 schedule should only get 8 days PTO.
- a) ii. – suggest providing a # of approved established holidays (US and Canada), and if there is room for religious considerations.
- Clinical hours are not stated in the Handbook but it states that there is a separate document "CPNME Guidelines for Resident Employment". The clinic hours in this employment guideline should be incorporated into standard 3.13.
- Please provide a definition of 'excessive workload'.
- Please define the expectation that supervision reflects the resident's experience and abilities.

Standard 3.15

- Suggest adding a "whistle blower clause" and defining how issues are resolved.

Standard 3.7

- The standard should provide additional information on the time commitment, qualifications, etc.

Standard 3.9b

- Does access to didactic/CME instruction imply that the site is financially responsible for the instruction or resources?

The salaries in the employment guidelines must be updated for 2022-2024. Additionally, applicants inquire if there is a published schedule when they can expect changes to employment and salary guidelines to be posted by the CNME.

The Handbook does not cover a resident who resigns from one program and wishes to join another, or acceptance of a position, only to later decide to take another position elsewhere.

Additionally, there is absence of the scenario where a resident agrees to a 2-yr program and resigns after 1 year.

The Handbook does not provide descriptions on the expected clinical competencies or EPAs.