STRATEGIES FOR CHANGE AND IMPROVEMENT

The Report of the
TASK FORCE ON ACCREDITATION
OF HEALTH PROFESSIONS EDUCATION

University of California, San Francisco
Center for the Health Professions

June 1999

THE CENTER
FOR THE HEALTH PROFESSIONS
University of California, San Francisco

Strategies for Change and Improvement

Suggested citation style: Gelmon, Sherril B., O'Neil, Edward H., Kimmey, James R., and the Task Force on Accreditation of Health Professions Education. *Strategies for Change and Improvement: The Report of the Task Force on Accreditation of Health Professions Education.* San Francisco: Center for the Health Professions, University of California at San Francisco, 1999.

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Created by the University of California, San Francisco in 1992, the Center is an outgrowth of the Pew Health Professions Commission. The mission of the Center is to assist health care professionals, health professions schools, care delivery organizations and public policy makers respond to the challenges of educating and managing a health care workforce capable of improving the health and well being of people and their communities.

TABLE OF CONTENTS

INTRODUCTION i

EXECUTIVE SUMMARY iii

PART I: THE BACKGROUND OF ACCREDITATION 1

What is Accreditation 1

History of Accreditation 2

The Evolving Roles of Accreditation 4

PART II: THE NEED FOR CHANGE IN ACCREDITATION 6

Concerns About Accreditation 7

Environment Factors and Trends 12

Looking to the Future 14

PART III. RECOMMENDATIONS 15

Public Responsibility – Recommendation 1 16

Assessment and Improvement – Recommendation 2 18

Innovation and Efficiency – Recommendation 3 21

The "5+1 Criteria" Approach – Recommendation 4 23

Self-Assessment – Recommendation 5 26

Strategies for Timely Change in Accreditation 27

Concluding Remarks 28

IV. PAPERS ON RELATED ISSUES 31

Challenges for Administrators 32

Proliferation of New Health Professions and Accrediting Bodies 35

The Collaborative Imperative 39

Competition/Duplication in Accreditation 44

The Influence of Accreditation Policies on Federal Funding for Health Professions Education and Training: The Role of the Bureau of Health Professions 50

Collaboration between Industry and Higher Education 55

The Increasingly Global Context of American Higher Education 58

Governance of Accreditation Agencies 64

Consensus Elements of Common Accreditation Criteria: The Results of a Delphi Process 74

REFERENCES 82

ENDNOTES 85

APPENDIX

Selected Stakeholder Consultations 86

INTRODUCTION

The Pew Health Professions Commission has been studying the future of health professions education in the United States since 1990. Accreditation, as the Commission recognizes, plays an important part in that future by assuring the quality of academic programs that prepare new health professionals for practice. Yet the health professions accrediting community faces many difficult challenges if accreditation is to live up to its mission and serve its many and diverse stakeholders. This report represents an attempt to identify and discuss those challenges and make recommendations on how best to meet them.

In its first report, published in 1991, the Pew Commission defined a set of 17 competencies for health practitioners for the year 2005, and established a framework for changing relationships between universities and their communities (Shugars, O'Neil, and Bader, 1991). These competencies were revised and updated in the final Pew Commission report (O'Neil, 1998).

The Commission's 1991 report acknowledged that accreditation and licensure have played major roles in regulating health professions education, providing a "legacy of improved academic programs" (Shugars, O'Neil and Bader, 1991, p.13). The Commission went on to indicate, however, that accreditation "often impede[s] change within the health professional schools rather than [encouraging] change" (p.13-14). The goals of accreditation and the means for achieving those goals needed to be reconsidered, the Commission recommended. The Commission also suggested that schools of health professions assess curricular effectiveness in order to monitor and improve program quality, that professional associations work closely with accreditors and educators, and that government encourage accreditation policies promoting outcome-based standards of performance.

In its 1993 report, the Commission reiterated its recommendation on the need for federal policy to stimulate the use of outcome measures in accreditation (O'Neil, 1993). One recommendation addressed professional policy, urging that the accreditation process "fully embrace the competencies developed by the Pew Commission as part of the institutional review of academic programs" (p.24). This Commission report also included some discipline-specific recommendations regarding accreditation for allied health and for dentistry, as well as general recommendations on the integration of the competencies into the disciplinary education programs.

The Commission's 1995 report, Critical Challenges: Revitalizing the Health Professions for the Twenty-first Century (Pew Health Professions Commission, 1995), focused on the changing health system and the resulting changing needs for health professions workforce preparation. This system, the Commission wrote, is still evolving, with an emphasis on better management, greater accountability, more effective and efficient resource use, population-based health care, and evidence-based medicine.

In 1996, the University of California at San Francisco Center for the Health Professions, with support from The Pew Charitable Trusts, established the Task Force on Accreditation of Health Professions Education to provide policy analysis and recommendations with respect to health professions accreditation. This national Task Force was asked to examine the issues, challenges and opportunities in accreditation; to facilitate dialogue with key stakeholders in accreditation, including educators, accreditors, professionals, consumers, and government; and to recommend policies, strategies, and specific actions for the improvement of health professions education accreditation. This work has been conducted in parallel with the work of the third Pew Health Professions Commission. The Task Force published its early work in a set of working papers, available from the UCSF Center for the Health Professions (Task Force on Accreditation of Health Professions Education, 1998).

This report is organized into four sections:

- THE BACKGROUND OF ACCREDITATION. This section defines and describes accreditation, provides a brief history of accreditation, and discusses the evolving roles of accreditation and tensions in the current system.
- THE NEED FOR CHANGE IN ACCREDITATION. The section discusses concerns about accreditation identified by the Task Force and key stakeholders, as well as environmental factors and trends that affect accreditation.
- RECOMMENDATIONS. The section contains the Task Force's five core recommendations and strategies for implementation.
- PAPERS ON RELATED ISSUES. This section is a set of issue papers by Task Force members on issues relevant to accreditation.

EXECUTIVE SUMMARY

Accreditation amounts to a public seal of approval—a guarantee of quality. Academic programs that secure and maintain accreditation status do so by engaging in a rigorous process of internal and external review and meeting defined criteria for educational excellence. But with the proliferation of agencies that accredit academic programs over the years, this process has become increasingly complex—to the point where many in higher education have come to question its value, especially in view of rising costs associated with accreditation. Critics say that accreditation focuses more on inspection and compliance than on improvement, and that, in a world where everything else is changing rapidly and dramatically, accreditation remains mired in obsolete traditions and requirements that are not only onerous but often irrelevant. They also complain about duplication and wasted effort because of overlap between regional and specialized accreditors. Clearly, it is time for the accrediting community to take a hard look at itself.

The Task Force on Accreditation of Health Professions recognizes that the most important challenge facing the accreditation community today is to create an environment and a process that is responsive to the changing needs of society and communities of practice. After engaging extensively with a wide range of stakeholders, the Task Force identified four major issues in accreditation:

- need for a simplified process,
- development of, and transition to, process whose focus is improvement,
- closer linkages with clients and customers, and
- use of generic benchmarks or standards.

These issues formed the basis for a set of core recommendations to make accreditation a more productive and positive force in health professions education. Following is a brief summary of those recommendations and strategies for implementing them.

Recommendation 1: Educational institutions, programs, and accreditors must recognize their shared responsibility for responding to the changing needs of the public, employers, professional bodies, and students.

The broad strategies for implementing this recommendation are:

- establish broad competencies needed for practice through a collaborative approach among educators, professional organizations, and employers, and an ongoing assessment and integration of changing practice needs; and
- integrate the accreditation process into a larger system of program review, improvement, and regulation. Reduce overlap and duplication of effort where possible in professional regulation, individual licensure and certification, organizational accreditation, peer review, state review, etc.

Specifically, strategies for accreditors include:

- require that educational programs establish effective linkages with their stakeholders, including the public, students, employers, and professional organizations; and
- require programs to define and measure achievement of competencies for professional practice.

For educators, the strategies are:

- establish effective linkages with stakeholders, and regularly seek their input about the effectiveness of educational programs in meeting stakeholder needs;
- define and measure student achievement of competencies for professional practice; and
- evaluate students' achievement of threshold performance levels, and make program improvements to assure students meet or exceed these levels.

Recommendation 2: Educators and accreditors must work together to foster an organizational culture centered on educational assessment and improvement that promotes necessary change in educational processes at the institutional level.

General strategies for implementing this recommendation are:

- articulate accreditation in the context of current practice and the anticipated future directions; and
- commit to continuous improvement as part of the everyday culture of institutions.

For accreditors, strategies include:

- collaborate with educational institutions and programs to help create a culture where improvement is planned and directed, and where processes that support accreditation are part of routine and ongoing daily work;
- make program review a lever for educational change by requiring that programs have processes in place for continuous self-assessment and improvement; and
- expand the professional training of site visitors to improve their program evaluation and consultation skills.

For educators, this recommendation suggests the following:

- collaborate with the relevant accrediting agencies to build a "culture of evidence" that facilitates continuous assessment and documentation of student and programmatic outcomes, as well as the impact of various educational initiatives on students, faculty, the institution, the profession, and the community; and
- take prompt action on accreditation recommendations to stimulate change and improvement.

Recommendation 3: Accreditation must reward innovative methods to enhance efficiency, minimize waste and duplication, and streamline assessment processes.

To implement this recommendation, general strategies are:

- accreditors and educators should collaboratively investigate alternative mechanisms for self-assessment and performance improvement and experiment with such frameworks as options to existing accreditation approaches; and
- institutional leaders should commission studies to identify best practices for enhancing efficiency and minimizing waste and duplication in accreditation and other internal assessment mechanisms.

For accreditors, strategies include:

- reward innovations that contribute to efficiency;
- streamline the accreditation process to increase accountability and minimize duplication and waste (including content of reporting, frequency of visits, and other redundant activities);
- restructure site visits as focused reviews, emphasizing opportunities for constructive consultation; and
- increase flexibility and responsiveness by integrating new, resource-conserving technologies into the accreditation process.

Educators should consider these strategies:

- work collaboratively with groups of educators, professional associations, regulatory bodies, and accrediting agencies to adopt common review mechanisms, schedule simultaneous site visits or program reviews, and determine other mechanisms to enhance efficiency and reduce rework;
- seek support to develop and test new ways of using electronic information management and communication for programmatic self-assessment, reporting, and monitoring; and
- collaborate with others to explore other resource-conserving methods that will enhance internal operations as well as reporting to external agencies.

Recommendation 4: All specialized and professional accrediting agencies should adopt a consistent approach to accreditation that uses five common criteria and one profession-specific criterion (these are referred to as the "5+1 criteria").

The common criteria would require that all educational programs:

- work closely with their practice communities and the public to prepare a workforce that can respond to and meet community assets and needs;
- provide appropriate, periodic, and ongoing faculty development and evaluation;
- regularly assess the competencies and achievements of students and graduates;
- have in place an effective process of continuous self-assessment, planning, and improvement; and
- inform and accurately represent themselves to their public(s) to ensure accountability and consumer choice.

Each accrediting agency would develop one additional criterion relevant to the profession at hand. The "+1" criterion might relate to the nature of practice, the role of the provider, or the defined scope of practice.

The major strategy for implementing this recommendation is to foster agreement among stakeholders on how to develop and apply consistent accreditation criteria.

Specific strategies for accreditors include:

- focus criteria on the knowledge and skills to be gained through professional preparation for practice;
- adopt and implement these five common criteria to allow collection and tracking of comparable data across institutions and programs;
- develop one profession-specific criterion in conjunction with key stakeholders that reflects the unique aspects of that profession (both knowledge and practice); and
- commit to requiring only those data that are relevant.

Strategies for educators include:

- ensure that programs define at the outset the outcomes students are expected to achieve as learning objectives, and that they frame these objectives in behavioral terms (knowledge, skills, competencies);
- work closely with professional associations and regulatory bodies to ensure that these learning objectives and projected outcomes incorporate professional competencies for entry into practice as defined by relevant professional groups;
- collaborate with accreditors to determine the specific implications of the 5+1 criteria for individual educational programs; and
- exchange and manage common information across multiple educational programs and institutions.

Recommendation 5: Accrediting agencies must continually review their own accreditation programs and make improvements to ensure that they respond to stakeholder needs.

Accreditors should do the following:

- learn all there is know about their own accreditation processes and practices, and engage in continuous self-assessment and improvement of their activities;
- make needed changes promptly to improve effectiveness;
- show responsiveness to the educational programs that they accredit by improving their efficiency and the user-friendliness of their products and services;
- develop professional training programs for their evaluators to ensure that they have the necessary skills and knowledge to conduct accreditation reviews that actually add value; and
- regularly seek feedback from educational programs and other customers on how to improve their work.

In turn, educators are encouraged to pursue the following:

- collaborate with accreditors to offer constructive suggestions for improving accreditation processes and practices that respond to professional, programmatic, and public needs; and
- respond promptly and frankly to requests from accreditors for feedback about programs, procedures, and activities.

At its best, accreditation should promote a process of guided self-evaluation and self-improvement. In that sense, the primary value of accreditation lies not in the determinations handed down by accrediting bodies but in the process of evaluation and program improvement stimulated by peer review. Thus, the effectiveness of accreditation may be judged by its ability to encourage programs to evaluate their educational activities and to use the evaluation results of accreditation for ongoing improvement to better meet customer needs. This is an ideal worth aspiring to. It is also the ideal that the Task Force hopes to promote with these recommendations. The Task Force challenges the accrediting community, in partnership with educators, practitioners and other key stakeholders, to assume a leadership role in facilitating and making change.

PART I THE BACKGROUND OF ACCREDITATION

Since its inception, the main purpose of accreditation in United States higher education has been the protection of the consumer and the assurance of the quality of educational preparation. Rising costs of higher education have helped to fuel the debate regarding the true value and role of accreditation as it currently exists. This debate has created a climate of controversy, creating a complex set of challenges for specialized accreditation within health professions education.

WHAT IS ACCREDITATION?

In this report, the term "accreditation" describes systems of evaluation and improvement related to post-secondary educational programs that prepare new health professionals for practice. Such accreditation systems are commonly referred to as "specialized" or "professional."[1] Accreditation is designed to assure the public of educational program quality and to promote continuing self-improvement by educational units in preparation for accreditation reviews. Ideally, accreditation is an integrated means of continuous assessment, evaluation, and improvement (Filerman 1984; Gelmon 1995; Millard 1984). In general, accreditation:

- is based upon guided self-evaluation and self-improvement, overseen by non-governmental organizations;
- relies upon peer review that in turn stimulates evaluation and program improvement; and
- judges the effectiveness of the academic unit against a set of defined standards.

Accreditation in U.S. higher education is a cyclical process that is repeated approximately every five to 10 years. It consists of a series of common activities:

- The program's faculty, administrators, and staff use the accrediting agency's standards and criteria as a guide for self-study. During this period, they also prepare whatever documentation the accrediting agency requires.
- The accrediting agency sends a team of peer visitors to conduct an on-site evaluation of the program, including interviews with faculty and staff.

- The peer team writes a report of its evaluation and makes a recommendation to the accrediting agency regarding the program's qualifications; the program is given the opportunity to respond to this report.
- The accrediting agency reviews the peer team's report and the program's response in the context of its standards and criteria and makes a judgment on the program's accreditation status, which it then relays to the program's administrators. These judgments are available to the public.
- This process is repeated, either on a regular, cyclical basis or in response to defined threshold triggers.

HISTORY OF ACCREDITATION

In 1862, Congress passed the Land Grant Act, which gave federal lands to states for the establishment of state universities. Eventually, questions arose about the quality of education provided by these institutions; accreditation emerged to answer those questions. Because the U.S. higher education system lacks a centralized control, accreditation developed initially in response to a need for non-governmental peer reviews and to address specific regional and professional standards for ensuring quality.

The earliest accreditation organizations in the health professions emerged around the turn of the century: osteopathy in 1897, medicine in 1904, and nursing in 1916 (Blauch, 1959). Most of these groups did not begin publishing lists of accredited programs for several years. In 1910, the Flexner Report, prepared by the American Medical Association in conjunction with the Carnegie Foundation, resulted in the adoption and enforcement of new standards for medical education and the closure of a number of medical schools that failed to meet those standards (Kells, 1994).

Regional accreditation evolved through membership associations created to improve relationships between secondary and higher education and to strengthen college admission standards. Six such regional associations were established between 1885 and 1924. With increasing professionalization and specialization of the workforce and proliferation of academic programs to educate new health professionals, the number of accrediting agencies with specific standards and evaluation programs has risen dramatically. Today there are more than 50 such accreditation programs in the health professions, ranging from acupuncture to dietetics to dentistry to nursing to pharmacy.

The proliferation of accrediting agencies and associations during the first half of this century prompted calls for coordination. In 1949, the National Commission on Accreditation (NCA) was established to coordinate accrediting bodies and control the expansion of specialized accreditation (Blauch, 1959). The Federation of Regional Accrediting Commissions in Higher Education (FRACHE) was created in 1964 as a forum for the regional associations to share concerns about institutional accreditation (Bemis, 1991). Although FRACHE and NCA worked closely together, the number of specialized accreditors continued to increase, resulting in the 1975 establishment of the Council on Postsecondary Accreditation (COPA).

Over time, the federal government has increased its involvement in accreditation activities, reaching a watershed in 1992, when Congress passed a new Higher Education Act (HEA) that mandated greater governmental oversight of the accreditation process and increased the gatekeeping responsibilities of the accrediting agencies. Congress acted largely in response to concerns about rapidly rising default rates in federal student loan programs, which many believed reflected the failure of accreditation agencies to adequately monitor the academic quality of higher education institutions. The 1992 HEA gave the U.S. Department of Education (USDE) greater oversight over the entire accreditation process. Thus, the culture and philosophy of accreditation shifted from one of peer review and professional judgment to one of government regulation and monitoring (Tanner, 1996).

At about this time, COPA disbanded, leaving no national voice for accreditation or coordination of accrediting bodies. The Commission on Recognition of Postsecondary Accreditation (CORPA) emerged as a temporary mechanism for filling that need until a new oversight entity could be established. That happened in 1996, with the establishment of the Council for Higher Education Accreditation (CHEA). CHEA assumed the functions of CORPA, which was dissolved that same year. Meanwhile, specialized and professional accreditors, worried that their professional and organizational needs were not being represented, created the Association of Specialized and Professional Accreditors (ASPA) in 1993.

ASPA has played an important role in developing common practices for specialized and professional accreditation and for disseminating information within this community (ASPA 1993, 1995). Today, ASPA continues to be a resource for the specialized accrediting community, working with both CHEA and with the Council of Regional Accrediting Commissions (CRAC), the new organization of regional accreditors, to develop common strategies for accreditation.

THE EVOLVING ROLES OF ACCREDITATION

Since its inception, accreditation has undergone a number of changes that have affected its role in higher education—and, indeed, led to some confusion about what the role of accreditation is and should be. In the health professions, the original goal of accreditation was to achieve an ideal in education as preparation for practice by defining and meeting explicit standards. In this way, accreditation could protect both the health of the general public and the futures of students seeking education. Over time, the accreditation stamp of approval has become a symbol of minimal quality, assuring that no harm will come to the student who enrolls in an approved program or to a patient or client who is served by a graduate of such a program.

More importantly, this minimal threshold now qualifies schools and programs for government funding and acceptance, and enables individuals in certain professions to sit for professional licensure. In the health professions, the link between accreditation and professional licensure or certification has particular significance, because aspiring professionals in many fields cannot even sit for a licensing exam unless they have graduated from an accredited program. Thus, although accreditation began as a voluntary process independent of government regulation, it has increasingly been tied to funding, eligibility for financial aid, individual licensure, workforce regulation, and other governmental responsibilities. This evolution has diminished the true "voluntary" nature of accreditation in many professions. In addition, because the stakes for achieving accreditation have become so high, accrediting agencies rarely withhold it, and its meaning for consumers has declined.

During the latter part of this century, many accreditation agencies have also taken on consulting or quality improvement roles. They offer advice to programs on how to improve their overall operations so that they can meet the agencies' standards for accreditation. Some critics believe that this coaching role is at odds with the role of the accrediting agency as an impartial evaluator; others believe it is an essential component of the accreditation process.

Finally, accreditation clearly serves to protect the interests of the various health professions, which developed their own accrediting programs to assure professional quality and to keep outsiders, particularly the government, from evaluating them. Although this guild function is perfectly legitimate, it may conflict with other functions, such as protecting the public.

Many of the problems facing the accreditation community today stem from this confusion of purposes, which may not always be explicitly acknowledged or discussed. Today, accreditation

is at a crossroads, caught between the "old way" of doing things and demands for a "new way" of doing business. The figure below illustrates these tensions.

Tensions in Accreditation

OLD WAY		NEW WAY
Stagnant	⟷	Evolving
Discourages innovation	⟷	Encourages innovation
Hold to standards	⟷	Emphasize consultation
Inspectors	⟷	Peer experts
Focus on courses	⟷	Focus on curricular content
Structural emphasis	⟷	Competency emphasis
Classroom learning	⟷	Community-based learning
Rigid curriculum	⟷	Personal development
Past practice	⟷	Future relevance
Quality assurance	⟷	Continuous improvement

These tensions must be considered in the context of the turbulent higher education environment, where an equal number of forces are driving change, with new emphasis on the nature of education (classroom vs. virtual), the format of education (full-time vs. part-time), the kind of student (young vs. adult learner), the background and experience of learners (from homogeneous to a diverse population), and the motivation for choosing an educational program (reputation vs. price and convenience).

As a result of these and other, external conflicts and tensions, the accreditation process often is inconsistent and flawed. However, these tensions also illustrate the potential for accreditation to evolve further, embracing a future that focuses on innovation rather than tradition, on process rather than content, and on improvement rather than compliance.

PART II THE NEED FOR CHANGE IN ACCREDITATION

"Traditional accreditation serves as an impediment, real or imagined, to changing education, and it has outlived its current social usefulness. It must be reinvented to serve the more pressing social need of making educational institutions truly responsive, or it must be simply discarded."

(Pew Health Professions Commission, 1995, p. 20)

Anyone who has seriously examined the process of educational accreditation must be left with two contradictory impressions. The first is that accreditation is a simple, direct, and effective process. On a regular basis, teams of highly skilled professionals visit educational programs and review their inputs, structures, processes, and outcomes against accepted standards. They assess shortcomings, and they may make suggestions for improvements. This wholly rational process is designed to protect the consumers of the products of these programs: members of the public, who are served by program graduates, and students, who need to know whether the program they have entered is of acceptable quality.

Not surprisingly, reality often differs from the ideal. Standards for accreditation are derived with little if any public input. Teams of site visitors are notoriously uneven in their evaluations across and within professions. In addition, they tend to be myopic, ignoring the larger system within which a specialized program operates. Recently, the accrediting community has aspired to consider outcomes, but it frequently defaults to indicators that are more easily measured. The entire undertaking provides meager value to the prospective student, marginal and inconsistent help to the program under review, and seems to protect the guild interests of the professions rather than the public's. Add to this the considerable human, physical, and financial resources consumed by the accreditation process, and it is not surprising that many in higher education circles are calling for fundamental changes in accreditation.

CONCERNS ABOUT ACCREDITATION

Early in its deliberations, the Task Force on Accreditation of Health Professions Education decided that it needed to engage in extensive consultation and discussion with a wide range of stakeholders in the accreditation process. Through written and electronic communication, presentations, discussions, and a series of national forums, a broad community of stakeholders was invited to provide input to the Task Force on the core issues relevant to accreditation today (see the Appendix for a list of some of the stakeholder groups consulted).

This led the Task Force to ask some key questions: What, fundamentally, is the purpose of accreditation in health professions education? Is it guaranteeing the "quality" of the student out of the gate—the new health professional? Or is it assuring the employer hiring the new graduate of the "quality" of the prospective employee? These discussions resulted in the articulation of a specific set of concerns, including:

- defining the essential values of accreditation,
- minimizing duplication and waste,
- linking regulation and accreditation,
- making exceptions to standards,
- promoting interdisciplinary education through accreditation, and
- conceptualizing accreditation as a model for assessment and improvement.

Following is a discussion of these concerns.[2]

DEFINING THE ESSENTIAL VALUES OF ACCREDITATION

In general, stakeholders view accreditation as a positive activity, but they also believe that the field lacks research or other proof of added value. The values that emerged from discussions with stakeholders as most central to accreditation include:

- continuous self-improvement,
- flexibility and relevance,
- civic responsibility and professional excellence,
- peer review and collaboration, and
- serving the public interest.

Several perspectives may be used to identify other potential values of accreditation. For example, from the perspective of an academic program, accreditation provides faculty with an opportunity for professional development and validation. It also serves as a gateway to licensure, financial aid, and eligibility for entitlement programs. For the professions, accreditation offers the opportunity to influence the educational process and build consensus on standards. It also promotes consistent outcomes and accountability and helps each profession protect its own turf. For students and graduates, accreditation ensures eligibility for licensure and certification, creates career ladders, and provides a public measure of comparative quality. For the public, accreditation helps assure the competency of practitioners and provides a measure of protection. For employers, it helps in the selection of qualified graduates for employment. These are just a few of the potential added values of accreditation.

MINIMIZING DUPLICATION AND WASTE

Accreditation is often criticized as duplicative and wasteful. Among the complaints identified in the Task Force's discussions:

- overlap in scope and focus between regional and specialized accreditors;
- subjecting institutions and programs to multiple standards and multiple visits, which require substantial time and money;
- numerous requests for the same data in different formats; and
- repetitious calculation and reporting of static information.

Frequently, accreditation requirements do not appear to add value to the assessment process. Accreditors are not often asked to justify their information requests and requirements, which frequently do not reflect current realities. Variation among accrediting agencies is evident in terms of frequency of site visits, site visit team composition, and documentation expectations. However, most recognized agencies follow similar procedures and seek potentially comparable data.

Many strategies for addressing these issues of duplication and waste were identified, including:

- Implement a common instrument for data collection, use a common language, and create a centralized database of institution/program information.
- Coordinate measurement of outcomes with certification and licensing boards.

- Increase coordination among accrediting bodies (cooperative site visits, single report for multiple programs).
- Decrease the number of site visits and time on campus by each accrediting agency.
- Discontinue standard forms; allow program to decide how to report.
- Computerize information transfer.
- Integrate program accreditation and professional licensure and certification processes.
- Increase dialogue among accreditation agencies, certification and licensure agencies, professional associations, and employers.

LINKING REGULATION AND ACCREDITATION

Because so many health professionals must graduate from an accredited program in order to sit for professional licensure, greater linkage between regulation and accreditation is an important issue. But whereas accreditation is a quasi-regulatory mechanism to evaluate educational programs, licensing evaluates individual competency. The two processes may be linked if both are focused on the same outcomes, such as competency-based performance assessment, but the fundamental emphasis—programmatic versus individual—remains different.

Barriers to achieving greater integration are largely driven by the varying roles of regulation across the health professions and by the varying impact of licensure on professional practice. Faculty and professionals often disagree on who should control curricula, so that for some professions the curricula do not reflect the actual skills and knowledge needed for employment. In most professions, there is no coordination between the work of national accrediting agencies and the state licensing boards, despite their inter-dependence.

Multi-skilling is an area where the roles of regulation and accreditation could be better articulated. There is some debate about whether the multi-skilled individual is a more effective health services provider and how such a person can maintain competency in the necessary procedural skills. Although multi-skilling may help providers address certain challenges, accreditors and licensing groups have not embraced the training of multi-skilled health care workers as a necessary future strategy, possibly because it might make their regulatory work more difficult.

Closer linkages between accreditors and regulators could help reduce waste and duplication and produce clearer, more objective standards for entry into a profession.

However, they could also lead to conflicts of interest, limits on alternative educational opportunities, and new barriers for graduates if a broader set of competencies is expected of all practitioners.

MAKING EXCEPTIONS TO STANDARDS

Accreditation is based on evaluation against a set of accepted standards, using a process that is consistent across multiple evaluations. Yet situations frequently arise in which making an exception to a standard seems justified.

Standards are supposed to be based on facts and current practice, but contexts vary and organizations change. The granting of an exception may be an opportunity for learning and improvement. Of course, any exception must be justifiable and true to the principles of fairness and due process. When considering an exception, accreditors must be clear on the content of their standards, the process for making exceptions, and their own ability to judge the fairness of the exception. Otherwise, the fundamental principle of comparability within accreditation programs will be compromised.

PROMOTING INTERDISCIPLINARY EDUCATION THROUGH ACCREDITATION

Several stakeholders expressed concern that accreditation is not incorporating increasingly interdisciplinary models of health practice and professional preparation. Interdisciplinary education among the health professions reflects the changing workforce demands of managed care organizations, as well as greater pressures for more cost-effective, coordinated care. However, there are many barriers to interdisciplinary education, including: resistance to change, turf protection, increasing specialization, fear of losing professional identity, unwillingness to understand other professions, the rigidity of current educational structures regarding curriculum content, and a lack of good models for interdisciplinary education.

The Task Force's discussions focused on the implications of interdisciplinary education for accreditation, particularly on what accreditation standards should include for training students, faculty, and site visitors for interdisciplinary assessments. The accrediting community could become more engaged in exploring interdisciplinary learning models, working with educators to develop measures of interdisciplinary competency, and beginning to implement them in program assessment. Site visitors would need training to ensure that they have the skills to accredit interdisciplinary experiences. One possible approach is to

start discussions among accreditors who already work in areas with overlapping knowledge and skill bases, such as physical and occupational therapy, or public health and health services administration.

CONCEPTUALIZING ACCREDITATION AS A MODEL FOR ASSESSMENT AND IMPROVEMENT

The Task Force explored how accreditation could be transformed from its current orientation of quasi-regulatory, periodic, external evaluation to one of self-assessment and continual improvement. Accreditation agencies would play a central role in such a repositioning. Currently, these agencies act as market-driven gatekeepers, and they tend toward slow and incremental change. Accreditors function as enforcers and sustainers of quality, providing students with a modicum of consistency across educational programs, all of which purport to meet common standards.

Accreditors could serve as resources to teach educators about alternative models and processes for assessment and improvement. They could help program leaders become better managers, particularly with data collection and management. To do this, accreditors would not only need to gain this knowledge and expertise themselves, they would have to assume a more active role in understanding current practice and health system realities. They would then be in a stronger position to provide consultation and mentoring as integral parts of their work—helping new programs, those seeking assistance, and new faculty work toward systematic and ongoing improvement of their programs and their work.

The accreditors also need to strengthen their knowledge about the use of educational outcomes assessment, and invest considerable effort in defining and applying suitable and measurable quality indicators. The growing emphasis on graduate competencies demands that programs and accreditors develop stronger and more comprehensive assessment processes that emphasize structural and process measures, as well as outcomes.

ENVIRONMENTAL FACTORS AND TRENDS

The environment in which accreditation operates is changing and becoming increasingly complex, and the accreditation community needs to keep up with the times. Five important trends are worth discussing in this context: the democratization of knowledge, the globalization of work, the changing health care delivery system, new challenges in the higher education system, and the growing momentum for public accountability.

DEMOCRATIZATION OF KNOWLEDGE

The structure for accreditation was largely built around the specialized knowledge that was once the domain of the individual professions. Thus, access to and a claim on special knowledge were key to the development of accreditation. When such knowledge was carefully husbanded and passed on in a personal way from one generation to the next, this guild-like tradition may have made sense. But with the arrival of the Information Age and widespread access to the Internet and other knowledge-coupling technologies, this tradition is increasingly outdated.

GLOBALIZATION OF WORK

As knowledge is changing, so is work—much of it driven by the service industry that has been so dramatically shaped by the information and communications revolutions of the past decade. The creation of a single workforce through agreements such as the European Economic Union or the North American Free Trade Act means that there is now a global market for the skills and services of most of the world's knowledge-based workers, including health care professionals. Employment is now migrating in accordance with the supply of needed skills and the levels of wage rates. For the health professional, the only option is to respond. In such a world, the traditionally narrow and inflexible approach to accreditation is obsolete.

THE CHANGING HEALTH CARE DELIVERY SYSTEM

The health care system is itself changing. First and most dramatically, it is actually becoming a system. What was once an idiosyncratic array of independent practices and community hospitals financed by a fee-for-service bill-paying system is rapidly becoming an integrated and more consolidated system of purchasers, plans, providers, and consumers. Driven by the enormous power of market mechanisms, this system is becoming increasingly focused on

public measurements of how well it is doing its job. To meet new goals of low costs, high quality, and improved patient satisfaction, the system must become more innovative. For the health care workforce, this means a higher level of competency, greater flexibility, and other new skill demands. Again, these changes leave the traditional workings and trappings of accreditation far behind.

NEW CHALLENGES IN THE HIGHER EDUCATION SYSTEM

Higher education today is frequently declared to be "in crisis." Social forces require educational leaders to do more, do it better, and do it with less, as they are faced with:

- growth in demand for resources and simultaneous constraints on availability;
- greater consumer advocacy and expectations of accountability;
- increasing need and drive for higher education institutions to become integral parts of their communities while learning how to specifically meet community needs; and
- an evolving policy domain shaping and redirecting higher education goals and initiatives.

GROWING MOMENTUM FOR PUBLIC ACCOUNTABILITY

Finally, the role of public accountability in American society across a range of issues—from school choice to profit-rewarded health care—is increasing, as the power of market forces to inform public decisions becomes more evident. This trend has spurred a number of efforts to educate consumers across a range of issues and participate more actively in decision-making. Accreditation must be reconsidered in light of these changes.

Issues of accountability are particularly charged when the multiple aims of accreditation work at cross-purposes. Accreditation's goals include protection of the public, assurance of quality, consultation, and professional protection; yet these objectives are not always consistent with each other. The true challenge for accreditors is to demonstrate that it can and does serve all four of these purposes simultaneously.

Changes in the environment pose not only threats but also opportunities for accreditation. Because the health services system needs a more diverse and innovative workforce, professional bodies have an opportunity to step up to the plate and develop new tests for emerging competencies. This is one way of ensuring high standards of quality that are in the public's interest.

Likewise, labor markets that move worldwide will need proxy measures of quality. U.S. standards serve this function now, but they are poorly positioned to become the dominant measuring stick for the world and they need to be aggressively redefined.

Finally, intellectual competence is already being transferred electronically. It seems unlikely that the federal government will regulate these exchanges, but here again a professional body (or bodies) that brings the power of peer review to this process could be well positioned to capture and direct what develops in this arena.

LOOKING TO THE FUTURE

In rethinking accreditation, the accreditation community must face the challenge of responding to rapidly changing global, health care, and higher education environments. Accreditors must work actively with key stakeholders to reinvent accreditation as a meaningful and valuable process in higher education. They must adopt a leadership position in these discussions to effect positive change. Following is a discussion of the Task Force's recommendations for the accreditation community to meet the challenges of the future.

PART III RECOMMENDATIONS

This report specifically addresses the accreditation of health professions education. However, many of the recommendations and strategies are relevant across the range of specialized and professional accrediting agencies, and may also have some relevance for regional accrediting agencies. Our hope is that this report can stimulate dialogue and action throughout the accrediting community.

Accreditation must be a value-added activity focused on assessment and improvement of educational programs. Through discussions with multiple stakeholder groups, the Task Force identified four major issues facing accreditation:

- need for a simplified process,
- development of, and transition to, an improvement process,
- creation of closer linkages with clients and customers, and
- use of generic benchmarks or standards.

These issues formed the basis for developing a set of core recommendations. The major challenge that confronts the community of stakeholders concerned with accreditation is to create a process that is responsive to the changing needs of society and communities of practice. To do this will require an environment conducive to the following five recommendations:

Recommendation 1: Educational institutions, programs, and accreditors must recognize their shared responsibility for responding to the changing needs of the public, employers, professional bodies, and students.

Recommendation 2: Educators and accreditors must work together to foster an organizational culture centered on educational assessment and improvement that promotes necessary change in educational processes at the institutional level.

Recommendation 3: Accreditation must reward innovative methods to enhance efficiency, minimize waste and duplication, and streamline assessment processes.

Recommendation 4: All specialized and professional accrediting agencies should adopt a consistent approach to accreditation that uses five common criteria and one profession-specific criterion (these are referred to as the "5+1 criteria").

Recommendation 5: Accrediting agencies must continually review their own accreditation programs and make improvements to ensure that they respond to stakeholder needs.

Each of these five recommendations has implications for the two principal partners in the accreditation process—the accreditor and the educational program seeking accreditation.

PUBLIC RESPONSIBILITY

Recommendation 1. Educational institutions, programs, and accreditors must recognize their shared responsibility for responding to the changing needs of the public, employers, professional bodies, and students.

Health professions educators view accreditation as a mechanism that helps to ensure the preparation of new health professionals for relevant practice. When accreditation does this, it is successful; when it does not, perceptions of its irrelevance increase. Accreditors can participate in developing broad competencies for practice by working with educators, professional organizations, and employers and assessing changing practice needs on an ongoing basis.

There is a pressing need to rethink accreditation as an integral part of a larger system of program review, improvement, and regulation. Presently, there is a good deal of overlap and duplication among various components of this system (professional regulation, individual licensure and certification, organizational accreditation, peer review, state review, etc.). More active dialogue and effective working partnerships across these components are essential to reframe accreditation as a valuable process.

New strategies for accreditation might lead to an assessment system that accommodates the current realities of a resource-constrained environment and uses limited amounts of data wisely. This system would be based on an understanding of the systems of education and accreditation, acknowledge inevitable variation, and foster innovation and creativity. The goal is not to denigrate the many positive aspects of accreditation as it exists today,

recognizing the individual strengths of many accrediting organizations, but to build upon the collective wisdom of the entire accreditation community so that accreditation can be a more effective force in promoting the quality of higher education.

Public accountability is a core value of the accreditation process, and accreditation can serve as a basic linkage between the educational process, the changing health care system, and the changing demands of the public, employers, professional bodies, and students. Accreditation must ensure that new health professionals are prepared sufficiently for relevant practice. Accountability will best be accomplished by:

- creating a process that engages educators, employers, and professionals in establishing broad competencies needed for practice;
- making or collecting frequent and collaborative assessments of the ongoing needs of practice and employers in a way that identifies specific competencies;
- developing formal processes that assess these needs and their relationship to successful practice;
- evaluating existing accreditation standards in accordance with how they encourage educational programs to achieve results that meet those needs;
- evaluating student achievement in light of those needs;
- creating threshold levels of performance by educational programs; and
- creating three-way mechanisms facilitated by accreditors for establishing competencies by educators, professional organizations, and employers.

In addition, the federal role in the accreditation process needs to be redefined to ensure an appropriate focus. Considerable concern was expressed, for example, several years ago when the federal government proposed using accreditation status as a proxy performance measure related to student loan default rates. Most members of the accreditation community found this measurement relationship without justification, and feared the implications of using accreditation decisions as a basis for disbursing federal funds. Although the evaluation inherent in accreditation may be of value to the federal government for decision-making, direct linkage to issues where accreditation is only one or an indirect factor does not reflect the true role and value of the accreditation review.

The broad strategies for achieving shared responsibility for accreditation are as follows:

- establish broad competencies needed for practice through a collaborative approach among educators, professional organizations, and employers, and an ongoing assessment and integration of changing practice needs; and
- integrate the accreditation process into a larger system of program review, improvement, and regulation. Reduce overlap and duplication of effort where possible in professional regulation, individual licensure and certification, organizational accreditation, peer review, state review, etc.

Specifically, strategies for accreditors include:

- require that educational programs establish effective linkages with their stakeholders, including the public, students, employers, and professional organizations; and
- require programs to define and measure achievement of competencies for professional practice.

For educators, the strategies are:

- establish effective linkages with stakeholders, and regularly seek their input about the effectiveness of educational programs in meeting stakeholder needs;
- define and measure student achievement of competencies for professional practice; and
- evaluate students' achievement of threshold performance levels, and make program improvements to assure students meet or exceed these levels.

ASSESSMENT AND IMPROVEMENT

Recommendation 2. Educators and accreditors must work together to foster an organizational culture centered on educational assessment and improvement that promotes necessary change in educational processes at the institutional level.

Accreditation should drive continuous, systematic improvement in educational institutions and programs. Commitment to continuous improvement should be part of the culture of health professions education, and processes related to accreditation should be integrated into everyday activities rather than conducted periodically as burdensome, externally imposed mandates. Self-assessment would then take on new

meaning as a part of routine planning, delivery, evaluation, and improvement of academic programs—a process of "intentional improvement" that is part of daily work, rather than an occasional response to external mandates (Gelmon, 1997). As a result, new learning opportunities would be stimulated, and accreditation would be the core of an evaluative system for education and learning.

The "Model for Improvement" proposed by Langley, Nolan, and Nolan (1994) provides a framework to gain and apply knowledge for the improvement of a wide variety of endeavors. It consists of three fundamental questions derived from the work of Deming:

- Aim: What are we trying to accomplish?
- Current Knowledge: How will we know that a change is an improvement?
- Cycle for Improvement: What changes can we make that will result in improvement?

Accreditation should recognize the changing demands for health services and for health professionals to practice in those services. Thus, the aims of accreditation must be articulated in consideration of the student, the consumer, the community, and the relevant practicing health professionals. That means responding to many of the criticisms raised in this report, including costliness, duplication, excessive focus on inspection, limited opportunity for innovation, and redundancy of work processes.

Recasting accreditation as a systematic improvement effort will require a cultural shift for many accreditors and the programs they accredit. Well-designed and executed assessment programs, either in preparation for accreditation or as part of routine program monitoring, will yield information about the strengths and weaknesses of academic units and the relationships among structures, processes, and outcomes (Gelmon and Reagan, 1995). That information will help programs identify opportunities for improvement, deal with challenges, revise goals, and wisely allocate resources.

How will educators and accreditors know that a change is actually an improvement? Consumer satisfaction—with the definition of consumers including students, community members, institutional administrators, faculty, professional leaders, or other concerned individuals and groups—is one critical measure. A second measure might relate to external perceptions of accreditation and how both critics and supporters of accreditation view a specific change. Generally, the effectiveness of a change will be judged by its measurable or at least perceivable impact. Perhaps the most positive impact would be the engagement

of individuals in self-assessment on a routine basis and the perception of accreditation as a value-added activity that enhances rather than compounds their work.

Finally, what changes can be made that will result in improvements? There are many possibilities for change, but they will require new ways of thinking about evaluation in higher education and about how all educators approach their daily work. These changes will challenge the current system, and will demand that leaders in higher education, including accreditors and their key stakeholders, begin to operate more flexibly.

This recommendation for assessment and improvement may be accomplished by a variety of strategies. In general, these are:

- articulate accreditation in the context of current practice and the anticipated future directions; and
- commit to making continuous improvement a part of the everyday culture of institutions and programs.

For accreditors, strategies include:

- collaborate with educational institutions and programs to help create a culture where improvement is intentionally planned and directed, and where processes that support accreditation are part of routine and ongoing daily work;
- make program review a lever for educational change by requiring that programs have processes in place for continuous self-assessment and improvement; and
- expand the professional training of site visitors to improve their program evaluation and consultation skills.

For educators, this recommendation suggests the following:

- collaborate with the relevant accrediting agencies to build a "culture of evidence" that facilitates continuous assessment and documentation of student and programmatic outcomes, as well as the impact of various educational initiatives on students, faculty, the institution, the profession, and the community; and
- take prompt action on accreditation recommendations to stimulate change and improvement.

INNOVATION AND EFFICIENCY

Recommendation 3. Accreditation must reward innovative methods that enhance efficiency, minimize waste and duplication, and streamline assessment processes.

The cost of accreditation today may well have surpassed its value. Consumers of accreditation—education, practice, the community, the health services system—all have to bear this heavy cost. Accreditation should promote more efficient use of limited resources; unfortunately, accrediting agencies generally have proved averse to testing innovative solutions that could reduce costs and streamline processes.

Streamlining the accreditation process is a critical challenge; one way to achieve this is for the accreditation community to agree upon a set of common data elements for collection across academic programs. A common data set would reduce preparation time for programs and institutions. Self-study would be less burdensome with the creation of common data collection procedures, especially those that use electronic communication. Examples include on-line self-studies, central data banks of key data elements, and electronic submission of self-study reports. New, resource-conserving technologies such as electronic mail offer considerable opportunities to increase flexibility and responsiveness.

In addition, accreditors should focus their site visits, possibly limiting their use to initial accreditation reviews or in response to defined threshold triggers. This approach requires accrediting agencies to define the purpose of their site visits as either consultative or for compliance assessment. Reviews should be scheduled so that they truly address quality issues, not according to an externally imposed timetable. In addition, accreditors should emphasize opportunities for and the benefits of constructive consultation.

Unfortunately, an inspection mentality dominates many accreditation systems. Yet lists, numbers, and quantitative measures may tell little about quality. Frequently, data are collected out of habit. Accreditors should focus their assessment process on the articulation of goals, objectives, and desired outcomes from which measures could be developed and relevant data elements identified. The act of measurement itself can be a trigger for improvement, bringing the work of routine assessment in line with the collection of information necessary for accreditation.

There must also be a shift in attitude to allow — and perhaps encourage — limited innovation and experimentation that will not compromise a program's accredited status.

Improvement efforts may require time to test changes and demonstrate their effects. Yet the current accreditation system discourages experimentation because the possible consequences of failure — for programs, professional stature and eligibility for federal funding, and for students, professional certification for licensure — are so dire. The inability of accreditation to accommodate innovation in turns limits the ability of programs to develop new methods and models.

Any major change in the operations of accrediting agencies will require them to be more flexible. For example, attempts to standardize data collection will need to accommodate varying levels of technological expertise and resources among different academic units. Similarly, considerable debate arises about the value of site visits. Although they are viewed as expensive and organizationally challenging, the merits of a well-conducted consultative site visit may be great.

General strategies for this recommendation on innovation and efficiency include:

- accreditors and educators should collaboratively investigate alternative mechanisms for self-assessment and performance improvement (such as the national Malcolm Baldrige performance assessment framework or the various state quality initiatives) and consider allowing experimentation with such frameworks as options to existing accreditation approaches; and
- institutional leaders should commission studies (perhaps funded by the national higher education policy organizations) to identify best practices for enhancing efficiency and minimizing waste and duplication in accreditation and other internal assessment mechanisms.

The strategies for accomplishing this recommendation may be framed as follows for accreditors:

- reward innovations that contribute to efficiency;
- streamline the accreditation process to increase accountability and minimize duplication and waste (including content of reporting, frequency of visits, and other redundant activities);
- restructure site visits as focused reviews, emphasizing opportunities for constructive consultation; and
- increase flexibility and responsiveness by integrating new, resource-conserving technologies into the accreditation process.

Educators should consider these strategies:

- work collaboratively with groups of educators, professional associations, regulatory bodies, and accrediting agencies to adopt common review mechanisms, schedule simultaneous site visits or program reviews, and determine other mechanisms to enhance efficiency and reduce rework;
- seek support to develop and test new ways of using electronic information management and communication for programmatic self-assessment, reporting, and monitoring; and
- collaborate with others to explore other resource-conserving methods that will enhance internal operations as well as reporting to external agencies.

THE "5 + 1 CRITERIA" APPROACH

Recommendation 4. All specialized and professional accrediting agencies should adopt a consistent approach to accreditation that uses five common criteria and one profession-specific criterion (these are referred to as the "5+1 criteria").

Accreditors are challenged to demonstrate the relevance to society of what an academic unit is or does. Traditionally, the focus has been on single disciplines and programs, but it will become increasingly important for accreditation in any field to use an approach that bridges disciplines and academic programs. The Task Force recommends that specialized accrediting agencies adopt a single comprehensive but consistent and flexible model that uses five common criteria or standards, supplemented by one standard specific to the particular profession. The common criteria would require that all educational programs:

- work closely with their practice communities and the public to prepare a workforce that can respond to and meet community assets and needs;
- provide appropriate, periodic, and ongoing faculty development and evaluation;
- regularly assess the competencies and achievements of students and graduates;
- have in place an effective process of continuous self-assessment, planning, and improvement; and
- inform and accurately represent themselves to their public(s) to ensure accountability and consumer choice.

Each accrediting agency would develop one additional criterion relevant to the profession at hand. The "+1" criterion might relate to the nature of practice (such as dentistry, medicine, or physical therapy), the role of the provider (such as primary care provider, team member, or specialist), or the defined scope of practice (such as the differentiation of the various nursing credentials as points of entry to practice). Agencies will need to be careful not to overload the "+1" criterion with other profession-specific content, keeping in mind that the goal here is an efficient, streamlined approach.

Today, evaluative criteria vary markedly among accrediting agencies. As a result, so do their data collection requirements and procedures. The Task Force reviewed most of the accrediting standards of specialized and regional accreditors (Berkman, Thomsen and Gelmon, 1998). The findings illustrate the continuing dependence on data—reams of paper, pages of tables, and uncertain utility of this information. Examination of the data items suggests the following questions:

- What difference does it make to have a particular piece of information?
- How much effort is required to collect it?
- Will it be used?
- What does it really mean?

Data collected for accreditation should be directly related to the evaluative criteria. However, they also should be directly related to and used for routine program assessment and improvement. Academic units collect extensive data, present them in various formats in accordance with the requirements of the accrediting, evaluating, or regulating entity, and then seldom revisit the information. Logically, academic units would collect and update this information regularly and use it for routine program monitoring, evaluation, and improvement. Yet this rarely happens.

Accreditation agencies should coordinate their data collection needs and streamline their formats to create a unified information base at each university from which the data necessary for all accreditation reviews can be extracted. All accrediting agencies would collect comparable data, use common forms, and share databases. Ultimately, professional judgment is the basis for determining the relevance of information to programmatic assessment. The core standards across all accreditation reviews would be standardized in format for input, data analysis, and output. This approach would reduce the reporting burden for institutions and programs and improve their overall satisfaction with accreditation.

The specialized accrediting community has responded favorably to this idea, recognizing the economies and efficiencies that it offers. However, implementation of this concept will not be simple. First, institutional and specialized accreditors will need to collaborate. This proposal will also entail some short-term risks, and it will require funding to support a series of carefully designed pilot experiments.

In developing new educational programs, faculty and professional leaders often look to accreditation criteria for guidance on how best to design them so that accreditation can be achieved. Elements that are not part of the criteria may be ignored or neglected. During a periodic review, programs generally invest their energies in responding to what is explicitly stated in the criteria—not to what is not stated.

The major strategy for implementing this recommendation is to foster agreement among stakeholders on how to develop and apply consistent accreditation criteria. Specific strategies for accreditors include:

- focus criteria on the knowledge and skills to be gained through professional preparation for practice;
- adopt and implement these five common criteria to allow collection and tracking of comparable data across institutions and programs;
- develop one profession-specific criterion in conjunction with key stakeholders that reflects the unique aspects of that profession (both knowledge and practice); and
- commit to requiring only those data that are relevant to the 5+1 criteria.

Strategies for educators include:

- ensure that programs define at the outset the outcomes that students are expected to achieve as learning objectives, and that they frame these objectives in behavioral terms (knowledge, skills, competencies);
- work closely with professional associations and regulatory bodies to ensure that these learning objectives and projected outcomes incorporate professional competencies for entry into practice as defined by relevant professional groups;
- collaborate with accreditors to determine the specific implications of the 5+1 criteria for individual educational programs; and
- exchange and manage common information across multiple educational programs and institutions.

SELF-ASSESSMENT

Recommendation 5. Accrediting agencies must continually review their own accreditation programs and make improvements to ensure they respond to stakeholder needs.

Accreditors need to look in the mirror and hold themselves to the same level of self-assessment that they demand from the institutions and programs they evaluate. Almost all health professions education accrediting organizations are recognized by the U.S. Department of Education (USDE) and by the Council on Higher Education Accreditation (CHEA). Yet the processes that accreditors undergo in preparation for periodic review by both of these organizations are similar to those applied in their own accrediting programs. Extensive effort is committed periodically and the required documentation is submitted, with little ongoing self-assessment.

Within individual professions, stakeholders must collaborate and develop new agendas for improvement. Within the accrediting community, groups such as ASPA and CHEA can offer support and leadership to build new knowledge and develop the leadership capacity that accrediting organizations need to implement this recommendation.

In particular, accreditors are encouraged to pursue the following strategies:

- learn all there is know about their own accreditation processes and practices, and engage in continuous self-assessment and improvement of their activities;
- make needed changes promptly to improve effectiveness;
- show responsiveness to the educational programs that they accredit by improving their efficiency and the user-friendliness of their products and services;
- develop professional training programs for their evaluators to ensure that they have the necessary skills and knowledge to conduct accreditation reviews that actually add value; and
- regularly seek feedback from educational programs and other customers on how to improve their work.

In turn, educators are encouraged to pursue the following:

- collaborate with accreditors to offer constructive suggestions for improving accreditation processes and practices that respond to professional, programmatic, and public needs; and
- respond promptly and frankly to requests from accreditors for feedback about programs, procedures, and activities.

STRATEGIES FOR TIMELY CHANGE IN ACCREDITATION

To effect change in accreditation, it will be necessary to identify leverage points within the professions and within higher education. Faculty members are often resistant to change; most perceive the preparation for accreditation as a major burden and a distraction from more important work. Accreditors should identify key leverage points in much the same way as the Joint Commission on Accreditation of Healthcare Organizations was able to when it first initiated its "Agenda for Change" in the late 1980s. Issues of public accountability, resource utilization, faculty roles and rewards, and/or new models of curriculum and teaching/learning could all prove valuable foundations on which to build new models of accreditation.

Innovation in accreditation will require partnerships among key stakeholders. The professions, the faculties, the professional societies, the students, and the customers of future graduates share responsibility for cooperatively defining what is necessary for professional education, determining educational models that will meet those needs, and then structure a responsive accreditation process. The accrediting agency needs to embrace these multiple perspectives in order to carry out its mission effectively.

Accreditation agencies are not independent in the development of standards and procedures; however, independence is essential in the processes of evaluation and decision-making. Accreditation should reflect education and practice needs, considering what is best for the health of the community and how professional education can improve it. Its role is not to issue mandates in isolation from stakeholders.

Accreditation as it has developed in this country emphasizes specialized, self-interested perspectives that validate discipline-specific bodies of knowledge and professional skills. Professionalization in and of itself is positive; however, many of the professions could identify and build upon their similarities, aspirations and challenges to work together to achieve specific desirable outcomes. Accreditors must feel empowered to assume the responsibility to lead this change, and be willing to take risks in experimenting with new models of accreditation.

Funding should be sought to organize a series of demonstration programs with selected agencies experimenting to implement the principles of accreditation advocated in this report. At the same time it will be necessary to offer leadership development for the decision-makers in accreditation — both the agency executives and those who chair and manage the individual accrediting commissions.

Accreditors might also consider using a set of change concepts recently introduced into the improvement literature by Langley et al. (1996). These concepts are intended to provoke new ideas, new methods, and new approaches. By themselves they do not suggest the improvement strategies. Rather, they can serve as the basis to assess accreditation and to generate ideas for changes which will result in improvements. Several of these concepts are presented below, along with an example of a change relevant to accreditation.

- focus on the product or service—differentiate product using quality dimensions
- eliminate waste—reduce controls on the system
- manage time—reduce setup or startup time
- manage variation—stop tampering
- improve work flow—move steps in the process closer together
- enhance the producer/customer relationship—focus on the outcome to customers
- optimize inventory—reduce multiple brands of same item

These change concepts can stimulate thinking about improvement to focus on feasible opportunities for change. Accreditors can benchmark their efforts for change and improvement against other industries where such efforts have been successful, learning from experiences in other contexts and applying the lessons in a manner relevant to their specific activities. Change is possible in accreditation, but a groundswell of commitment is needed to stimulate change that is forward-thinking and self-motivated.

CONCLUDING REMARKS

Change is often frightening. Today, the accreditation community is faced with the choice of leading, embracing, and shaping change or being swept away by it under the direction of outside forces. Clearly, the better alternative is to create a culture of innovation and self-improvement that will benefit not only accreditors but also higher education in general.

Innovation in accreditation can be achieved by taking concerted action to change the accepted way of operating. Langley et al. (1996) offer some strategies for stimulating innovation that may be useful for accreditors and other stakeholders to adopt:

- **Challenge the boundaries.** Real reform of accreditation will occur when boundaries and barriers are expanded or eliminated through creative new methods and approaches.

- **Rearrange the order of the steps.** The process of accreditation should be broken down into its component activities, and then serious consideration given to reordering the process of these activities to identify opportunities for change.

- **Look for ways to smooth the flow of activities.** Multiple hurdles and obstacles appear throughout the accreditation process; it will be necessary to identify mechanisms at both the level of the local program and the accrediting agency itself to improve, streamline, and smooth the flow.

- **Evaluate the purpose.** For the most part, the process of accreditation has not been questioned or evaluation. A careful examination of the reasons for specific inputs, processes, and outputs may reveal steps that can be eliminated.

- **Visualize the ideal.** Accreditors and those being accredited should engage in discussions about the ideal future for accreditation. They should consider whether health professions education could exist without specialized accreditation, articulate the true value of accreditation, and define the ideal system for making it operational.

- **Remove "the current way of doing things" as an option.** If the current system is no longer considered viable, no choice remains but to identify new ways to conduct accreditation. Exploring such alternatives will generate concepts and methods that will be more suited to the purposes for which accreditation was designed.

Creating a culture of innovation will shift the emphasis of accreditation. The Task Force's recommendations were developed with this goal in mind. Actions will need to be considered, plans developed, strategies refined, and new ones embraced as they emerge.

Much work remains to accomplish substantive reform in accreditation. The Task Force challenges the accrediting community, in partnership with educators, practitioners, and other key stakeholders, to assume a leadership role in making positive and productive change.

PART IV PAPERS ON RELATED ISSUES

The following papers reflect a series of issues that are important to accreditation but that were not covered in the preceding discussion. They are presented here with opportunities and recommendations for action.

One or more Task Force members wrote each paper, and all Task Force members were invited to review and comment on the papers. The views expressed in these papers are those of the authors and do not necessarily reflect the consensus of the Task Force, the Pew Commission, or the organizations represented by the Task Force members.

The papers are:

- CHALLENGES FOR ADMINISTRATORS James R. Kimmey and Roger J. Bulger
- PROLIFERATION OF NEW HEALTH PROFESSIONS AND ACCREDITING BODIES John E. Trufant
- THE COLLABORATIVE IMPERATIVE Steven D. Crow
- COMPETITION AND DUPLICATION IN ACCREDITATION Janis P. Bellack
- THE INFLUENCE OF ACCREDITATION POLICIES ON FEDERAL FUNDING FOR HEALTH PROFESSIONS EDUCATION AND TRAINING: THE ROLE OF THE BUREAU OF HEALTH PROFESSIONS Bernice Parlack and Neil Sampson
- COLLABORATION BETWEEN INDUSTRY AND HIGHER EDUCATION John P. Evans
- THE INCREASINGLY GLOBAL CONTEXT OF AMERICAN HIGHER EDUCATION Carol L. Bobby
- GOVERNANCE OF ACCREDITATION AGENCIES Catherine Thomsen and Sherril B. Gelmon
- CONSENSUS ELEMENTS OF COMMON ACCREDITATION CRITERIA: THE RESULTS OF A DELPHI PROCESS Catherine Thomsen, Carol L. Bobby, and Sherril B. Gelmon

CHALLENGES FOR ADMINISTRATORS

James R. Kimmey and Roger J. Bulger

Competition for good students in undergraduate and graduate education is increasing, as academic institutions come under mounting pressure to attract the best students from a limited pool. Well-documented trends within higher education include spiraling financial aid, resulting in steeper discount rates; greater investment in market research and advertising; and preoccupation with so-called rating systems advanced by national magazines that are heavily weighted toward selectivity and average GPAs and test scores. In this emerging higher education market, external validation of academic programs, both for currency of content and quality of instruction, is more important than ever. Demonstrating quality through accreditation is a key component of any institution's overall strategy for presenting the most positive possible face to potential students, their families, and employers.

But the costs associated with the many, often overlapping activities required for accreditation can be overwhelming, particularly from the perspective of institutions with specialized programs. Regional and institutional accreditation is a well-established necessity, but it is only a beginning — multiple specialized and professional accrediting bodies that focus on specific schools or programs also come into play. Generally, the activities of these bodies lack any coordination, adding significantly to the costs of accreditation for institutions. Some of these costs, such as application fees and costs of site visits, are direct. Other costs, such as time spent by faculty and staff for review preparation, are indirect.

Accrediting bodies only occasionally share information or accept information prepared for other agencies. Each accrediting body wants even the most basic data submitted to it in a specific format. Few utilize modern technology effectively. As a result, institutional administrators frequently view accreditation as a labor-intensive but unavoidable process of questionable value.

The higher education community is already under considerable pressure to rein in escalating costs. Institutions are re-engineering their internal processes to eliminate redundancy and increase efficiency. They are putting outside vendors and contractors under the microscope to ensure that their products and services represent good value. Accreditation will not escape this scrutiny. To the extent that institutions perceive accreditation as a wasteful and inefficient service that provides low value, they will deal with accrediting agencies as they would other service providers.

Accordingly, the accreditation community should take it upon itself to improve the quality and efficiency of its services and become more consumer-friendly. From the perspective of the institutional administrator, there are several specific actions that accrediting bodies should undertake—sooner rather than later.

Make accreditation a more cost-efficient process. There is a very high degree of overlap in the information required by regional and specialized accreditation bodies for self-study documentation. Each of these bodies has its own formatting requirements; for academic institutions, that means re-keying or re-ordering the information to meet those specifications. Streamlining those data requirements and agreeing on a standard format for submitting information would be a great boon to institutions. In addition, specialized accrediting bodies should focus their documentation requirements on the programs they are evaluating and keep their institutional information requirements to a minimum. Ideally, regional accreditation should be accepted as de facto evidence that the institution has a mission, strategies, affirmative action programs, an adequate library and learning and teaching resources, and a faculty governance structure. At the very least, this information could be incorporated by reference into a specialized self-study.

Commit to better use of existing technology for enhancing the efficiency of the accreditation process. This is an area where accrediting bodies could lead by example. Accreditors usually include criteria relating to a program's use of information technology, but they require supporting information in hard copy, which they incorporate into an often-voluminous set of self-study materials for site visitors. Most institutions have the technology to support electronic submission of this information, as well as Internet-based conferencing for team members and institutions. Electronic exchange cannot and should not replace the consultative site visit as a tool. It can, however, help improve the efficiency and the quality of the visit, and reduce costs associated with accreditation.

Train site visitors to be more effective, particularly in consultation roles. The accreditation process is very dependent on the volunteer efforts of faculty and administrators who agree to participate as site visitors. These volunteers come to the site visit with varying perceptions concerning their role and the process. Most institutions perceive self-study and the consultative aspect of the site visit as the most valuable components of the accreditation process. Accordingly, accrediting organizations should provide site visitors with orientation and training that stress this consultative role.

Foster the interactive nature of the process. Site visitors must have a clear understanding of the forces affecting cost, quality, and access for the discipline under review. They should discuss with program administrators what elements are necessary for an adequate program and educate them on relevant workforce needs and demands. Site visitors should also advise administrators of trends in international or transnational accreditation that could affect their programs.

Although these recommendations are largely directed at the accrediting community, a successful accreditation process is a joint venture between an accrediting body and an institution. Institutional administrators can also help make the system work better. Most significantly, they can prepare program administration and faculty to participate more effectively in the accreditation process. Among the materials prepared for the Task Force is an excellent paper by Arthur MacKinney[3] that describes a research-based approach to accreditation. This paper should be widely circulated in both the institutional and the accreditation communities. It provides a model for assessing educational effectiveness through the use of established empirical methods, and should help institutions enhance their understanding of and participation in accreditation activities.

PROLIFERATION OF NEW HEALTH PROFESSIONS AND ACCREDITING BODIES

John E. Trufant

During the past 50 years, the number of differentiated and distinct health fields has increased substantially, with estimates ranging from 50 to nearly 200. Many of these new fields fall into a category called "allied health." Numerous federal reviews and foundation studies of allied health professions have concluded that despite the enormous size of this health workforce, little is known about it—either by the government or by the public at large. Unlike its sister health professions, allied health has grown dramatically with scant understanding about the individuality or collectivity of the health professions. Consequently, allied health has expanded exponentially with relatively little notice.
How did this happen? The factors are numerous and include:

- changes in government reimbursement and private insurance that made health care more available and personally affordable,
- rapid development in new medical treatments and technologies,
- increases in the average life span of Americans,
- relative and recurring shortages and maldistribution in the physician and nursing workforces,
- growth and specialization of medical knowledge,
- the setting of limitations on tasks for given professions,
- the use of health care personnel with less education and training to reduce costs, and
- the growing political influence of professional organizations.

As differentiated work roles developed and as those who filled them received new designations, new fields emerged and the demand for educational and training programs to produce these new workers also increased. In some cases, what started as on-the-job training programs were transformed into certificate requirements and then into associate or baccalaureate degree programs. Following in the successful footsteps of other legitimate health professions, many of these new disciplines determined that accreditation was the path to respectability and independence. Accreditation was also necessary to build quality assurance mechanisms into the system that was now educating and producing new members of their professions.

As the number of practitioners in each field increased, professional societies formed. Those groups that had the acumen and resources worked to establish regulations for certification, licensure, or registration at the state level. In many instances, eligibility for licensure or certification to practice was tied directly to graduation from an accredited program.

As educational programs for new health professions developed, so did new accrediting agencies. During this period of unrestrained growth in the costs of both health care and higher education, the professions had few if any incentives to cooperate with each other in providing accreditation services. In addition, accreditation provided a means for each profession to exert some control over its future. Separate accreditation of the field also created a sense of professional identity and prestige.

Furthermore, as each new field identified the boundaries of its knowledge base, it placed restrictions on who could be considered capable of participating in accreditation, which resulted in even fewer opportunities for developing cooperative approaches to accreditation services across disciplines. Of course, many professions had only a few programs, but this limitation was considered an advantage because their accreditation systems, though perhaps more costly, were also viewed as more manageable and controllable.

For many years, a major force for cooperation in allied health accreditation was the Committee on Accreditation of Allied Health Education (CAHEA) of the American Medical Association (AMA). CAHEA was an umbrella organization for providing accreditation services in many though certainly not all allied health fields. In the mid-1990s, the AMA decided to disband CAHEA, and a new organization was established, the Commission on Accreditation of Allied Health Education Programs (CAAHEP). In response, several large allied health fields, including occupational therapy, medical technology, and nuclear medicine technology, established their own independent accrediting agencies. The result was further proliferation of accrediting agencies. Recently, a new accrediting agency, the Commission on Collegiate Nursing Education, was created in nursing, in competition with the longstanding National League for Nursing Accrediting Commission. Institutions offering nursing programs at the baccalaureate level and higher now have a choice of accreditation programs—an unprecedented competitive dynamic in health professions education.

How has the proliferation of health professions and accrediting agencies affected the institutions and programs that prepare new practitioners? Few efforts have been made to

study this question. For patients and clients, the most pressing concerns have to do with the continuing fragmentation of care among so wide an assortment of practitioners and with patients' and clients' abilities to judge the qualifications of those whose care they seek. For practitioners, the proliferation of professions increases the difficulty of developing team approaches to care. For health care institutions, rising costs and operational inefficiencies have become major problems. Educational institutions face a host of dilemmas, including rapidly changing employment patterns, constantly shifting and increasing entry competencies, lack of adequately prepared faculty, shortages of clinical practice sites, and increasing accreditation costs. State governments must deal with increasing pressures for licensing as well as with the more complicated information systems necessary to track and monitor individuals who receive practice credentials. Professional societies must deal with the economies of small numbers and the isolation of specialization.

It is unclear whether this proliferation will continue. Fewer new professions have been created during the past decade, possibly due to saturation, resource constraints, the multi-skilling movement, and other factors.

However, new accrediting agencies have continued to emerge, sometimes within the same profession. Without strong leadership, this trend may well continue. Most educators would deplore government regulation of accrediting agencies. History has shown, however, that unbridled expansion that produces questionable quality often leads to governmental controls and limitations. It behooves accreditors and academic leaders alike to address the issue of proliferation now. Possible initiatives to reduce proliferation of accrediting agencies include:

- streamline accreditation processes to focus on outcomes assessment and measurement,
- focus accreditation on reporting student and graduate achievement,
- create competitive accreditation agencies so that institutions have options, based on their particular interests and needs,
- create incentives for collaboration among accrediting agencies,
- experiment with multiple approaches to quality assurance, and
- disengage accreditation from licensure and certification requirements.

Accreditation is a highly valued component of American higher education. Parents, students, government agencies, and others place great trust in it. Nevertheless, the proliferation of

accrediting bodies in the health professions that have no relationship to each other is placing ever-increasing burdens on institutions. The costs, in the view of many observers, far outweigh the value and threaten the entire accreditation system. Without question, it is time for significant reconsideration.

THE COLLABORATIVE IMPERATIVE

Steven D. Crow

The sea change in American higher education is fostering new collaboration in the health professions accreditation community. Multiple pressures that reflect heightened concerns about costs and changing workforce demands challenge accrediting agencies to engage in new, cooperative efforts that respond to new patterns of change and that, on a more basic level, recognize the need to establish a new culture of accreditation.

NEW PATTERNS OF COLLABORATION IN INSTITUTIONS AND PROGRAMS

Although higher education might not be as fiscally strapped in 1999 as it was in 1992, financial pressures continue to push institutions toward greater efficiency and higher productivity, as well as increased responsiveness to the needs of students and employers. Unwilling to fund large numbers of program-specific courses, institutions have set out to study, reduce, and even eliminate curricular overlap. While this trend is most noticeable in the general education component of degree programs, it is increasingly evident in some of the "proprietary components" of professional programs as well. Programs that once were almost autonomous now seek common ground in curricular offerings. Many of the pressures for curricular streamlining come from academic administrators who are leading restructuring and re-engineering endeavors. Their success, however, rests heavily with faculties that recognize curricular inefficiencies and move to address them.

Financial pressures also have made institutions, and the people in them, responsive to external needs. Collaborative efforts are often shaped by an institution-wide commitment to respond to new educational needs — either those of employers or of new student clienteles. In the rapidly changing health care environment, responsive institutions create new packages of skills for particular settings and, in the process, they cross disciplinary and professional training boundaries. As licensure requirements change, professionals desiring further certification or specialized training and paraprofessionals seeking new entry points into the profession need institutions and programs that offer creative ways to meet those needs. Collaboration among programs frequently is necessary. Forward-looking faculty and administrators have moved to develop interdisciplinary or cross-disciplinary programs and courses with the aim of training health professionals who have the flexibility and multiple skills needed to navigate rapidly changing job markets.

Higher education institutions are finding that not only do they need to foster collaboration among their own programs and departments but they also need to work more productively with each other. Shared development of library resources is one example of this type of approach; it has worked for nearly three decades. Now institutions are also finding that faculty, courses, and courseware can be shared to the benefit of all participants. Some collaborative arrangements involve the moving of students among consortium partners, while others call for shifting faculty and courses. An increasing number of shared endeavors build on models of articulation and transfer arrangements that have marked many successful collaborations for decades.

New technologies can provide cost-effective access to expensive programs. Rural Americans might well be more familiar with distance learning programs in health professions than urban Americans. Videotape and interactive television have been used in widely distributed settings and remain viable means of delivering programs for certain health care professionals. In addition, the Internet is rapidly developing into an alternative education delivery system. In a highly competitive education marketplace, these technologies might have the effect of weeding out weaker programs, but they may also strengthen them by tapping into a richer variety of courses or program components than any single institution could afford.

Responsiveness to needs of adult learners, particularly those of professionals and paraprofessionals scattered throughout a state or region, invites collaboration. Local institutions can serve as host sites for institutions delivering a program (witness the 2+2 model found in several states, where a community college serves as the basic instructional site for programs offered by baccalaureate and comprehensive institutions). In some states, the response to expanding service areas is to develop a multi-purpose higher education center open to several institutions that are working together. Moreover, the high cost of producing quality distance education, particularly computer-based courses with high levels of interactivity, appears to be prompting several institutions to collaborate on distance-delivered courses and programs.

Although education of health care professionals has always required collaboration with non-educational entities, such as clinical sites, these relationships are evolving. Campus-based instruction will include significant components of field-based instruction, drawing on the skills and talents of practicing professionals working in various settings, including the training settings of health professional organizations or community-based organizations. Demands for high-quality, technologically mediated instruction will require colleges and

universities to collaborate with courseware designers and providers. It is likely that several for-profit companies will find this a lucrative market, and institutions will enter a variety of contractual arrangements with companies that provide exceptional courseware or other services.

Policy makers and students are demanding greater flexibility and portability in learning achievement, through, for example, more innovative approaches to credit transfers or recognition of competency achievement regardless of how competency is achieved. This issue has the potential to involve institutions and programs as much in credentialing as in instruction, and inevitably will result in collaborative endeavors to recognize learning achieved in settings other than institutions of higher education.

Some observers suggest that health professions education lags behind other professions in embracing many new opportunities for collaboration. But evidence of collaboration in higher education, including health professions education, abounds. Although these collaborative efforts may seem few and far between, they will become more common, and accrediting associations should take note of them.

ACCREDITORS NEED TO COLLABORATE

For the most part, accrediting agencies are responding to this trend by reviewing their accreditation standards. Although institution-based and institution-owned instruction still informs many standards, some agencies are trying to make their standards more flexible and more amenable to institutions and programs that are engaged in collaboration. However, they seem to be doing this work in isolation, with little input from others engaged in this task or from the academic health centers that frequently assist in standards revision.

The history of creative collaboration in accreditation is very short. Many of the resources tapped for accreditation come from volunteers; in this way, accrediting agencies can operate on shoestring budgets with relatively small staffs. But in times of rapid change, these staffs have neither the resources nor the energy to reflect, develop long-term strategies, and collaborate with others. In addition, accrediting agencies tend to approach change with caution. This seems to be particularly true in the health professions, where so much change has occurred in recent years.

Collaboration, especially in uncharted territories, can be daunting. However, unless accrediting agencies step boldly into the changing worlds of both higher education and health professions education, they risk losing their credibility and authority.

Some minimal expectations for collaboration are clear. The first expectation comes from the institutions of higher education in which accredited programs are located. They demand that accrediting activities at the very least support current institutional and program commitments to continuous improvement. Accrediting activities that are out of sync with or add unnecessary costs to institutional programs for quality improvement and planning fail the test of collaboration with institutions. Accreditors need to recognize the relationship between these institutional efforts and the objectives of accreditation—and, indeed, foster that relationship. A significant step forward in that area would be a consensus among all accrediting agencies on a common institutional data set.

A second expectation comes from a broad community of stakeholders in higher education, and particularly in health professions education. The educational marketplace demands systems of quality assurance that provide useful, dependable, and consistent information about student achievement. Greater openness is expected and new opportunities for involvement are desired. The educational industry must not appear to be more concerned with protecting its interests than with assuring educational programs that equip students to be productive professionals. By cloaking accreditation processes with confidentiality and limited disclosure, accreditors open themselves to charges of self-interest.

Accreditors face two important challenges that require collaboration. The first challenge is to restructure accreditation processes so that they complement rather than interfere with institutional and program cycles of evaluation and planning. In other words, accrediting agencies must develop and implement new strategies of accreditation that are more institution- and program-friendly. Collaboration to define essential documentation is necessary; collaboration to spell out self-study processes and improve the impact of on-site visits is desirable. The development of cooperative relationships among specialized agencies in the health care professions should be a high priority, and these agencies should demand cooperation from institutional accrediting agencies as well.

The second challenge is to create a new culture of accreditation that places students and their learning at the center of accrediting activities. No single agency, no matter how large or small, will be able to transform this culture on its own. Ultimately, successful collaboration depends on agreement within the accrediting community to foster this new culture.

Perhaps the new Council for Higher Education Accreditation (CHEA) will prove to be the agent of change. Through its programs, CHEA can call on agencies to address the need for

new approaches to accreditation. However, leadership could as readily emerge from the Association of Specialized and Professional Accreditation (ASPA) or from the Council of Regional Accrediting Commissions (CRAC). Regardless of who leads the effort, accrediting agencies must be learning organizations, and they must be supported by groups and agencies that are committed to the openness and receptivity required of such organizations.

COMPETITION AND DUPLICATION IN ACCREDITATION

Janis P. Bellack

For a number of years now, colleges and universities have grappled with issues of competition and duplication in their institutional missions and academic programs amid increasing pressure to boost revenues and justify their costs. The accreditation community, however, has been largely immune from such competition, leading to a virtual monopoly by both regional and specialized accrediting agencies. In fact, the notion of competition in accreditation has long been eschewed by accreditors and oversight agencies in the belief that the accreditation process should remain untainted by market forces. Consequently, accreditors have been able to offer their services as sole source agencies unhampered by a need to compete for business. Without at least two independent parties working to secure the business of a third party by offering the most favorable terms, competition (and duplication) cannot exist. In the absence of competition, the sole providers of accreditation services are free to exercise complete control of the accreditation market in a particular field or region. How did this system of sole source accreditation arise?

BACKGROUND

In the first half of the 20th century, the proliferation of accrediting agencies and associations prompted a need for a coordinating body to oversee and control the expansion of specialized accreditation (Blauch, 1959). In response, the National Commission on Accreditation (NCA) was established in 1949 as the coordinating agency for higher education accreditation. The NCA's operating principles spelled out that the regional associations would deal only with professional accrediting agencies that were recognized by the NCA and, in turn, that the NCA would recognize only one agency in a given field of professional study. The expressed intent was to prevent competition and duplication of effort in specialized accreditation, and thus assure a single set of standards by which all programs in a particular field of study would be judged. The NCA also contended that having one set of standards and a single hallmark of approval for each profession made it easier to establish a program's credentials to the public. However, the NCA's policy also ensured that the regional and specialized accrediting agencies would be able to operate free of competition, and concentrated control of and decision-making authority for accreditation within a single agency in any given field.

Over time, the number of specialized accrediting agencies proliferated as individual health professions split into subspecialties, and as the specialty fields matured and pushed for control and administration of their own accreditation standards and processes. As new agencies were created, their respective professional sponsoring organizations proved successful in also linking eligibility for licensure to graduation from an accredited program, thereby strengthening their professional gatekeeping role, preventing competition and duplication, and assuring their status as the sole accrediting body for the profession.

This long-standing practice of recognizing a single agency for a given professional field remained intact until 1992. That year, the revised Higher Education Act (HEA) gave the U.S. Department of Education (USDE) expanded regulatory and oversight powers. The new USDE regulations did not preclude recognition of more than one accrediting agency in a given profession, and thus opened the way for competition in professional program accreditation.

Outside the health professions, business schools provide an example of competition in program accreditation. Until the late 1980s, the American Assembly of Collegiate Schools of Business (AACSB) was the sole accrediting agency for business education programs. Of its approximately 650 member departments, schools, colleges, and institutions, fewer than half had been successful in achieving accreditation. Critics charged that the AACSB's "one-size-fits-all" application of its accreditation criteria regardless of institutional mission and context was inappropriate for many business education programs. For example, under the AACSB's criteria, programs in colleges and universities whose primary mission was teaching were held to the same research productivity standards as programs in research universities. Dissatisfied with the process, a group of non-accredited business programs representing smaller and non-traditional institutions pushed for the development of a second agency, the Accrediting Commission on Business Schools and Programs (ACBSP), which was established in 1989 to provide an alternate avenue for earning accreditation.

The advent of competition from a second agency prompted the AACSB to commission a "clean sheet" revision of its accreditation process to achieve greater flexibility in adapting criteria to the unique mission of the program seeking accreditation. Presently, both accrediting agencies offer accreditation services to business education programs, although the ACBSP typically accredits programs in smaller institutions, including those in two-year community colleges. Thus, in a sense, each agency has carved out a market niche within business education, and programs choose the agency that best fits their mission.

While competition in this case led to greater responsiveness by the established accrediting agency, there is some evidence that it also created a two-class system of accreditation.

Within the health professions, the Commission on Accreditation of Allied Health Education (CAAHEP), the largest specialized accrediting agency in the U.S., weighed in on another scenario involving competition. In the early 1990s, a schism within the respiratory therapy professional community resulted in a proposal to create a second accrediting agency and allow schools and programs to choose between an established agency and a proposed alternative. During the process of defining a second and competing "committee on accreditation" for respiratory care programs, CAAHEP — the parent agency — voted that only one "committee on accreditation" would be recognized by the agency, thus preserving the policy of recognizing a single accrediting agency for a given health profession. In the process, however, changes were made in the accreditation process for respiratory therapy programs that addressed the dissenters' concerns. In this instance, CAAHEP — itself an umbrella accrediting agency for 17 allied health professions — clearly acted to prevent competition and duplication of accreditation services for programs within its domain, thus preserving their established control as gatekeepers in the allied health fields.

A CASE EXAMPLE OF NURSING

Nursing provides the most recent case example of a challenge to the long-held tenet of monopoly in profession-specific accreditation. For more than 40 years, the National League for Nursing (NLN) was the sole recognized accrediting agency for all levels of nursing education (practical through graduate). In the early 1990s, the American Association of Colleges of Nursing (AACN), an institutional membership group of more than 500 baccalaureate and higher degree programs in nursing, explored the possibility of creating its own accrediting arm specifically for the baccalaureate and graduate nursing education community. In 1998, the NLN created the NLN Accrediting Commission (NLNAC) as a "separate and independent" agency, as required by the Department of Education for official recognition. That same year, the AACN's proposed accrediting arm — the Commission on Collegiate Nursing Education (CCNE) — was formally chartered and began operations. Consequently, there are now two accrediting agencies offering similar services to baccalaureate and higher degree nursing education programs.

To ascertain the impact of this milestone event on specialized accreditation in nursing, members of the Task Force on Accreditation of Health Professions Education surveyed the 620 baccalaureate and higher degree nursing programs accredited by the NLNAC (at the time of the survey, the CCNE had not begun its initial cycle of accreditation). Findings revealed that during the first year of competition, one-fourth of the programs switched from the NLNAC to the CCNE, while another quarter elected to be accredited by both, at least for the time being (Bellack, Gelmon, O'Neil, and Thomsen, 1999). Only one-quarter of the programs had definitively decided to remain with the NLNAC. These findings indicate that the NLNAC's model of nursing accreditation may not have been operating satisfactorily for all of the schools it was accrediting. Given a choice, schools chose the agency whose accreditation services they believed were best suited to their needs and preferences.

The advent of a second accrediting agency in nursing suggests that the demands and preferences of the consumer can be powerful drivers in creating competition and, thus, a more market-oriented approach to accreditation. In this case, a critical mass of baccalaureate and higher degree nursing education programs demonstrated a preference to be accredited by an agency that they felt better addressed their unique needs. Specifically, their choice may reflect the continuing dissension within the profession over the appropriate entry-level credential for professional nursing practice. Survey respondents who chose the CCNE indicated they believed that the CCNE, with its sole focus on baccalaureate and graduate education, would be more responsive to their particular issues and needs than the NLNAC, which serves the diverse and sometimes conflicting needs of the full range of nursing education programs (Bellack et al., 1999).

THE CHANGING MARKET FOR ACCREDITATION

The changing environments of health care and higher education may themselves be factors in this seeming move toward greater competition in accreditation. In the health care and higher education environments of the past five decades, the single agency approach to accreditation was viable because programs experienced little pressure for redirection and renewal from their constituents. The process of accreditation easily accommodated the limited demands placed upon it in such an era. In the changing environment, however, health professions education programs are facing dramatic new challenges — from the health

care industry and from funders and consumers of professional education programs — that require them to be far more responsive and adaptable.

A competitive accreditation environment may be more advantageous than its single-source, no-choice predecessor if it provides alternatives that focus less on regulation and compliance and place greater emphasis on services that help schools meet the needs of their constituents (students, employers, payers) with greater flexibility and responsiveness. Free-market competition also has the potential to hold down costs and motivate accreditors to search for more efficient and effective ways of conducting accreditation reviews.

However, moving to a competitive model may also result in further proliferation and fragmentation of an already burdensome system, especially in health professions with more than one professional association or with several subspecialty professional associations. Currently, some allied health schools undergo accreditation reviews by 10 to 25 agencies. The creation of duplicate agencies in competition for the accreditation business of even a handful of allied health professions could result in a confusing and duplicative morass of agencies, regulations, and processes. Such competition also could lead to lower standards as accrediting agencies strive to make their accreditation processes easier for schools to meet in order to keep their business.

Regardless of motivations or potential outcomes, it appears that the standard monopoly model of accreditation in each of the health professions is poised for change. Many programs are driven to compete for students, faculty, and fiscal resources; in the future, accreditors also may be pushed to operate in a market-driven system. Being in a position of competing for business presumably will enhance customer focus and responsiveness, and place greater emphasis on holding down costs while continuing to deliver high-quality accreditation services. Cost control, customer satisfaction, and improved outcomes will likely become the hallmarks of accreditation quality, just as they are for health care quality. Time will tell if accreditors are able to transform themselves to meet the challenge.

OPPORTUNITIES FOR ACCREDITORS

Currently, there are a number of opportunities that accreditors can and should take advantage of, as suggested below.

Establish forums for dialogue and debate on adopting a competitive market approach to health professions accreditation. Such forums should involve accreditors, professional associations,

educational programs, and other interested parties. At a minimum, the forums should address the following questions:

- Will educational programs and potential consumers be better served by a choice of accrediting agencies than by the traditional monopoly of a single agency?
- What impact will a choice of accrediting agencies have on the professional education community and the quality of education?
- What advantages might result from having a choice of accrediting agencies? What are the potential disadvantages?

Monitor and track the outcomes of the dual accrediting agency experience at the baccalaureate and higher degree level in nursing as an object lesson for other health professions. This competition between two accrediting agencies for baccalaureate and higher degree nursing education offers a "living laboratory" to monitor and track the dual accrediting agency experience for at least one segment of nursing education. It affords the health professions education accreditation community an opportunity to determine whether competition leads to improved customer satisfaction and educational program quality while also holding down costs, or whether less favorable outcomes will ensue.

Explore opportunities for collaboration on accreditation both within and among the various health professions. Two or more professional organizations in a given health profession might adopt a collaborative model in which they share responsibility for accreditation in the field. The American Medical Association and the Association of American Medical Colleges have demonstrated the viability of such an approach in the accreditation of undergraduate medical education programs with a joint Liaison Committee on Medical Education. Similarly, the American Public Health Association and the Association of Schools of Public Health co-sponsor the accrediting agency for public health education, the Council on Education for Public Health.

Another opportunity for collaboration between disciplines is in selected fields of allied health. For example, accreditation of programs in occupational therapy and physical therapy might be shared by their respective accrediting agencies, using common core criteria that also allow programs to highlight their respective unique features. Although the accreditation criteria for allied health programs within CAAHEP are quite similar in some instances, program reviews are typically conducted as completely separate and autonomous processes and thus fail to take advantage of an opportunity to reduce duplication of reviews.

THE INFLUENCE OF ACCREDITATION POLICIES ON FEDERAL FUNDING FOR HEALTH PROFESSIONS EDUCATION AND TRAINING: THE ROLE OF THE BUREAU OF HEALTH PROFESSIONS

Bernice A. Parlak and Neil H. Sampson

Within the U.S. Department of Health and Human Services, the Health Resources and Services Administration (HRSA) has been responsible for health professions education and training since the early 1960s. The 1967 creation of the Bureau of Health Manpower, the predecessor of the present Bureau of Health Professions (BHPr), coordinated the authorities of the Health Professions Assistance Act of 1963, the Nurse Training Act of 1964, the Allied Health Professions Personnel Training Act of 1966, and the limited public health training authorities. The current Health Professions Education Partnerships Act of 1998 focuses the BHPr's mission on:

1. improving the distribution of health care providers to assure access to health services for urban and rural populations;
2. helping to increase the numbers of under-represented minorities in the health professions;
3. emphasizing the training of primary care providers and the promotion of interdisciplinary, community-based training; and
4. developing the public health workforce.

The Bureau also serves as the federal focal point for health workforce information.

LIMITATIONS OF ACCREDITATION POLICIES

The BHPr's and the public's interest and investment in accreditation are the same: Both demand the best investment of the public dollar and the application and maintenance of high standards of quality for health professions education to benchmark the accomplishment of that objective. The 1992 Higher Education Act (HEA) not only strengthened the regulatory functions of the Department of Education (USDE) but also essentially defined the role of the BHPr as a customer or user of the USDE process for recognition of approved accrediting organizations.

In the spirit of private-public collaboration and in keeping with the new customer focus of quality improvement strategies, the BHPr has the potential to develop a participatory,

non-regulatory role in the deliberative functions of accrediting organizations — more so than the USDE. This type of collaborative participation by federal representatives would help balance private and public concerns without the onus of government control. Federal representatives, as vested partners in the accreditation process, should serve ex-officio on local, state, regional, and national accreditation boards and committees.

Accreditation standards and processes today are too specific and do not allow for frequent examination of changes in scope of work, practice, and evolving educational technologies. As a result, the status quo is maintained and the advancement of new standards of excellence is inhibited. The BHPr through its grant award policies continues to foster innovative approaches to curriculum and program development that advance the frontiers of health professions education and practice. The outcomes of these projects often advance the boundaries of current accreditation standards. For example, the BHPr's emphasis on the incorporation of new knowledge and skills in interdisciplinary continuous quality improvement and the development of academic-community partnerships to strengthen clinical, community-based training sites has prompted swift change in health professions education systems as they seek to adapt to new grant program criteria. Accrediting bodies should also be able to respond quickly to incorporate new standards of excellence that reflect these advancements.

Health professions education and training continues to evolve toward a more highly interactive, integrative learning process with greater emphasis on the continual improvement of health care and service delivery systems. Students should be enabled to practice in these fluid environments with confidence and pride.

In the future, accrediting bodies may be hard-pressed to shift focus from affirmation of individual schools and programs to affirmation of learning environments and pathways within a variety of interdisciplinary, culturally sensitive practice settings. Assessing the quality of education programs "without walls" is feasible. Assessing the value of the educational experience in environments committed to continual change may require a quantum leap of faith and knowledge.

BHPR RESOURCES BEYOND FUNDING

Although the BHPr has no legislative authority for the accreditation process itself, it maintains a high level of interaction with accrediting organizations through a variety of specialized activities including:

- participating on advisory committees;
- funding projects that provide useful resource data focused on workforce development, curriculum evaluation, and new technologies such as distance learning and telemedicine; and
- promoting quality improvement in health professions education.

For example, the BHPr has had federal representatives to the Accreditation Council for Graduate Medical Education (ACGME) since 1975, and to the Accrediting Council for Continuing Medical Education (ACCME) since 1990. The federal representative attends meetings of these organizations as an observer and presents federal government reports and perspectives as requested. This participation provides a way for the BHPr and HRSA to keep abreast of accreditation issues and activities in medicine, and to share the federal perspective with these accrediting agencies.

Issues of accreditation of nursing programs are of major significance to the BHPr, since only programs currently accredited by an agency recognized by the Secretary of Education are eligible to apply for funding. Although the BHPr does not have a specific role in setting accreditation standards, it does support the nursing profession's desire for discipline-specific accreditation. The BHPr's Division of Nursing maintains a constant dialogue with the field through interaction with the grantee constituent group and keeps appraised of actions taken by the USDE and by the various national and state accrediting bodies.

A major resource for accrediting organizations is the new National Center for Health Workforce Information and Analysis (NCHWIA), funded and administered by the BHPr. Staffed by a combination of health professionals, economists, statisticians, and information specialists, the NCHWIA sponsors and conducts research on issues that affect the national health workforce. It is the focal point for health workforce policy analysis — performing, reviewing, and evaluating highly technical multidisciplinary and cross-cutting health professions studies; developing approaches to policy analysis, including suitable database models; and preparing and coordinating technical reports and publications to aid in the development of health professions policy initiatives. Under NCHWIA auspices, four National Centers for Health Workforce Distribution Studies have been created in cooperation with the University of Washington, the University of Illinois at Chicago, the State University of New York at Albany, and the University of California at San Francisco.

These centers are public-private partnerships focused on the development of state-level databases and health information infrastructures to effectively assess health workforce needs and distribution.

Outcomes of the federal workforce analysis and research projects have provided the analytic foundation for all major councils and national committees, including the Pew Commission, the Institute of Medicine, the Council on Graduate Medical Education, MedPAC (formerly the Prospective Payment Review Commission and ProPAC), and the Allied Health Commission.

Of considerable value to grantees and their respective schools of the health professions is the BHPr's Comprehensive Performance Monitoring System (CPMS). The NCHWIA is responsible for the development, maintenance, and analysis of the database that houses grants management information and outcome data collected from grantees. The value of these data is twofold for the grantee: 1) the data document the grantee's accomplishment of objectives, and 2) provide a new standardized set of data for use in the accreditation process. These data are useful to accrediting organizations for the same reasons.

The BHPr also promotes the development of partnerships designed to bring stakeholders together to effect a common agenda, establish action networks, and to achieve goals otherwise unattainable by single entities. The BHPr frequently invites accrediting organizations to participate in collaborative projects focused on the development of national agendas for health professions education, including the cross-cutting and interdisciplinary fields of geriatrics and allied health. For example, the objective of the Allied Health Accreditation Project (funded in 1998) is to conduct validity and reliability studies on essential elements for eight allied health professions. These common elements can then be included in their respective or joint criteria for accreditation.

BHPR AS A COLLABORATIVE PARTNER

One goal of the BHPr's Strategic Plan is "advancing continuous quality improvement in health professions education and training." That goal includes the following objective: to promote accreditation and certification policies that (a) call for active school involvement in using outcomes data to evaluate and improve education; (b) respond to emerging health professions workforce needs; (c) foster redefinition of health professions curricula; (d) expand training experiences in community-based, medically underserved settings; and (e) involve educators, employers, and payers in their formulation.

As the BHPr revisits its commitment to quality initiatives in accreditation, several options emerge for consideration:

- Using its non-regulatory government status, the BHPr can serve as a public partner in the development of collaborative partnerships among health professions accreditation agencies and/or broader partnerships that involve business, law, employers, consumers, minority groups, and the marketplace.
- The BHPr can collaborate with accreditation coordinating organizations such as the National Policy Board on Higher Education Institutional Accreditation, as well as individual accrediting agencies, to develop policies and outcome indicators promoting advancement in areas of diversity and cultural competence.
- The BHPr can conduct research and evaluation on workforce and marketplace needs and demands that are relevant to accreditation issues raised by cross-training, multi-skilling, and interdisciplinary education and practice.
- The BHPr can promote the involvement of its health professions program officers to provide technical assistance, consultation, and public perspective to the essentially private accreditation process.

The BHPr can assist with the development of quality indicators and outcomes measures that promote continuous improvement and thus enhance both the institution's and the accreditor's capability to maintain the highest quality of education.

CONCLUSION

Changing the focus of accreditation from compliance to seamless continuous improvement may be a daunting task, but it will be easier to accomplish with new and expanded partnerships with both private and public organizations. Common ground for improving public policy lies in developing collaborative linkages with federal agencies such as HRSA, whose goals for workforce education emphasize access to care for the underserved and vulnerable populations, diversity and cultural competency, and quality in the health care industry.

COLLABORATION BETWEEN INDUSTRY AND HIGHER EDUCATION

John P. Evans

Rapid changes in health care delivery create special challenges for the educational programs that prepare people for employment opportunities, both present and future. To ensure relevance for practice, health professions education programs must assure that curricula adapt appropriately. One way to accomplish that objective is for programs to enlist the collaboration of the health care industry, those organizations that will employ future program graduates. These employers have an interest in the quality of the programs whose graduates they hire. This discussion addresses a range of issues related to the possible benefits of industry and higher education collaboration in the accreditation processes for these programs.

COLLABORATION: A WIN-WIN APPROACH

Employing organizations clearly have a substantial stake in the quality of education provided to students in health professions educational programs. Similarly, representatives of these programs have strong reason to be concerned with the employing environment. Potential employers have important perspectives concerning the knowledge, skills, and professional qualities they are looking for in future employees. Administrators and faculties of educational programs can enhance their understanding of these needs and refine programs to meet these needs more effectively if they engage in regular interaction with the employing community. In addition, industry representatives can be valuable resources for students through career planning workshops that can help students focus and plan job searches, prepare for the interview process, and develop clear expectations about the work environment. These concepts are all consistent with the first element of the "5+1 criteria" model of accreditation proposed by the Task Force on Accreditation of Health Professions Education. That element encourages "connecting with the community of practice and the public to meet needs and prepare the workforce for the unique needs, contexts, and assets of relevant communities." In this instance, the relevant community of practice would include the spectrum of potential employers of a program's graduates.

FACULTY DEVELOPMENT

Collaboration between industry and higher education offers several opportunities for faculty development and program improvement.

The first of these opportunities is access to research resources, such as data for testing research propositions in clinical care and the delivery of health services. Good working relationships between faculty members and practitioners could also support the design of research models that represent agreement on goals for professional improvement. Such relationships are common among business and engineering schools and business organizations. They would also foster research that is more relevant to employers' concerns. Finally, organizations that provide funding for research might view this type of collaboration as an asset when making funding decisions.

A second opportunity for faculty development comes from access to information about clinical environments. Practical knowledge about the realities of these environments can enrich the content of courses and have a favorable impact on curriculum planning, delivery, and effectiveness. Perhaps most importantly, a third benefit arises from the creation of opportunities to provide "real-world" learning for students. Faculty who oversee certain types of learning experiences, such as externships, can also benefit from additional insights into the world of practice.

INDUSTRY CONTRIBUTIONS

Collaboration can also spur improvements in accreditation processes, making them more effective. Inclusion of industry representatives on accreditation teams is a common practice in a number of specialized accreditation processes, including accounting, business, health services administration, and law. This type of involvement provides employers with a voice in these accreditation processes. In addition, industry representatives can be particularly insightful in assessing the effectiveness of educational programs in helping students with career planning and placement.

THE NEED FOR EXPERIMENTATION AND INNOVATION

Collaboration with industry can help higher education face the challenges posed by rapid change in an environment of scarce resources and growing demands for accountability. This collaboration may include creative ways of integrating curriculum planning, instruction,

clinical experience, and professional preparation to improve curriculum content and delivery. The potential benefits of these activities seem clear. Although the quality assurance role of accreditation is important, it must not impede experimentation and innovation that could improve or speed learning for students. For example, rather than insisting that certain material be presented via specified teaching methodologies, accrediting agencies should design processes to both encourage and evaluate curriculum planning and effectiveness of delivery. Indeed, accreditation processes should be designed to encourage experimentation and learning about new educational processes. Yet, too often accreditation processes have condemned non-traditional curricula or delivery, without considering the results produced by such innovations.

To keep pace with change in the world of health care delivery, the world of health professions education must explore creative and effective ways to improve the content and delivery of its programs. Including the voice of industry in the design and execution of accreditation processes will ensure program relevance and responsiveness—as well as support for learning and innovation in health professions education.

THE INCREASINGLY GLOBAL CONTEXT OF AMERICAN HIGHER EDUCATION

Carol L. Bobby

American higher education is going global. Two newsworthy items demonstrate this major transformation:

- The University of Phoenix recently made headlines with its announcement of a joint distance education project with Hughes Network Systems. The Chronicle of Higher Education (August 19, 1998) described the move as representing "a marriage of content and technical expertise" that would expand the University's for-profit ventures abroad. The University of Phoenix currently operates programs only in the United States, Puerto Rico, and London, England.
- Great Britain's well-known Open University announced plans in the spring of 1998 to partner with domestic U.S.-based institutions such as California State University and Florida State University. Furthermore, the Open University plans to open its own programs in the U.S. by seeking regional accreditation for its operations after incorporating in Delaware.

These two examples illustrate three major components of a change in U.S. higher education. First, the transformation has a global context. Second, the transformation is occurring in part due to new technology and its ability to provide new avenues to educational information. Third, the transformation is based in market demand.

EDUCATION IS A GLOBAL MARKET COMMODITY

People do not often think of higher education as a business. More often, they associate higher education with an ivy-covered campus where great thinkers philosophize and conduct research. Higher education is equated with "going to college." Rarely are students viewed as consumers making purchases.

Over the years, the concept of the "traditional" college or university education has evolved, as the age of the typical student continues to increase. Women and members of the current workforce are seeking first-time degrees, returning to college for advancement in their current career track, or perhaps looking for a whole new career opportunity. As a

result, night classes aimed at providing convenience to working students are now common at many institutions of higher education. Computer and Internet-based classes represent a breakthrough in convenience in the delivery of education.

Beliefs about what constitutes higher education have also changed. The context of where, how, and to whom higher education is delivered has suddenly been broadened to include the world. Today, the University of Phoenix and the British Open University are seeing the world as their market, and they are not alone. Virtually every institution in the U.S. is now considering how to market education across borders, whether national or international, through new innovations in distance learning technologies.

EDUCATION, THE PROFESSIONS, AND THE ROLE OF TRADE AGREEMENTS

International business ventures have forced institutions and professions in the U.S. to begin examining the comparability of education across borders. While professions such as accounting, engineering, and architecture have been at the forefront of this movement, other professions—including the health professions—are rapidly moving into the international arena. International trade agreements such as the North American Free Trade Agreement (NAFTA) and the General Agreement of Trade in Services (GATS) specifically include provisions designed to prevent discrimination against foreign professionals (Ascher, 1996). In other words, professionals desiring to work in foreign territories must be able to seek licensure based on fair, objective, and clear criteria. Educational requirements, experience, and examinations may be required, but they may not be burdensome and commonalities should be identified and allowable. Quality must be at the core of what is needed to ensure competent provision of services.

The need to determine commonalities has a direct relationship to accreditation of professional programs in the U.S. The relationship is based in professional licensure regulations that cite accreditation of institutions and programs as meeting the educational eligibility criteria of credentialing boards. Accreditation is seen by many credentialing bodies as the stamp of quality assurance for pre-service education; it provides the benchmark for meeting minimum educational requirements.

Because graduation from an accredited program has often been used as an eligibility criterion for a professional license in the U.S., program accreditation has become important to three distinct consumer groups. The first type of consumer is the individual

professional—such as an architect, physician, accountant, or physical therapist—who wishes to cross a national border and have his or her education and skills accepted and approved for practice in a foreign territory. A second type of consumer is the educational provider—the institution or program—that wants to prepare competent graduates for job placement in a global society. The third consumer group represents the businesses and organizations seeking to hire the professional who can travel across borders. All three consumer groups understand that comparability of training and degrees facilitates professional movement. Since the accreditors set the standards for what constitutes quality education, the accreditation standards become the basis for comparison of minimal educational degree requirements.

THE INTERNATIONAL APPLICATION OF STANDARDS

Requests for U.S.-based accreditors to review overseas programs are on the rise because of the ease with which accreditation provides entry to practice. In some cases, U.S. institutions are exporting programs to other countries. In other cases, foreign programs desire the U.S. accreditation credential. Either way, consideration must be given to defining the appropriate use of U.S.- based accreditation standards in an international setting.

Defining how accreditation standards should be used in international settings is a complex issue. The accrediting agency should ask itself whether it should get involved in the first place. Will international involvement benefit the profession? Is it a question of being the only provider of quality assurance? Is the value of the service provided greater than the cost that will be incurred? Who is requesting the service and what are the political, social, and cultural ramifications of this involvement?

If the agency decides to "go global" the next decision is to determine how to proceed. There are several models to consider (see, for example, Aberle 1998). The accrediting agency could provide guidance and consultation, enabling the host country and host professionals to create their own quality assurance review system. In another model, a U.S. agency could develop alliances among the professional associations within other countries whereby substantial equivalencies could be determined and reciprocity agreements created. A third model might be to collaborate within regions to create a new "international" oversight agency that develops its own standards for broad application across borders.

A CASE STUDY OF INTERNATIONAL COLLABORATION

Many professions are attempting to globalize. The professions begin their attempts by scheduling international meetings and roundtables. Yet, during these international professional gatherings, the natural tendency is for discussion to focus on the many interesting differences in practice and training.

Getting beyond the differences is not easy, but it is the only way to globalize. The nurse anesthetists provide an example of a successful model (Lenn, 1997). The roots of this model lie with the creation of the International Federation of Nurse Anesthetists (IFNA) and its commitment to 1) provide the best medical care possible around the globe, and 2) recognize that, as a profession, nurse anesthesia has a core set of standards for training and practice that is greater than any border. Once these two premises were accepted, the IFNA set about creating its Educational Standards for Preparing Nurse Anesthetists (1990) and the Standards of Practice and Code of Ethics (1991). These two documents were created to fulfill the IFNA's established objectives and place the nurse anesthetists in a leadership position of globalizing professions.

Coming to agreement on internationally recognized standards is but one step in the process of a profession's globalization. The next series of steps—the adoption and implementation of the standards adopted on a local or regional level—determines the extent to which a profession has truly globalized. Here again the actions of the IFNA are worth considering. Member countries of the IFNA, while supportive of the creation of the standards for training and practice, are now at a point where they must decide whether and how they will use the international standards. The IFNA as an organization has to decide which of its member countries are best suited for the pilot testing of the new standards. To this end, the IFNA has decided to begin with a regional approach.

In choosing a region, certain factors have been considered. For example, the IFNA felt it best to test its standards in an area where experienced accreditors could be used and where language and cultural differences, although evident, would not necessarily impede a common understanding of professional training requirements. The IFNA chose the Caribbean region, where it had access to experienced accreditors through the U.S.-based accrediting agency, the Council on Accreditation of Nurse Anesthesia Educational Programs. Furthermore, this is a region that is not unfamiliar with higher education quality assurance reviews. That the IFNA continues to move forward with its planning is the most important aspect of the process at this time.

There are other models that foster reciprocity agreements, such as the Washington Accord for engineering and the bilateral agreement for occupational therapists in the U.S. and Canada, or that suggest that an American-based accrediting agency can successfully provide quality assurance reviews abroad, such as AACSB's accreditation of overseas business programs. The nurse anesthetists' model is perhaps the most forward-thinking. It is also perhaps the most difficult to accomplish.

CONCLUSIONS AND RECOMMENDATIONS

As more professions find themselves competing in a global marketplace, the preparation of individuals crossing borders becomes an even more important commodity. Using accreditation as one measure of what constitutes program quality places a greater emphasis on defining what competencies the graduating professional must acquire before entering the marketplace. It also requires higher education institutions, program faculty, and accreditors to have a clearer picture of what the marketplace is demanding.

One way to develop an understanding of the bigger picture is to know who is involved with international quality assurance issues. Since 1993, the Center for Quality Assurance in International Education (CQAIE) has been at the forefront of these issues and has acted as a change agent with many professions and in many regions around the world. The mission of CQAIE is to assist countries in the development of quality assurance systems, to convene international conferences that focus on globalizing professions, to provide international trade and educational consultation, and to monitor and effect appropriate change in U.S.-based quality assurance systems relative to globalizing professions. CQAIE meets this mission by providing forums for networking, along with timely publications and databases for those seeking information.

CQAIE also serves as the secretariat for an international, not-for-profit alliance of multinational corporations, accrediting and licensing authorities, and higher education institutions and programs known as the Global Alliance for Transnational Education (GATE). GATE's programs are designed to explore issues that corporations face in international hiring practices while simultaneously examining the issues that colleges and universities face in international admissions. To that end, GATE has developed a certification (accreditation) process to externally evaluate and recognize quality transnational educational offerings through a peer review process.

In conclusion, higher education in the U.S. has been transformed and will continue to change at a rapid pace as enhanced technology allows us to transfer knowledge across borders almost instantaneously. No profession is in isolation. The health professions are already experiencing the challenges of telemedicine. Licensing authorities of health professionals will need to rely on quality assurance agencies to an even greater extent to determine what constitutes quality educational preparation, regardless of where training occurs. Knowing and trusting those involved in quality assurance issues in higher education is the first important step to take. Finding the commonalties among quality assurance systems and then building on them is the second major step. From these two initial steps, the health professions and others can determine which model will work best — collaboration at an international level, reciprocity agreements, or the creation of systems that require multiple reviews.[4]

GOVERNANCE OF ACCREDITATION AGENCIES

Catherine Thomsen and Sherril B. Gelmon

Specialized accreditation is traditionally a voluntary process of self-evaluation and peer consultation to ensure quality and promote improvement of educational programs. The system has, however, been accused of being regulatory and bureaucratic. Based upon anecdotal evidence, some have alleged that it serves the profession more than the public. An increasing number of empirical studies are being conducted to determine the outcomes and relative cost of specialized accreditation (for example, education as cited in Dill, 1998) and to examine the importance and assessment of specific criteria (such as medicine in Kassebaum, 1997, and engineering in Scales, 1998). To date, however, there has been little evidence either to support or refute claims that accreditation agency practices limit entry into a profession or that processes for establishing standards or making accreditation decisions are closed to some stakeholders.

During discussions of the work of the Task Force on Accreditation of Health Professions Education, representatives of various health-related education associations expressed concern about the lack of synthesized data on the range of current accreditation governance structures and practices. Accreditation is built upon the concept that objective observers can judge the current and future quality of educational programs based upon some accepted criteria. Thus, it is of paramount importance to know how and by whom the standards by which programs are judged are established and who has final authority in accreditation decisions. These tasks fall under the jurisdiction of the accrediting agency's governing board.

Most accrediting agencies fit into one of three models of governance. First, they may be sponsored by a single organization, generally a professional association, under which the agency operates independently. An example of this model is the Committee on Accreditation of Physical Therapy Education, sponsored by the American Physical Therapy Association. The second model involves a partnership of education and practice organizations to support accreditation activities, such as the joint sponsorship of the Council on Public Health Education by the American Public Health Association and the Association of Public Health Schools. A larger alliance of stakeholders forms the final model. The Accrediting Commission on Education for Health Services Administration is an example of this coalition approach, with 10 sponsors, including the American Hospital

Association, the American College of Health Care Executives, and the Association of University Programs in Health Administration.

A STUDY OF ACCREDITING AGENCY GOVERNANCE

In response to the request from the representatives of health education associations, the Task Force set out to identify differences and similarities between accrediting agency governance beyond the three models. This information is also critical for understanding how accreditation governance structures and practices may promote or inhibit the implementation of Task Force recommendations.

Fifteen large health professions education accreditation agencies were chosen for the survey, which was developed with input from those who requested the study. Each of the selected agencies is perceived to have strong leverage in academic institutions; choices were also designed to maximize the diversity both of professions and scopes of practices.

The Task Force staff reviewed governance policies, as described in available accreditation agency documents, to complete as much of the survey instrument as possible. The survey was then sent to the administrative director of the relevant organization to verify the responses, clarify certain points, and replace any missing data.

Questions were designed with three objectives in mind:

- to inform the Task Force and other interested parties about the differences in the constitution and authority of the governing boards or commissions that make accreditation decisions,
- to explore the variety of decision-making processes, and
- to find out how stakeholders are included in initiatives to shape professional education through the revision of accreditation standards.

The following data are based upon the responses of the 13 health education accrediting agencies listed in the appendix to this paper. These results represent the policies and practices at the time of the survey, and are subject to change as the agencies continue to evolve in response to internal and external needs.

Accrediting Commission Composition

Governing bodies of nine of the 13 accrediting agencies are sponsored by professional organizations or coalitions; four are separately incorporated. The number of voting members on accrediting commissions ranges from nine to 29, with an average of 14 seats. Three commissions also have one to two non-voting members. Slightly over two-thirds of the commissions have three-year terms of service for voting members, all of which are renewable. Terms of service in the other commissions are not renewable and range from two to six years.

All of the accrediting commissions include at least two and as many as 10 representatives of academic programs, accounting for 14 to 64 percent of voting seats *(see Table 1)*. To qualify for recognition by the U.S. Department of Education (USDE), at least one member of the decision-making body must represent the public; the agencies surveyed had one to four public members. Slightly fewer than three-quarters of the commissions include three to five representatives of the practice community, who may also belong to a professional association. Professional associations are formally represented on seven commissions, holding from three to nine seats. Five of the commissions have one or two members representing other constituencies, including related professions or interested organizations. Four (31 percent) of the commissions include one to three members from regulatory or licensing bodies and two specify representation of the relevant trade association. Two commissions explicitly call for at least one student member, while another commission allows for optional student representation, depending on appointment by a partner sponsoring organization.

Table 1 CONSTITUENCIES REPRESENTED ON ACCREDITING AGENCY GOVERNING BOARDS
(rounding and estimations may result in totals other that 100%)

AGENCY	Academic	Trade	Prof.	Practice	Regulation	Student	Public	Other	Total
1	22%	-	33%	-	22%	-	22%	-	9
2	20%	30%	30%	-	-	-	20%	-	10
3	40%	-	-	40%	-	-	20%	-	10
4	30%	-	30%	-	30%	-	30%	10%	10
5	64%	-	-	27%	-	-	9%	-	11
6	27%	-	-	27%	18%	-	18%	9%	11
7	46%	-	-	23%	-	-	31%	-	13
8	60%	-	-	20%	-	-	20%	-	15
9	33%	6%	56%	-	-	-	6%	-	16
10	53%	-	-	29%	-	-	12%	6%	17
11	35%	-	35%	-	-	12%	12%	6%	17
12	53%	-	-	26%	-	-	11%	11%	19
13	14%	-	14%	14%	3%	14%	14%	3%	29

In most accrediting agencies, commission members are appointed. Approximately 70 percent of appointments are made by an organization, the commission itself, an executive board, or an official. In some cases, appointment follows nomination by a committee or organization. The remaining 30 percent of commission members are nominated and/or elected by a professional organization, the commission, an executive board, or a nominating committee. Some accrediting agencies require, and most take into consideration, experience as a site visitor and either professional or academic qualifications of potential commission members. Public members are an exception and may not practice or teach in the respective field; some agencies disqualify a person if a family member is in the profession.

The Process for Changing Accreditation Criteria/Standards

All of the commissions surveyed report initiating changes in accreditation criteria and standards, often on a scheduled basis. Where a periodic review of standards is mandated, the timeframe ranges from an interim internal review every two years, to a five-year maximum, to a 10-year revision cycle with specific steps. Some accrediting agencies systematically solicit suggestions for changes from identified stakeholders before drafting new criteria or standards. Respondents also reported reviewing general trends within the USDE and higher education to inform the process.

Each accrediting agency surveyed has more than one formal mechanism for stakeholders to review draft changes before they are adopted. Many agencies use multiple comment cycles through various media, including mailings, web publications, and public hearings. Data collected range from narrative responses on open-ended questions to scaled ratings. While most public comment occurs during standards revisions, two accrediting agencies reported gathering "continuous input." These data are collected using a variety of techniques, including surveys, discussions at professional meetings, and validity studies. The results are used in the process for revising criteria and to improve the accreditation process.

Accreditation Decisions and Status

Each commission surveyed has final authority in accreditation decisions. Appeals of these decisions are handled directly by two of the commissions; the others use an external hearing panel. Of those 11 commissions, five have a reconsideration or evaluation process as an interim step before (or, in one case, as an option to) a full appeal, calling for the commission to review its decision and/or decision-making process.

The point at which a program is eligible for accreditation varies. Half of the agencies will review a program for accreditation after one or two classes have graduated and, in one case, taken qualifying exams. At least five agencies offer an interim status to programs seeking accreditation, termed "pre-accreditation," "provisional," "developing program," or "candidate" status. Four of those agencies either allow or require applicant programs to complete the accreditation process before the first class graduates; for the fifth agency, programs are eligible for "full" accreditation in the year in which the charter class graduates. One other agency will consider a program for accreditation after the first class has been enrolled for one year.

Initial accreditation is granted for a maximum of two to 10 years, and the majority of agencies grant a maximum of five years. Three accrediting agencies have also established minimum initial accreditation status periods that range from one to 5 years. Programs seeking continuing accreditation status are eligible for a maximum of six to 10 years, and while the average upper limit is eight years, five agencies grant at most seven years and three grant maximums of eight or 10 years. Only two accreditation agencies reported minimum continuing accreditation timeframes (of three and five years).

DISCUSSION AND CONCLUSIONS

Given the current climate of change in the health professions, the uncertainty surrounding approaches to quality assurance, and the lack of historical data on the range of governance practices in accreditation, the results of this survey offer only a snapshot of the situation at this moment in time. Future research can illuminate the trends in specialized accreditation and aid in identifying and promoting the best practices to inform the direction of further improvement efforts. Nonetheless, several lessons can be drawn from this study.

Stakeholder Representation

Accrediting agencies should carefully monitor the composition of and selection of their governing boards to ensure that a balance of interests are represented, and to consider how students' interests are represented. Professional and practice organizations have a great deal of power over appointments in several of the accreditation commissions surveyed. Affiliation with these organizations is a requirement for certain seats. Accrediting agencies that fit the partnership and alliance models are less likely to have their public accountability questioned than are those sponsored more directly by a professional organization.

The Pew Health Professions Commissions recently recommended that at least one-third of members of state regulatory professional boards be public representatives to ensure greater accountability to the public (Finocchio, 1998). In the case of health professions education accreditation, however, there are multiple, distinct categories of stakeholders (see Table 1). Academic institutions (those "subject" to accreditation) account for an average of 38 percent of the membership of those surveyed. All commissions include at least as many academic representatives as public members. On three commissions, the majority of members are academics. On 10 commissions, the number of seats held by academic representatives is equal to or greater than the number occupied by representatives of trade or professional organizations.

The federal government uses its regulatory oversight function to ensure that consumers are represented in accreditation agencies. Recognition by the USDE's Office of Postsecondary Education (USDE) is important to accreditors, granting them some power as gatekeepers for government funds. In order to qualify for recognition as a reliable authority on the quality of education or training offered, accrediting agencies must have voluntary membership and remain "separate and independent" of governors of "any related, associated, or affiliated trade association or membership organization" (USDE, 1997). Federal criteria regarding public representation on governing boards range from requiring at least one public representative to one-seventh of the total board composition.

Based on the present data, it is difficult to determine how well employers are represented on governing boards. Although the higher education literature often refers to students as both consumers of education and partners in the learning process, it appears that they are either not perceived as major stakeholders in specialized accreditation or they are not organized enough to actively participate in accreditation activities beyond self-studies and site visits. Only two of the accrediting agencies surveyed have student representatives, although one other governing board allows for student appointment. Students in higher education are often employed and have family responsibilities, so they may have relatively little interest in or time for participating in such national organizations. Recent graduates offer an alternative source for the student perspective. However, most new professionals experience a time of transition into the workforce and the establishment of a professional career; they may not be likely candidates for appointment by professional or practice organizations.

Decision-Making

Without easily measurable criteria, it is difficult to demonstrate how standards are met and enforced by accreditation agencies, leading to the same concerns for public accountability as state regulation of professions. While the decision-making process may be inclusive and the criteria thoroughly documented, standards may be enforced inconsistently due to variation in site visitors or others who assess applicants. All of the accreditation agencies surveyed have extensive appeals processes with well-established protocols and procedures, allowing recourse when necessary for the educational programs and institutions. However, no formal mechanism was identified for appeals by consumers—including students, employers, or the general public.

Another way to enhance specialized accreditation's accountability is to openly provide more information about site visits and to make accreditation documentation available to consumers. With full disclosure of information collected in the accreditation process, educational institutions may understandably be concerned about confidentiality. Nonetheless, providing more data could help consumers—students and those who use health services—to make more informed decisions. The imperative to make information available could help integrate accreditation activities into a larger improvement process.

Inclusiveness of Standards Revisions

While all of the surveyed accrediting agencies actively include stakeholders in the process for changing accreditation standards, specialized accreditation does not always meet the perceived needs of accredited institutions. The importance of stakeholder input into the standards used to judge programs has been underscored recently by widely published criticisms of law and teacher education accrediting agencies for continuing to employ criteria that some faculty and administrators have deemed invalid for assessing academic quality. One organization of educational institutions felt strongly that criteria for teacher education did not reflect institutional diversity, focused too heavily upon "inputs" at the expense of process and outcome measures, and did not sufficiently assist improvement efforts. As a result, it has established an alternative accrediting agency (Council of Independent Colleges, 1998).

The variety of mechanisms to solicit input on proposed changes in criteria used by the surveyed agencies is impressive. All use traditional techniques of circulating drafts to

identified stakeholders and holding hearings or open forums, often in conjunction with regional professional meetings. Proposed criteria are often circulated through professional periodicals and other routine publications. Several agencies also reported using electronic media to reach the broadest possible audience, such as posting draft changes on the Internet. Two respondents reported using formal survey instruments to solicit input, and several employ iterative processes to collect and incorporate feedback into revised standards.

One of the most innovative approaches was used by two agencies that routinely seek feedback and collect data on their standards and accreditation procedures to complement monitoring of environmental data. They reported using a variety of techniques, including surveys of accredited programs, practitioners and administrators; discussions at professional meetings; and validity studies. Results are used to improve the accreditation process in addition to providing a starting point for revising criteria that reflect stakeholder perspectives. Students were again conspicuous in their absence on the lists of stakeholders targeted to participate in these reviews of proposed standards.

Challenges of Emerging Technologies

A major challenge facing the health professions and other specialized accrediting agencies is accommodating new educational methodologies such as distance or technology-based learning. Adopting flexible standards and acting upon stakeholder input may help accreditation keep pace with changing market demands to accredit new types of education. Yet a question that has received a great deal of attention by the federal government, the Council of Higher Education Accreditation, and other parties remains: How can the quality of distance education be assured?

The Western Governors University (WGU), an Internet-based postsecondary education and training system sponsored by the Western Governors Association, has made one of the first efforts to establish standards to ensure quality distance education. WGU criteria for affiliation currently require either that education providers be regionally accredited, recommended, or certified by the American Council on Education's College Credit Recommendation Service or by "a supplier of educational programs/courses that are widely recognized in their field for their quality and need" (Western Governors University, 1998). This flexibility in the unit of quality assurance, focusing either on the education provider (institution) or the course, and the acceptance of non-accredited providers may be the first of many challenges that distance learning provides to traditional accreditation.

Accreditation Collaboration

Joint accreditation site visits have been promoted as a way to decrease the burden of accreditation by promoting the centralization of data collection, analysis, and use. This is a very promising approach for supporting improvement efforts by educational institutions and within individual programs. Nonetheless, the results of this survey suggest that structural differences could hinder collaboration. One obstacle is the diversity of eligibility requirements for accreditation. At least one agency surveyed requires program graduates to take a qualifying exam for professional practice before the final accreditation review and decision. Because neither the program nor the accreditors control the scheduling of such tests, flexibility for accreditation collaborators could be limited.

A second barrier is posed by the use of different accreditation status levels. Five accrediting bodies surveyed employ an interim status before granting "full" accreditation. In states that restrict examinations, licensing, and/or certification to those with a degree from an accredited program, early recognition by the accrediting agency may be critical to new programs and their initial graduates for entry into practice and employment. Yet among those agencies with some sort of interim accreditation status, one requires that the program complete the full accreditation process before graduating the first class. Eligibility requirements for both interim and "full" accreditation vary in this group.

Finally, the range of accreditation cycle lengths identified in this survey demonstrates a major obstacle to interagency coordination. Some agencies have minimum status tenures; maximum, initial, and continuing terms vary considerably. If a program does not fully meet the accreditation standards, an agency may shorten the cycle or delay the review until the scheduled site visit. Coordination of accreditation across agencies could create pressure on accrediting agencies to maintain a schedule despite concerns about program quality.

Traditionally, accreditation has adapted to changing professional and societal needs by revising standards. More recently, the structure and governance of accrediting agencies has been called into question as higher education struggles to meet the continuously evolving needs of multiple stakeholders. These pressures are both internal, from educational institutions and leaders, and external, from the USDE and other governmental and oversight groups. Hopefully, continuing efforts to improve accreditation will be informed by identification of current best governance practices among health education accrediting agencies.

The Task Force on Accreditation of Health Professions Education would like to thank the following accreditation agencies for participating in the governance survey:

Accreditation Council for Occupational Therapy Education
Accrediting Commission on Education for Health Services Administration
American Council on Pharmaceutical Education
American Optometric Association Council on Optometric Education
American Speech-Language-Hearing Association
Commission on Accreditation/Approval for Dietetics Education
Commission on Accreditation, Council on Chiropractic Education
Commission on Accreditation of Physical Therapy Education
Commission on Collegiate Nursing Education
Commission on Dental Accreditation
Council on Education for Public Health
Liaison Committee on Medical Education
National League for Nursing Accrediting Commission

CONSENSUS ELEMENTS OF COMMON ACCREDITATION CRITERIA: THE RESULTS OF A DELPHI PROCESS

Catherine Thomsen, Carol L. Bobby, and Sherril B. Gelmon

Accreditation frequently is criticized as a costly, duplicative and wasteful process. Institutions and programs are subject to multiple standards and site visits from regional and specialized accreditors, who often want the same information but in distinct formats. This creates significantly more work for the institutions and programs seeking accreditation. In addition, overlapping jurisdictions among accrediting agencies may impede interdisciplinary education and training.

Another problem concerns the use of prescriptive criteria that limit innovation. Educational institutions want flexible criteria that are relevant and respond to individual programs. However, more general standards may be more difficult to quantify and may not ensure the desired level of educational quality.

Multiple discussions in recent years have addressed the need for a core set of common data elements for accreditation, regardless of discipline. Institutions and programs have long recognized that many accrediting agencies require the submission of specific data on faculty, admission and graduation rates, placement rates, etc. But formatting these data is a major problem, because each accrediting agency wants the data submitted in its own specified format. This situation has lent some credence to complaints of duplication, waste, and inefficiency; in addition, it makes it more difficult for agencies to coordinate review efforts for collaborative visits. A common data set, coupled with a uniform approach to requesting information and possibly to developing common standards, would address many concerns about accreditation. Common standards would also allow accrediting agencies to coordinate team training efforts and foster greater consistency in how teams interface with campus personnel.

With the help of a number of stakeholders, the Task Force on Accreditation of Health Professions Education set out to design a model that uses common standards and offers flexibility, yet holds institutions accountable. The result is expressed in the Task Force's fourth recommendation in this report: "A consistent framework for accreditation should be adopted by all specialized accrediting agencies, consisting of five common criteria and one

profession-specific criterion (the '5+1 criteria')." This model seeks to ensure that each institution or program has in place a system for continuous self-improvement.

The Task Force presented the "5+1 criteria" concept and five draft standards to the Association of Specialized and Professionals Accreditors (ASPA) in March 1998, and invited ASPA members to participate in developing core elements for each criterion that reflect the interests of the accrediting community. The members eagerly agreed to participate in this project.

DEVELOPING CONSENSUS ELEMENTS

The method for developing these elements was a three-stage Delphi-like approach that included sequential questionnaires to generate and refine a list of concepts (Linstone and Turoff, 1975; Stritter et al., 1994). This structured technique is particularly useful for pooling expert opinion and judgment on complex issues, providing anonymity, and allowing everyone to participate equally. Each questionnaire was transmitted by electronic mail to allow participants to respond quickly and easily.

Approximately 60 potential participants from health-related and other specialized education accreditation agencies were identified from ASPA's membership and the Task Force mailing list. All of the invitees worked actively in accreditation and had an interest in improving specialized and professional education accreditation. A total of 20 experts participated in the nominal and ordinal phases of the study, while several others provided narrative comments.

In April 1998, the first e-mail message was sent, providing background on the project, an explanation of the Delphi technique, and an invitation to participate in this structured brainstorming and priority-setting exercise. The first round of the Delphi process asked participants to suggest core measurable elements for each of the five criteria proposed by the Task Force (see Recommendation 4 in this report). The experts were encouraged to look at their own agency's criteria as a starting point, and to think creatively.

More than 20 elements were suggested for each of the criteria. These responses were synthesized to eliminate duplication. A list of more than 125 elements was included in the second round of the Delphi process, and respondents were asked to rank the importance of each element with respect to each criterion, using a five-point scale. The ratings from the second round were

collated and mean scores were computed. In the third and final round of the Delphi process, respondents were asked to review the mean scores from the second iteration for each element, and to rank their top three to five selections for each criterion. The results were then summarized to determine the number of responses for each element and the respective mean ranking.

Task Force representatives reviewed the resulting ranked elements, looking for selection patterns and determining natural break points in the data. The highest scoring elements were then edited and, finally, closely related elements were combined where possible. While the use of electronic mail speeded this process, and probably increased participation, it is difficult to cull the responses generated by the panel without losing some of the original meaning or intent. The group's efforts to condense the prioritized list were critical to creating a useful product for accreditors.

A PROPOSED SET OF ELEMENTS FOR THE FIVE COMMON CRITERIA

The Task Force has recommended that all specialized accrediting agencies adopt the common model of "5+1 criteria." The following five criteria and the accompanying core measurable elements to assess compliance are consistent with the core competencies espoused by the Pew Health Professions Commission (O'Neil, 1998).

Criterion 1 – The institution or program works closely with the community of practice and with the public to identify changing health care needs and to prepare a workforce that can respond to and meet community assets and needs.

- The program's mission, philosophy, and goals reflect professional and public expectations.
- The program of study (and supervised practice, where applicable) results in learning outcomes appropriate to market expectations for entry level performance.
- Input and feedback are solicited from communities of interest (including practitioners, students, faculty, employers, etc.) on a regular basis and used to improve program relevance.
- The institution or program develops and documents cooperative relationships among departments or units, off-campus training sites, and other community resources that contribute to the professional preparation of students, including the means to assess student learning outside the institution.

Criterion 2 – The institution or program has sufficient qualified faculty for effective program design and instruction, and provides appropriate, periodic, and ongoing faculty development and evaluation.

- The number and qualifications of faculty are sufficient to meet the institution's or program's mission and goals and to allow faculty the time required to teach effectively.
- The institution encourages and supports appropriate professional development of faculty (e.g., participation in professional organizations and activities, research, travel, tuition remission for continuing education).
- Faculty members are evaluated annually, based upon clearly outlined criteria to assess their knowledge of current practice, continuing development of teaching methods, and use of technology as needed to meet their teaching, advising and/or student assessment responsibilities. Multiple sources of information are used to assess performance, including student evaluations.
- The institution or program recognizes the central role of faculty in developing, implementing, and evaluating curriculum.

Criterion 3 – The institution or program prepares graduates with the skills and knowledge relevant to practice and regularly assesses the competencies and achievements of students and graduates.

- A variety of methods and tools are used to measure students' academic performance, personal development, and professional development.
- Developmental and systematic assessments of students' progress are conducted throughout their tenure in the institution or program, based upon a master plan for educational goals and achievement with clearly defined outcome-based competencies and evaluation criteria.
- Institutions or programs identify, monitor, and evaluate indicators of student success, such as performance on professional examinations (national, state, or regional boards; registration, certification or licensure results) and use these data to focus improvement efforts.
- Feedback on graduate performance is solicited from the community of practice, the public, and alumni, and is used in planning and improvement.

Criterion 4 – The institution or program has in place an effective process of continuous self-assessment, planning, and improvement.

- The institution or program has a program of systematic and comprehensive assessment that is conducted on a regular schedule and integrated into overall planning and improvement efforts.
- Program assessment and planning are based on clearly defined and measurable goals, and supported by regular, systematic collection and assessment of data.
- The institution or program documents how evaluation and assessment results are incorporated into program planning and efforts to improve the program's effectiveness.

Criterion 5 – The institution or program accurately represents itself to its public(s) and provides sufficient information to ensure accountability and consumer choice.

- Current and accurate information is available to applicants and the public about institutional and programmatic admissions policies, tuition and fees, financial aid, graduation and credentialing requirements, academic policies, and student services.
- The institution's or program's documents and publications accurately reflect its mission, philosophy, and goals.
- Advertising, recruitment, and admissions materials are regularly evaluated and revised to ensure that they clearly and accurately represent the program and graduate career opportunities.
- The institution or program fully and clearly states the accreditation status of the institution and program, including the results of accreditation reviews.

THE "PLUS ONE" CRITERION

The model proposed by the Task Force includes a sixth criterion, to allow each accrediting agency and its stakeholders to create a standard that reflects the unique character of the individual profession. The "plus one" criterion provides flexibility and can encourage discussion within each field of the profession's defining attributes and how to measure them.

There are many options for accrediting agencies in developing and implementing a "plus one" criterion. The Accreditation Board for Engineering and Technology, in its proposed Engineering Criteria 2000, states that program faculty must assure a curriculum that includes 1) one year of a combination of college math and sciences and experience; 2) 1.5 years of engineering topics, including engineering sciences and design appropriate to the student's field of study; and 3) a general education component that complements the

technical curriculum. A comparable criterion might be developed by each of the health professions accrediting agencies.

The profession of counseling offers another example: Several program specializations may be offered by the same academic unit, from school counseling to marriage and family counseling to career counseling. In this case, the "plus one" criterion may address the need for students to declare a specialization that offers both curricular experiences and clinical site work appropriate to the area of specialization. Accreditation in the arts may have a similar need to focus on specializations within the field. Several of the health professions offer such areas of specialization, and a "plus one" criterion would require each profession to clearly define its unique professional role.

BARRIERS AND INCENTIVES

Despite several barriers to universal adoption of common criteria and standard elements, this strategy offers many obvious benefits. The National Policy Board on Higher Education Institutional Accreditation proposed the establishment of consistent standards for assessing institutional quality and student outcomes, as well as public disclosure of information about the effectiveness of educational and accreditation processes. But this proposal fell victim to perceptions that it would undermine regional accreditation and infringe upon institutional autonomy (Dill et al, 1996).

All professional bodies, their corresponding accrediting agencies, and educational programs have a vested interest in preserving and improving the quality of practice and the learning experience of future practitioners. Nonetheless, they may be reluctant to abandon the current, familiar criteria and adopt standards and measures that are universal and not specific to their field. They may also have concerns about meeting the fairly rigid requirements of the U.S. Department of Education.

The benefits of these common standards are very compelling. This standardized system provides criteria and accompanying elements that are sufficiently broad and flexible to avoid prescription and promote innovation. It offers the opportunity to reduce the costs and paperwork associated with accreditation, as well as the potential for developing common data collection forms and even a shared, computerized database for centralized reporting. Such a database could also provide comparable information on programs and accrediting agencies to the public.

Barriers to interdisciplinary education and training will be reduced with common standards. This system could also promote collaboration among the professions in accreditation activities, which could reduce costs. Perhaps most importantly, institutions and programs would actively focus their resources on improvement, emphasizing stakeholder involvement, data collection and use, and outcomes.

A CHALLENGE TO IMPLEMENT

Attempts are already underway to establish common accreditation standards to cross traditional jurisdictions. Four institutional accrediting agencies worked together to develop pilot Interregional Accreditation Standards for the Western Governors University (WGU), the mission of which is "to promote competency-based degrees through high-quality distance education." The resulting set of 10 common criteria represent a new effort at crossing geographical boundaries to encourage distance learning and other non-traditional education models. It may also represent a first step toward creating universal institutional accreditation standards, which could include a "plus one" criterion to account for unique aspects of the individual regions.

The Malcolm Baldrige National Quality Awards Program has adopted universal criteria for assessing the quality of education (NIST, 1998). These standards offer an alternative to current self-assessment criteria, providing a common framework that transcends professional and disciplinary boundaries. The 1998 education criteria are based on 11 core values and concepts, including learning-centered education, continuous improvement and organizational learning, valuing faculty and staff, partnership development, management by fact, and result orientation. To encourage even broader cooperation among the professions, language and basic concepts of the Baldrige Award Business Sector Criteria were adapted to education. "A major practical benefit from using a common framework for all sectors of the economy is that it fosters cross-sector cooperation and sharing of best practices information" (NIST, p. 36).

The Task Force challenges members of the health professions education accreditation community to test the proposed common criteria and develop implementation models. Professions that already collaborate — such as occupational therapy, physical therapy, and speech therapy — could pilot the "5+1" criteria and core elements to evaluate the effectiveness of this system. Academic health centers present another opportunity for cooperation in this

area by investigating models for institutional accreditation. Thus, this system may create incentives to expand professional collaboration within and across institutions.

Acknowledgment: The Task Force on Accreditation of Health Professions Education would like to thank the participants in this project from the membership of the Association of Specialized and Professional Accreditors and ASPA Executive Director Cynthia Davenport for their support and participation in this work.

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ENDNOTES

1. Accreditation is also used in institutions, organizations, and post-graduate or continuing education programs, but these forms of accreditation are outside the scope of this report.

2. A more detailed discussion of these concerns may be found in the Working Papers of the Task Force, published in 1998.

3. See the Working Papers of the Task Force on Accreditation of Health Professions Education (1998) available from the UCSF Center for the Health Professions.

4. For further information on the services and publications offered by the Center for Quality Assurance in International Education (CQAIE) and the Global Alliance for Transnational Education (GATE), please contact these organizations at One Dupont Circle, NW, Suite 515, Washington, DC 20036; email CQAIE@aacrao.nche.edu.

APPENDIX

Selected Stakeholder Consultations, 1996-1998

American Association of Higher Education, Assessment and Quality Conference (1997, 1998)

American Public Health Association (1997)

Association of Academic Health Centers, Education Policy Seminar (1997)

Association of Academic Health Centers, Health Professions Educational Policy Group (1998)

Association of Schools of the Allied Health Professions (1997)

Association of Schools of Public Health (1997)

Association of Schools of Public Health, Accreditation Council (1998)

Association of Specialized and Professional Accreditors (1997, 1998)

Commission on Accreditation of Allied Health Education Programs (1997)

Commission on Collegiate Nursing Education (1997)

Council on Higher Education Accreditation (1998)

Council on Social Work Education (1999)

Division of Nursing, Bureau of Health Professions, US Public Health Service (1996)

Health Professions Network (1997, 1998)

Maricopa County Community College (1998)

National Council of State Boards of Nursing (1997)

National Forum on Quality Improvement in Health Care (1998)

National Forums on Accreditation of Health Professions Education (1997)