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

The Task Force on Accreditation of Health Professions Education

WORKING PAPERS
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These documents are a series of independent papers based on the work of the Taskforce on Accreditation. They are intended to be stand alone documents, although taken as a set they provide a comprehensive overview of the history, purpose and future course of the health care education accreditation process.

The Task Force on Accreditation of Health Professions Education

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INTRODUCTION

Background

Since its inception, the main purpose of institutional and specialized accreditation has been stated to be protection of the consumer and assurance of the quality of education. However, as education costs and the costs associated with the accreditation process have increased, there has been considerable debate about the true value and role of accreditation. Some of the strengths of the accreditation process include assurance of quality; promotion of self-assessment and continuous improvement; establishment of standards derived by educators and practitioners which serve as a baseline for entry to professional practice; and peer review and consultation. Arguments against accreditation include such concerns as the amount of fragmentation among professions around accreditation; the perceived inflexibility and inability of accreditation to respond to environmental changes; the existence of accreditation as a barrier to innovation; and the fact that accreditation seems to focus more on compliance and process rather than improvement and outcomes. These conflicting viewpoints of accreditation have created a situation where the actual value and merits of accreditation are often misunderstood.

Coupled with the recent and continuing transformation of the health care system, specialized accreditation of health professions education faces even more challenges. The challenges are centered around the ability of accreditation to maximize its strengths while minimizing its weaknesses amidst all of the changes in the health care system. The key strengths which will need to be maximized are elements such as the public assurance of quality; promotion of self-assessment; peer review and consultation; and the establishment of standards derived by educators and practitioners serve as a baseline for entry into professional practice help form a springboard for change and improvement in specialized accreditation.

Accreditation was established to ensure quality of education and thereby protect the public, both students enrolling in programs and customers of professional services provided by program graduates. But concerns have arisen about the usefulness of accreditation. Critics claim that the process, with required quantitative information and outside judgments, does not help the program or even ensure quality. There is also a great deal of duplication of paperwork and processes between regional and specialized accreditation. Some institutions submit multiple applications to a single accrediting body for related degree programs. Accreditation requires extensive financial and personnel resources that some claim could best be used elsewhere.

On the other hand, the accreditation process offers the opportunity to introduce improvement methods and peer review and promote innovation. Accrediting agencies can also provide a locus for interested parties to influence professional education standards and ensure competencies are current and relevant.

The Task Force on Accreditation of Health Professions Education

The deliberations of the Pew Health Professions Commission throughout the 1990's have suggested the need to examine health professions education accreditation, and to make recommendations which can serve as the basis for key stakeholders to make improvements. In 1996, the Center for the Health Professions, with support from The Pew Charitable Trusts, established the Task Force on Accreditation of Health Professions Education. This national Task Force was charged to lead this examination and facilitate dialogue among key stakeholders in the accreditation process including educators, accreditors, professionals, consumers, and government. The Task Force expects to submit its report to the Pew Health Professions Commission in the summer of 1998.

The goal of the Task Force is to make recommendations to improve the accreditation process so that it better meets evolving social needs. To meet this goal, the Task Force established four objectives:

- To identify issues associated with the current system of accreditation of health professions education.
- To engage the community in these discussions.
- To propose strategies which when implemented will strengthen accreditation's role in protecting the public interest.
- To recommend specific actions for improvement for accreditors, educators, practitioners and other key stakeholders in the health services system.

A cross-section of the interested parties who participate in or are affected by health professions accreditation are represented on the Task Force, as well as individuals from outside of the health professions who have insights into U.S. higher education and systems of educational accreditation and assessment. Each member of the Task Force has had considerable previous experience with accreditation, and all have participated in the work of at least one accrediting agency. By virtue of its organization through the Center for the Health Professions, the Task Force can act as an independent party with no vested interests, and can therefore provide an objective and constructive perspective of accreditation.

In order to better understand how educational program accreditation interacts with various health system processes, the Task Force first identified issues associated with the current system of accreditation of health professions education. This was conducted through Task Force discussions, as well as briefings with a number of interested organizations. In May 1997, two national forums were held in Chicago, IL and Washington, DC, to engage the broad community of interest in dialogue about issues and possible models of innovations in accreditation. Approximately 75 participants attended the forums, including representatives of accrediting organizations, accredited institutions, professional associations and other interested parties responding to public notices about the forums.

The forums provided an opportunity to consider issues related to the changing health services system and current issues in accreditation. In break-out sessions, participants defined the essential values of health professions accreditation and discussed core topics identified in advance by participants:

- Minimizing duplication and waste;
- Linkage of regulation and accreditation;
- Making exceptions to standards;
- Accreditation and interdisciplinary education; and
- Accreditation as a model for assessment and improvement.

Comments from the small group sessions were then synthesized, including recommendations and possible actions to improve accreditation. A summary that captures the full range of the discussions at the forums can be found on the Center's Web site at http://futurehealth.ucsf.edu.

Since the forums, the Task Force has continued to pursue dialogue with interested stakeholder groups, including the National Council of State Boards of Nursing, the American Association of Higher Education, and the Commission on Collegiate Nursing Education. Task Force members also solicited feedback from participants in the Academic Public Health Caucus at the American Public Health Association 1997 annual meeting. Over the next few months, further discussions will be held with the Association of Specialized and Professional Accreditors, the Council on Higher Education Accreditation, and the Association of Academic Health Centers.

As part of the continuing efforts to encourage discussion in interested communities and solicit feedback, the Task Force is publishing this set of working papers. First, a history of educational accreditation in the U.S. provides a

background for the development of the current environment. The Task Force has conducted a comprehensive review of health professions and other education accreditation standards and procedures; this second paper also contains a comparison of current accreditation standards with the practitioners competencies identified by the Pew Commission. The next paper discusses the linkage of assessment to accreditation to encourage improvement is included. Finally, a former university president offers a perspective on the future role of educational accreditation.

The Task Force is drafting a series of recommendations for the future of accreditation in the health professions. These include strategies to strengthen accreditation's role in promoting quality education and preparing competent health services practitioners for a changing environment. Input will be solicited at upcoming meetings of key stakeholder groups. The Task Force is also exploring mechanisms to promote the adoption and implementation of final recommendations.

Further information about the work of the Task Force may be found on the UCSF Center for the Health Professions Web site (http://futurehealth.ucsf.edu). To provide feedback on the work of the Task Force, please contact Dr. Sherril Gelmon via e-mail (gelmons@pdx.edu).

THE CURRENT CONTEXT: Where We Are and How We Got Here

The Current Reality

With the rapid pace of change in the educational and health care systems today, the ability of health professions education accreditation to respond to the needs of the professions, educational institutions, students and the ultimate consumers of health services has come into question. The accreditation process in U.S. higher education includes a common set of components: self-study, preparation of documentation, on-site peer evaluation, presentation of findings in report format, decision-making regarding accreditation status, and ongoing periodic review, updates and reporting.

The current system of specialized accreditation in the health professions reflects the environmental and political forces of the past few decades. The Pew Health Professions Commission has called repeatedly for reform of accreditation in its reviews of health professions education and work force regulation (Shugars, O'Neil and Bader, 1991; O'Neil, 1993; Pew Health Professions Commission, 1995). In 1996, the Commission created a Task Force on Accreditation of Health Professions Education, and charged this interdisciplinary group with engaging the broad community of accreditors, professional associations, and higher education organizations in a series of discussions on accreditation and with developing policy recommendations to improve health professions education accreditation (Center for the Health Professions, 1996). The Task Force membership is listed in the Introduction to this set of papers.

The members of the Task Force began by identifying and analyzing key issues in health professions accreditation. The accreditation process is intended to serve multiple customers: students, graduates, employers, institutions, and ultimately the public. In order to determine how specialized accreditation emerged as a measure of program quality, and why its supporters continue to advocate its importance, the Task Force began its work by asking several key questions and generating answers as discussed below.

The first question was: **What are the current strengths of specialized accreditation in health professions education?** It elicited the following responses:

- Provides a hallmark of program excellence and achievement beyond minimum standards,
- Formalizes the shared values of a profession and integrates them with those in health care and higher education,
- Provides public policy makers with a strong tool to assure the public's interest and investment is protected,
- Ensures that programs are responsive to changing public needs and demands,
- Facilitates professional marketability and mobility through a broadly recognized and valued credentialing process,
- Provides a voluntary, non-regulatory (non-governmental) process of peer review and collaboration for program improvement,
- Provides leverage for programs to preserve and strengthen institutional support and ensure equitable access to institutional resources,
- Fosters continuous improvement of educational programs, and
- Encompasses a broad range of measures of program quality, including structures, processes, and outcomes.

Despite these strengths, accreditation has been criticized increasingly for not meeting the needs of its multiple customers. Therefore the second question asked was: **What are the major weaknesses of specialized accreditation in health professions education?** It was answered as follows:

- Focuses more on single point inspection and compliance than on continuous program improvement,
- Emphasizes policies and practices that are often more regulatory and punitive than voluntary and consultative/collaborative,
- Protects and elevates the self-interests of the individual professions above those of the public,
- Provides minimal opportunity for involvement/input by certain stakeholders, e.g., practicing health professionals, employers, consumers, policy makers, and payers,
- Creates and/or reinforces fragmentation and segmentation within the institution as a result of the proliferation of multiple accrediting bodies,
- Creates competition with other disciplines that do not have specialized accreditation (specialized programs are often viewed within the institution as getting more than their fair share of resources because of their specialized accreditation status),
- Varies widely among the health professions in terms of criteria, processes and procedures,
- Prohibits cross-disciplinary or interdisciplinary standard-setting and program review,
- Uses a highly prescriptive, "one size fits all" approach in some disciplines,
- Responds slowly to changes in society and in health and higher education environments because of cumbersome processes for developing, approving, and implementing changes in established accreditation criteria and practices,
- Discourages experimentation, innovation, flexibility and the capacity to be responsive to local/state needs and specific institutional character and mission,
- Diverts resources from core operations (teaching, research, service) to support costly, burdensome and often duplicative reporting/self-study activities,
- Offers insufficient evidence that accreditation criteria and processes are valid and reliable,
- Focuses heavily on structures and processes, with insufficient attention paid to outcomes and added value.

The need and demand for change in the current system and processes of specialized accreditation are being driven by a variety of forces, both within and external to the programs and institutions themselves. Unfortunately, many barriers that inhibit change and protect the status quo exist in the current environment. Some of the obstacles are endemic to the change process itself, while others are specific to specialized accreditation.

This leads to the third question: **What are the barriers to change in accreditation of health professions education?** Barriers identified by the Task Force include:

- Established traditions in health professions education and general resistance to change,
- Decentralization and overspecialization of the health professions, with each accrediting agency and profession wishing to preserve its autonomy and "turf,"

- Self-interests of the professions and their respective accrediting bodies, and the desire to maintain established boundaries and hierarchies,
- Well-entrenched structures and processes within the current system of specialized accreditation, establishing accreditation as a "big business,"
- Wide variation in accreditation practices among the different health professions and their accrediting agencies,
- Wide variation among health professions educational programs themselves (length of program, requirements, professional vs. technical, etc.), thus requiring different measures of program quality,
- Escalating costs (human, material, technological, time) associated with specialized accreditation,
- Rigid, prescriptive criteria and policies of the current approval bodies, especially the U.S. Department of Education, that violate the spirit of voluntary accreditation, and
- A generally litigious society.

This is the reality we find ourselves in today. How did we get here?

History of Educational Accreditation

The nature and evolution of accreditation in U.S. higher education dates back to 1862 when Congress passed the Land Grant Act. This act granted federal land to the states to facilitate the establishment of state universities. As these "land grant" and other universities and colleges flourished, Congress and the public began to question the quality of education being delivered. Accreditation emerged as a response to meet expressed concerns.

The commonly accepted purpose of accreditation is the promotion and assurance of the highest quality in education. However, the process for ensuring program quality through accreditation has changed over time. In the late 1800's and early 1900's, the federal government and the institutions themselves struggled to make higher education more accountable to the public. One of the principal weaknesses of the U.S. higher education system was its lack of centralized control (Blauch, 1959). The absence of a "ministry of education", similar to that found in many other countries, was viewed as a limitation in the U.S. system (U.S. DHEW, 1977). Thus, voluntary accreditation emerged as a way to achieve greater control in assuring the delivery of high quality education by colleges and universities, while at the same time avoiding government regulation, historically feared in the U.S. Thus, accreditation bodies developed initially in response to a recognized need for non-governmental peer review, and secondly, to address specific regional and professional standards for assuring quality.

Early on, accreditation was four-pronged (Blauch, 1959). First, agencies charged with accreditation responsibility established criteria and standards for higher education programs. Second, inspection of institutions was provided by competent authorities to determine if the institution met these standards. Third, a list of institutions that met the public standards was published regularly, and finally, periodic reviews were instituted to make certain that these institutions continued to meet the established standards.

Over the past 70 years, accreditation has shifted from a fairly rigid to a more flexible approach. Accrediting agencies have taken the initiative in adapting their processes to encourage institutional and program individuality, rather than mandating that all academic units look alike. There also has been a shift from strictly external review to a review process that relies heavily on internal self-evaluation and self-regulation. These changes reflect changing societal expectations and demands (Young, et al., 1983).

The earliest accreditation organizations in the professions appeared around the turn of the century (Blauch, 1959). Dates of establishment include osteopathy in 1897, law in 1900, medicine in 1904, and nursing in 1916, although

most did not begin publishing lists of "accredited" programs until several years later. A significant point of leverage for reform of higher education was the publication in 1910 of the Flexner Report, prepared by the American Medical Association in conjunction with the Carnegie Foundation (Kells, 1994). This report prompted the adoption and enforcement of specific standards for medical education, resulting in the closure of a large number of inferior medical schools and generating a ripple effect across other professions and academic institutions. By providing a template for educational standards and program review, the Flexner report served as a catalyst for re-evaluating what was meant by "quality" professional education.

Regional accreditation of colleges and universities grew out of membership associations that had been established to improve the relationship between secondary and higher education and to strengthen college admission standards. While the six regional associations were established between 1885 and 1924, it was the North Central Association of Colleges and Secondary Schools that took the lead in accreditation, adopting its first standards for colleges in 1909, publishing its first list of accredited colleges in 1916, and incorporating standards for junior colleges and teachers colleges by 1918 (Blauch, 1959). With increasing professionalization and specialization of the workforce, and proliferation of academic programs to educate these new professionals, multiple accrediting agencies were established over the years to create program-specific standards and ensure the quality of specialized programs.

Given concerns about maintaining oversight of accreditation as a non-governmental voluntary function, various national organizations have played a number of roles over the years in officially recognizing accrediting bodies and providing certain membership services for these and other interest groups. From 1910 to 1948, the Association of American Universities (AAU) published lists of "approved undergraduate institutions" whose graduates were considered qualified for admission to the graduate schools of AAU members (Blauch, 1959). During the 1930's and 1940's, various approaches to appraising graduate schools for consistency across their educational programs were attempted, but were never implemented. All of the regional accrediting associations now include standards for evaluating graduate education.

While efforts to strengthen and ensure non-governmental oversight of higher education were underway, the federal government was becoming increasingly involved in accreditation. Specific activities included federal legislation that linked eligibility for federal funds (such as those authorized by the 1952 Serviceman's Readjustment Act) to accreditation, other "gatekeeping" mechanisms that connected student loan or special educational program funds to accreditation, and state legislation that tied eligibility for professional licensure and practice to graduation from an accredited program. State involvement in judging the quality of educational programs began in New York as early as 1784, with an emphasis on teacher education and liberal arts, although most state agencies did not begin accrediting or approving educational programs until early in the twentieth century (Blauch, 1959).

The proliferation of accrediting agencies and associations during the first half of the 20th century prompted calls for coordination of accreditation, and in 1949 the National Commission on Accreditation (NCA) was established to coordinate accrediting bodies and control the expansion of specialized accreditation (Blauch, 1959). The NCA was an institution-based organization that did not include the accreditors on its governing board. It established a series of operating principles, most of which are still in effect as fundamental components of the decentralized pattern of oversight and review of higher education in this country. These principles specified that:

- the six regional associations would be responsible for formal accreditation of colleges and universities in their respective region;
- the regional associations would deal only with national professional accrediting agencies recognized by the NCA, and colleges and universities would deal only with officially recognized professional agencies;

- professional accreditation agencies would meet certain requirements established by the NCA, and would coordinate their activities with the regional associations;
- no more than one agency would be recognized in a particular field of study, thus limiting the number of accrediting agencies and the potential for duplication of effort or competition; and
- the policies and procedures of all recognized accrediting agencies would reflect qualitative indicators as well as quantitative measures.

In 1964, the Federation of Regional Accrediting Commissions in Higher Education (FRACHE) was established as a forum for the regional associations to share concerns about institutional accreditation (Bemis, 1991). FRACHE worked closely with NCA, but over time, the number of specialized accreditors continued to increase, prompting rising concern about effective coordination among regional and specialized accrediting agencies. While a Council of Specialized Accrediting Agencies existed within the NCA, it became increasingly apparent that there was a compelling need to improve coordination among multiple accrediting agencies. The push for more effective coordination by a non-governmental organization eventually resulted in the creation of the Council on Postsecondary Accreditation (COPA) in 1975.

Initially, COPA concentrated its attention on recognition of specialized and professional agencies, but in 1980 assumed recognition of the regional associations as well (Bemis, 1991). For much of its history, COPA consisted of three constituent assemblies -- regional, specialized and professional, and higher education institutions (via their national membership organizations). Each constituency was represented in COPA's governance structure. One of COPA's main purposes was to monitor accreditation bodies to ensure they met certain standards. COPA also provided a network for collaboration and information sharing among the various accrediting groups.

In the early 1990's, the U.S. Congress expressed concerns about the significant increase in default rates in federal student loan programs, suggesting that default rates were linked to poor academic quality and reflected the failure of accreditation agencies to adequately monitor these programs. Students who default on their loans may be those who do not graduate or who graduate but are unemployable. Despite the fact that the overwhelming majority of high default rates occurred in financially unstable trade and proprietary institutions, Congress passed a new Higher Education Act (HEA) in 1992 that mandated greater governmental oversight of the accreditation process, increased the gatekeeping responsibilities of the accrediting agencies, and created super oversight bodies at the state level. These new oversight bodies, the State Postsecondary Review Entities (SPREs) were charged with monitoring federal student aid programs, assessing outcomes, and uncovering illegal and fraudulent activities. In 1994, however, federal funding for the SPREs was eliminated and they were dissolved.

The 1992 HEA also expanded the gatekeeping and regulatory functions of the DOE, converting the DOE from an agency concerned only with monitoring loan default rates and controlling access to federal training funds to an overseer and regulator of the entire accreditation process. Thus, the 1992 HEA shifted the culture and philosophy of accreditation from one of peer review and professional judgment to one of government regulation and prescriptive monitoring (Tanner, 1996). It is evident that these changes to accreditation have added regulatory functions to specialized accreditation, thus moving it beyond a solely voluntary, peer-review process. Concurrent with these developments, the long-established system of accreditation in higher education began to unravel. The directors of the regional associations decided in 1991 that the costs of participation in COPA exceeded the benefits, and announced their intention to reduce their support (Bemis, 1991). This announcement triggered serious discussions about the long-term viability of COPA, given increasing public and Congressional criticisms of accreditation, the added regulatory functions, and the competing agendas of COPA's constituent

organizations (Rubin, 1997). In 1993, the board of COPA voted to dissolve the organization. The following year a special committee of former members of COPA established a new entity, the Commission on Recognition of Postsecondary Accreditation (CORPA), to serve as a temporary mechanism for recognizing regional, specialized, and proprietary accrediting organizations until a new oversight entity could be established.

During this time, many of the specialized and professional accreditors worried that their professional and organizational needs would not be met once COPA dissolved. Under the leadership of the elected officials of the Assembly of Specialized Accrediting Bodies within COPA, private discussions began among the specialized accreditors in 1992 and the next year an organization was established to address the unique needs of specialized and professional accrediting agencies. This new organization, the Association of Specialized and Professional Accreditors (ASPA), became an important catalyst for developing common practices for specialized and professional accreditation and for information sharing within this community. Today, ASPA continues to be an effective resource through its clear mission and goal of meeting the needs of the specialized accrediting community. ASPA published a "Code of Good Practice" in 1995 which focuses on the values inherent in accreditation and outlines the responsibilities that should characterize the process and practice of specialized and professional accreditation (ASPA, 1995).

In 1994 the National Policy Board on Higher Education Institutional Accreditation (NPB) was formed by leaders of the regional accrediting associations and national higher education organizations to constitute a national coordinating body to succeed COPA. The NPB included representation from the nine regional accrediting commissions and from the seven organizations of higher education whose members are college and university presidents (National Policy Board, 1994). The NPB assumed responsibility for creating an organization that would take COPA's place in overseeing regional and specialized accreditation, and developed a proposal for a new oversight organization. The Board proposed the establishment of consistent standards for assessing institutional quality and student outcomes, as well as public disclosure of information about the effectiveness of both the accredited institutions and the accrediting agencies themselves. These proposals met with widespread opposition. The regional accreditors viewed the NPB's proposal as intrusive and undermining their responsibilities for setting regional standards for accreditation, while college and university leaders expressed concern that the NPB's standards would interfere with institutional autonomy and prerogative (Dill, et al., 1996). The proposal failed to garner sufficient support, and the NPB quickly dissolved.

Following the NPB's dissolution, a work group of college and university presidents formed to explore other ways to achieve coordination and recognition of accrediting agencies. In 1995, this group proposed the creation of a Council for Higher Education Accreditation (CHEA), which was overwhelmingly endorsed by the nation's college and university presidents. The principal difference from its predecessors, COPA and CORPA, is that CHEA is "owned" by the institutions, whereas COPA and CORPA represented and were supported by the accrediting agencies themselves (Braskamp, 1996). CHEA's members include degree-granting colleges and universities that are accredited by an organization recognized by CHEA. It is interesting to note the similarity in structure and governance of CHEA to that of the National Commission on Accreditation (NCA), created some forty years earlier!

CHEA became operational in 1996, and has several functions (CHEA, 1996). First, it provides a recognition function for the regional associations as well as specialized and professional accreditors. Second, it acts as a lobbyist for the community of accreditors. Finally, it has responsibility for ongoing evaluation of the accreditation process and for recommending improvements. CHEA assumed the functions of CORPA in late 1996, and CORPA was dissolved.

Accreditation's Future

Within this historical context, accreditation of health professions education programs evolved and was influenced by the many forces driving change in post-secondary accreditation in general. The system must continue to evolve in order to meet the demands of the changing society and rapidly changing health care industry. Accreditation needs to be more responsive. It should be a process of consultation and guidance through the use of peer experts. It must focus on processes and improvement, emphasizing the competencies of new graduate health professionals and the acquisition of skills and knowledge that will have relevance for future professional practice and community citizenship. In order to move toward a such a future, the Task Force asked a final question: **What/who might be facilitators of change?** The list of potential change agents includes:

- Policy groups, such as the UCSF Center for Health Professions
- Professional associations that cross disciplinary boundaries, such as AAHE and ASPA,
- University and college presidents through CHEA,
- Large health care organizations/employers,
- The accrediting agencies themselves, and
- Funding agencies, e.g., federal and state governments, foundations, etc.

These change agents must address issues such as those raised by stakeholders at the 1997 National Forums on the Future of Accreditation, which are summarized elsewhere in this set of working papers. In doing so, perhaps they will be able to agree upon a new, integrated approach to specialized accreditation in the health professions that will improve efficiency and flexibility, and increase the value of the process to educational institutions and their customers.

The goal of such a new model would be to shift the focus of accreditation from single-point inspection and compliance, to one of seamless data-gathering, self-assessment, decision-making and improvement. Up-to-date and reliable information would be accessed to ensure ongoing program quality. With such internal evaluation, the role of accreditors could then evolve into one of providing consultation and advice, from an external, interdisciplinary perspective. The Task Force will present specific recommendations and strategies in its final report, toward the end of 1998, to stimulate positive changes in health professions education accreditation.

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Understanding Accreditation Standards: A Review and Synthesis

The Task Force on Accreditation of Health Professions Education was established to explore strategies for improving accreditation. Accreditation, when operating at its fullest potential, acts as a tool for improvement and change. Similarly, accreditation standards have the potential to provide health professions education with a framework and a guide to realize improvement and change. Therefore, the task force has concentrated some of its efforts into conducting this review, recognizing the power of standards to drive meaningful change. A major activity has been to review current accreditation standards to identify areas of consistency and of variation, and to define core elements for improvement and change that could be applied to most agencies.

The Task Force identified key questions to frame this review. What values are expressed by the accreditation bodies? How do accreditation agencies justify the effort required to engage in the accreditation process? How are improvement concepts integrated into the accreditation process? What is the nature of accreditation criteria in use? How are outcome measures used, and are certain outcomes required? How do the standards reflect the health workforce competencies identified by the Pew Health Professions Commission? Finally, how do accreditors support the process and facilitate self-study?

This paper examines the variety of accreditation standards that exist in health professions education and analyzes how they reflect a core set of values and characteristics identified by the Task Force, as well as how they meet the competencies for the health workforce defined by the Pew Health Professions Commission. Periodically, accrediting agencies review their own standards; however, a comprehensive review across the accreditation standards of health professions education had not yet been conducted. The task force has attempted to fill this gap by completing a review of accreditation standards across health professions education.

These standards include those of most of the health-related professions that are members of the Association of Specialized and Professional Accreditors (ASPA) and others that are recognized by the U.S. Department of Education, as well as other non-health accrediting organizations that are known to incorporate innovative approaches into their accreditation processes. A list of agencies reviewed, including the acronym by which they are known, is included in the glossary in Appendix 1.

Values Expressed through the Accreditation Process

The first question is what values are expressed by the accrediting agencies in their published standards and guidelines. The Task Force identified seven values embedded in accreditation, closely related to the fundamental principles outlined by the Association of Specialized and Professional Accreditors (ASPA, 1995):

- promote and facilitate continual self-improvement,
- be contemporary, flexible and relevant,
- maintain core values of higher education, civic responsibility and professional excellence,
- align accreditation with changing realities,
- promote collaboration and an interdisciplinary focus,
- serve the public interest (protect consumers), and
- be cost-effective.

Each of the documents reviewed began with statements about organizational values. Many accreditors see themselves as something other than arbiter of educational quality and enforcer of standards. Some accrediting agencies describe their role as providing a service, as an advocate for members and applicants, or as an agent for

change. For example, Dietetics identifies two fundamental purposes for accreditation: "to assure the quality of the institution or program, and to assist in the improvement of the institution or program" (CAADE (a), p.88).

Each of the values is discussed below, with illustrations from selected documents of various accrediting agencies. In all cases throughout this paper, the documents reviewed are those provided in response to the Task Force's request; we recognize that in some cases revised documents have been published since this review was conducted, but it was not feasible to repeat each individual review. Any misinterpretations are the responsibility of the authors. Examples cited are intended to illustrate practices; no attempts have been made to include each agency each time it offered information relevant to a particular point of discussion; the review is not intended to be exclusionary, but rather to be illustrative by example.

- **Promote and facilitate continual self-improvement:**
  Health Information Management seeks to "encourage and stimulate improvement in the quality and conduct of professional educational programs" (AHIMA (a), p.3). A guiding principle for Business accreditation is "the achievement of high quality and continuous improvement" (AACSB (c), p. v) and Education states that an essential function is "to encourage continuous improvement" (NCATE, p.1).

  This value is also evident in the statements of some accrediting bodies with respect to the shift from critics to consultants. Accreditation "changed from that of a policing activity to one of providing educational institutions with assistance and guidance to insure the continued development of quality educational programs" (CAPTE, p.A2). The Council on Naturopathic Medical Education states that the accrediting body will act as "friendly" consultants as well as critics (CNME, p.20). The American Council on Pharmaceutical Education also describes the new role of accreditors as being more of a consultant, of a guidance counselor, and of an assistant in improvement (ACPE (a), p.20).

- **Be contemporary, flexible and relevant**
  Counseling points out that "standards are intended to accommodate the strengths unique to different programs" (CACREP, p. 89) and "has developed policies permitting the development of new specialty curricular standards ... and reserves the right to discontinue selected curricular standards" (CACREP, p. 54). In order to ensure that programs continue to be relevant, most accrediting bodies call for frequent self-evaluation. Radiologic Technology calls for accredited programs to periodically evaluate and revise their mission and goals (JRCERT, p.2).

  Many accreditors also apply this same standard to their own process: Social Work "will continue to revise standards and interpretive guidelines" (CSWE, p.1). Health Information Management "continuously evaluates the effectiveness of the accreditation review process for educational programs" (AHIMA (a), p. 4). Architecture has a formal procedure of continuous study of criteria and procedures with stakeholders every three
  years (NAAB, p.7). Education standards describe how the accreditation organization, its process, objectives and improvement activities are evaluated (NCATE, p.69).

- **Maintain the core values of higher education, civic responsibility and professional excellence**
  Many accreditors note their responsibility to the public is to ensure educational quality, and adequate preparation for professional practice. Some also note the need to encourage continuing education and personal/professional development.

Architecture states that it "exists to assure the maintenance and enhancement of an appropriate educational foundation for the profession of architecture, the aggregate effect of which will assure the maximum opportunity for success of the aspirants to the profession and, ultimately, a profession known to be both qualified and excellent" (NAAB, p.6).

- **Align accreditation with changing realities**
  Social Work seeks to "improve accrediting procedures on the basis of findings from educational research, new knowledge, changing needs and experience, and recommendations from the social work community" (CSWE, p.1). Architecture develops services to aid schools "in accord with the consensus needs of a dynamic and evolving profession" (NAAB, p.5).

- **Promote collaboration and an interdisciplinary focus**
  Many of the accrediting bodies are composed of representatives of various organizations that serve the profession. Counseling consults with other accrediting agencies (CACREP, p.11) and avoids overlap among their accreditation processes (CACREP, p.1). Dietetics calls for program curricula to "include experiences with other disciplines and expose students to a variety of settings, individuals, and groups" (CAADE (b), p.10). Specialized accreditors may also call for coursework in liberal arts, humanities and social sciences to broaden students' background, such as mandated by Computer Science (CSAB (b), p.11, 13).

  Architecture "criteria and procedures developed in coordination with professional schools, academic institutions, professional society, state regulatory boards, members of the profession, representatives of related professions, students and the concerned public" (NAAB, p.1). Engineering has interested parties outside of the commission review and comment on proposed standards and procedures (ABET (a), p.4). Business stood out for encouraging the frequent and meaningful involvement of many stakeholders in both the accreditation process and the continuous review of programs (AACSB (b), p.3-5, 7-9).

- **Serve the public interest**
  Dietetics states "accreditation cannot guarantee the quality of individual graduates or of individual courses ... but can give reasonable assurance of the context and quality of the education offered" (CAADE (c), p.88). Social Work accreditors seek to maintain the confidence of the public in the profession (CSWE, p.3). Psychology notes that "accreditation is intended to protect the interests of students, benefit the public, and improve the quality of teaching, learning, research, and professional practice" (APA, p.2).
  Psychology also focuses on the need to clearly describe the goals and model of training so that the different "publics" can make informed decisions about the program (APA, p.2).

- **Be cost-effective**
  While costs were not explicitly addressed in most standards reviewed, Counseling seeks to "keep the accreditation process as efficient and cost-effective as possible by minimizing the use of visits and reports, and by eliminating, wherever possible, duplication of effort between accreditation and other review processes" (CACREP, p.1). Counseling also calls for weighing the benefits of accreditation against the costs (CACREP, p.29). Dietetics offers programs an approval designation as an alternative to accreditation, eliminating the need for a site visit (CAADE (a), p.10). Coordination of site visits with regional accreditation visits and elimination of duplicative paperwork are goals of NCATE (p.6). Many agencies are simplifying the accreditation process, and thus reducing costs, by providing computer disks with forms so they need not be recreated.

Dentistry addresses the value of streamlining the accreditation process through the use of its criteria (CDA, p.i). Other accrediting bodies also use terms such as efficiency and effectiveness as values of accreditation which are related to the concept of streamlining accreditation.

Diversity

Most accrediting agencies explicitly address diversity in their standards and guidelines. The Dietetics 1997 proposed revisions require applicants to "protect student civil rights and comply with institutional equal opportunity programs" (CAADE (b), p.3). In its standards, Counseling calls for the recruitment and retention of diverse students and faculty members (CACREP, p.69). Social Work's handbook has extensive language regarding diversity, from providing the background and guidelines for affirmative action plans (CSWE, p.15-17) and requiring that policies demonstrate non-discrimination "on the basis of race, color, religion, creed, gender, ethnic or national origin, disability, age, political orientation, or sexual orientation" (CSWE, p.31), to asking each program to "document how it infuses cultural diversity into the curriculum" (CSWE, p.29).

In fields other than health, Architecture, Law and Psychology have strong statements about diversity. Architecture requires evidence that all students, faculty and staff are given "equal access to a supportive and positive educational environment in which to learn, teach and work," demographic diversity is monitored, and the program must "prepare students to enter a pluralistic society" (NAAB, p.11, 14). Law calls for "equality of opportunity in legal education, including employment of faculty and staff, without discrimination or segregation on ground of race, color, religion, national origin, sex or sexual orientation" (ABA, p.18) which includes retention and extends to potential employers assisted by the program. Cultural and individual diversity respect is required of accredited Psychology programs, and the APA criteria also mention language and socio-economic status as non-discrimination factors (APA, p.5).

Values of diversity and inclusiveness are also expressed in the composition of the commissions that implement, oversee, and/or coordinate the accreditation process. The accreditation commission for Health Information Management includes practitioners, educators and a dean (AHIMA (a), p.3). Social Work's commission includes 20 representatives of accredited programs, two public members
and three at-large members (practitioners or students) (CSWE, p.4). "Members of the public must . . . play an active role in the accreditation decision-making process" according to the Dietetics manual (CAADE (a), p.4). Computer Science's accrediting board consists of appointees of member organizations, including industry representatives (CSAB (a), p.2). The commission for Architecture is composed of professionals, school representatives, students, the regulatory board and the public (NAAB, p.6). Education has teaching, teaching education, specialty, student and public representation (NCATE, p.61).

Site visits are a common element across the accreditation process. Most accreditors use site visit teams consisting of "peer reviewers" nominated from a list of trained members or from lists provided by the member professional organizations. In most cases, the applicant program reviews the list and can petition to replace a particular member by documenting a potential conflict of interest. Social Work maintains that "the formation of accreditation site teams is a collaborative effort between the programs and the staff" (CSWE, p.46); the applicant program nominates reviewers from a Roster of Certified Site Visitors and the staff assists to ensure "a balanced team" with respect to ethnicity, gender and geographic composition while respecting the program's perspective. Similar procedures are found among many other of the accrediting agencies.

Site visit teams generally meet with a variety of stakeholders, including administrators, faculty, students and community representatives. Accrediting agencies often specify the need for interviews with individuals as well as groups. Many explicitly call for discussions with alumni (Counseling) and with the local professional community (Social Work).

Outside of the health professions, Architecture includes a member of the student organization on the site visit team (NAAB, p.27). Psychology has applicant institutions select their peer reviewers directly from a list (APA, p.22). Site visitors for Business ask to meet with external supporters of the program (AACSB (b), p.7-9) and Computer Science reviewers hold discussions with local industry and other potential employers (CSAB(b), p.11)

Justification of the Accreditation Process

All of the reviewed accreditation publications noted the need to maintain minimum standards to protect consumers and to support professional development and professionalism. Radiologic Technology notes in their standards that "the accreditation process offers both a means of providing public assurance of a program meeting accreditation standards and [serves as] a stimulus to programmatic improvement (JRCERT (b), p.i). The Dietetics manual also includes the full text of "The Role and Value of Accreditation" (adopted by COPA/CORPA), which states that "institutional and specialized accreditation are complementary ... the former assuring the total operating unit is satisfactory and the latter the nature and details of the particular program" (CAADE (a), p.89). Health Information Management notes three purposes for the accreditation process, including assisting "in the development and improvement of procedures and instruments for the evaluation of the educational programs and their effectiveness in preparing qualified practitioners" (AHIMA (a), p.3).

Several agencies also mentioned the need to provide a service to member and applicant programs, aiding the improvement process. Psychology states that accreditation is intended to "achieve general agreement on the goals of training .. to encourage experimentation on methods of achieving those goals and ... suggest ways of establishing high standards in a setting of flexibility and reasonable freedom" (APA, p.2).

When looking for the values expressed by the different accrediting bodies through their documentation, the Task Force considered the wording used in the accreditation standards, the composition of the commission and site visit teams, the stated mission and philosophy of the individual accrediting agency, and the explicit references made to the values of the organization and the profession.

All of the accreditation manuals/standards utilized an introduction/foreword/preamble as a place where the values of the agency were explicitly stated. Most agencies include a history of accreditation (both specialized and institutional) and of the accrediting body. This indicates that the history of accreditation and of the professions represents value to the agency involved.

One of the values of accreditation stated in every agency's standards is the assurance of educational quality. The accreditor for medical education -- the Liaison Committee on Medical Education -- states the values of medical education as "contributing to the advancement of knowledge and to the intelligent growth of its students and faculty through scholarly activity." (LCME, p.5). In its mission statement, the Commission on Dental Accreditation states that ensuring the quality of education ultimately leads to quality dental care for the public (CDA, p.i). The Accrediting Commission on Education for Health Services Administration includes, in its mission and vision, the value of encouraging universities to maintain and improve the quality of education (ACEHSA, p.1). Another example is offered by the Council on Nurse Anesthesia Educational Programs, which describes the value of accreditation as the "promotion of quality without inhibiting innovation" (CANAEP, p.ii).

Another value that all accreditation agencies assumed was that of the protection of the public through the inclusion of the public in the process of accreditation. In all of the "commissions" at least one public member was included. A few agencies included public members on the site visit teams as well. Other stakeholders that were represented on many commissions included members of the profession, representatives of institutions, educators, and members of the accrediting bodies themselves.

Dentistry also included the protection of the public welfare as one of the many purposes of accreditation (CDA, p.i). Health Administration states in its manual that another purpose of accreditation is to serve the public through the promotion, evaluation and improvement of educational quality (ACEHSA (a), p.9).

Interestingly, none of the agencies defined the population served in any specific terms. Some agencies, such as Public Health noted that they served "human populations" (CEPH, p.1), Physical Therapy mentioned "service to society" (CAPTE (a), p.A2), Nursing stated that the commission should be as "diversified as possible" (NLNAC, p.5), Medicine writes in terms of "patients" (LCME, p.1), and Pharmacy defined its multiple constituencies broadly (e.g. students, faculty, etc.) in terms of what the purpose of accreditation is for each group (ACPE (a), p.19). Naturopathic Medicine states in its eligibility section that schools must serve the interests of the students, rather than the board, faculty or the staff (CNME, p.8). Even though many accrediting bodies mention the populations which they serve, details about the diversity and scope of these groups were not always available.

As the shift slowly takes place from accreditation as a "policing" entity to one that is more consultative, some accrediting bodies have highlighted this shift in their narrative. For example, Physical Therapy describes how accreditation ". . . changed from that of a policing activity to one of providing educational institutions with assistance and guidance to insure the continued development of quality educational programs" (CAPTE (a), p.A2). Pharmacy also refers to the accreditor's role as a consultant, as one who provides guidance on the process, and as an assistant in improvement (ACPE (a), p.20).

Concepts of Continuous Improvement in Accreditation

The concept of continuous improvement is explicit in most accrediting agency guidelines. To answer the question of how improvement is incorporated into the accreditation process, we selected as the framework "the system of profound knowledge" outlined by Deming (Batalden and Stoltz, p.426); it includes four key concepts of improvement:

- knowledge of systems,
- knowledge of variation,
- knowledge of psychology, and
- a theory of knowledge.

All agencies used language such as "improvement", "ongoing assessment", "program development", "evaluation", and the "assurance of quality". However, few go into detail about the key concepts of improvement listed above.

- **Knowledge of Systems**

  The first principle, applied to accreditation, seeks to ensure that the applicant or accredited program understands the system in which it functions -- how and why it prepares professionals, the players within that system, and the outside forces affecting the work of the system.

  Dentistry mentions systems when it defines dental institutions as an important component of a system of higher education (CDA, p.1). Pharmacy details the importance of system planning and assessment as a means for continuous improvement (ACPE (b), p.9-10). Other accrediting agencies write implicitly about accreditation as a system, yet do not address this concept explicitly. Health Information Management states that a "primary goal of the accreditation process (initial and continuing) is the development of a thorough

understanding by an institution of its existing program and the needs of the community of interest" (AHIMA (a), p.8).

Among the non-health accreditors, there are also relevant examples. Business approaches accreditation from a systems perspective, describing the accreditation plan as establishing how to monitor and assess continuous improvement, beginning a constant review process for the applicant program (AACSB (a), p.13-14). Education calls for programs to increase quality over time through continuous review and refinement, including regular, systematic evaluation of the conceptual framework and programs (NCATE, p.12). Music specifies regular evaluation, planning and projection, which "should contribute to general understanding about the relationships of the parts to wholes, both for the music unit and its component programs" (NASM (a), p.64). The concept of accreditation as one element of a systems approach to program planning is seen in those agencies that suggest regular, on-going self-studies to review the goals and objective, models and curriculum of a program, such as demonstrated by Psychology (APA, p.2).

Counseling acknowledges that "specialties of today may not necessarily be appropriate in the future ... it is important to prepare students to be professional counselors first and counseling specialists second" (CACREP, p. 54). This comment suggests that this group is maintaining a broader system focus, recognizing the need to monitor and respond to the external environment.

While an understanding of internal and external systems seems like a fundamental concept relevant to accreditation, the lack of attention to this concept suggests that more attention could be given to defining systems concepts and knowledge within the accrediting manuals.

- **Knowledge of Variation**

The second principle of improvement, knowledge of variation, is also important to accreditation. Deming notes two kinds of variation: common cause, which is a result of normal variation and does not require adjustment of the system, and special cause, where a response to the particular situation is required (Batalden and Stoltz, 1993).

Many accrediting agencies implicitly acknowledge common cause variation. Most allow for minor exceptions to standards to account for the individual needs of an institution or a geographic region. Professional education programs need to understand variation over time, from the range of chance or common causes that may require adjustment of the system, to special causes which need a more focused response. How accreditors respond to special cause without violating consistent application of their standards is a common challenge for accreditation practice.

The potential for "over-reaction" to common cause variation is not addressed in many accreditation standards; however, all accrediting agencies detail the procedures which would be followed if any changes occurred. Nursing identifies these changes as "substantive" changes while other agencies termed these as "additions" (NLNAC, p.32). However, the theory of variation in terms of continuous improvement and a clear understanding of the "normality" of variation is not found in any accreditation manuals in any explicit wording or concepts.

Dietetics provides guidelines for programs to create new emphasis areas (CAADE (b)**,** p. 7). Counseling "has established policies permitting the development of new specialty curricular standards" (CACREP, p.54). Applicants for Counseling accreditation are "encouraged to submit statements of rationale as part of their self-studies" if they wish to justify variations from standards (CACREP, p.54).

Law calls for schools to address current and anticipated legal problems (ABA, p.13). Computer Science encourages "innovative, experimental and non-day programs" (CSAB (b), p.15). Business interprets their standards based on the institution's chosen mission and goals, allowing for adjustments in the accreditation plan and notes the need to identify when a program needs to change (AACSB (b), p.5). Education accreditors expect that programs will undergo regular change and improvement, designing new programs, phasing other out; they encourage innovation and experimentation (NCATE, p.12, 49). Architecture notes the changing needs of society, allows for diverse education philosophies and practices and encourages the development and implementation of innovative and unique learning and teaching strategies, methods and materials (NAAB, p.5, 14).

An explicit policy of engineering accreditors is "to avoid rigid standards as a basis for accreditation in order to prevent standardization or ossification ... and to encourage well-planned experimentation" (ABET (a), p.2). This suggests a recognition of the occurrence of variation, and a willingness to respond to it. Accredited architecture programs are encouraged to "select programs that challenge the status quo to develop and implement innovative and unique learning and teaching strategies, methods, and materials" (NAAB, p.15). Architecture accreditors will also "consider innovative methods" for satisfying the established criteria, provided the program has a formal evaluation process to assess and document student achievement (NAAB, p.15). Again, this orientation recognizes the inevitable presence of variation and attempts to accommodate it.

- **Knowledge of Psychology**

The third concept addresses the understanding of how motivation, design and internal change relate to continuous improvement. Most agencies explicitly address the need to motivate students, educators and programs that may seek accreditation, including recognizing and responding to change in the underlying system. Accreditation criteria commonly include the need to provide support to students and faculty. All addressed the need to retain qualified faculty and provide for development opportunities, including mentoring and observing current practices, as well as ensuring academic freedom. Often accreditors, such as Radiologic Technology, require programs to "provide the opportunity for faculty and students to participate in program governance" (JRCERT (b), p.3). Architecture calls for giving faculty, staff and students appropriate access to forming policy, procedures and academic programs (NAAB, p.23). Counseling accreditors ask that research support be available to faculty and students, and that students be encouraged to participate in workshops and seminars (CACREP, p.58).

Pharmacy addresses the theory of psychology when describing the needs of learners and the need to communicate and to appreciate the diversity of colleagues and patients. Pharmacy also describes the goal of education as meeting the diverse needs of learners, and outlines the educational process as involving students as active self-directed learners who will transition from dependent to independent learners (ACPE (b), p.8).

Dietetics states that professional education "should reflect the needs of students and prepare them for current practice and life-long learning" (CAADE (a), p.18). Architecture education "must take place in a pedagogical setting that prepares the individual for continuing personal and professional growth and development" (NAAB, p.13). Other accreditors cite the need to encourage continuous personal and professional growth.

- **Theory of Knowledge**
  One of the most difficult tasks for educational programs is to link theory to action. Program staff must learn to use evaluation and feedback to change processes. This also requires time and a forum for reflection by administration and faculty to make and implement plans, study results, and act upon the findings.

  Public Health utilizes student competencies as a way of defining quality, and is one of the only agencies reviewed which discusses transforming schools into "learning organizations" (CEPH, p.21). Medicine states that each program must utilize methods for determining the quality and level of achievement of its students (LCME, p.1). Dentistry states that a program needs to produce "life long learners" (CDA, p.9).

  Health Information Management encourages accredited programs to link the evaluation process to change. A committee, consisting of representatives of administrative staff, faculty, students, external program advisors and affiliated clinical sites, and chaired by the program director, is responsible for conducting the self-study (AHIMA (a), p.8). Not only must the self-study include strategies for correcting weaknesses and plans for future development of the program, but as well the results of the "ongoing [program] evaluation must be appropriately reflected in the curriculum and other dimensions of the program ... and [the program] must systematically use the information ... to foster student achievement" (AHIMA (b), p.4).

  Dietetics calls for using the data from the self-study as a basis for long and short-range planning (CAADE (a), p.13). Music accreditors advocate using the information derived from the self-study for long-term planning and projection. Activities that should be based upon information obtained in the self-study include development of new curriculum, identifying new activities, and even new programs (NASM (b), p.10).

  Another important aspect of improvement is the need to allow for and even facilitate experimentation and the implementation of changes in programs. Most accrediting bodies have guidelines specifying that if curriculum or the way certain criteria are met is modified, the accredited program must submit documentation for approval. The Dietetics policy revised in 1996 states that it "does not wish to stifle innovation by requiring excessive documentation of these changes" (CAADE (c), no page). Extensive examples of major program changes that must be reviewed and approved by the Commission prior to implementation are given, ranging from a change in mission to replacing or restructuring more than 30% of courses, and "are defined as significant changes that may affect compliance with the Standards of Education" (CAADE (b), p. 1).

  In its proposed revisions to the criteria, Engineering added to its basic objectives the need to encourage "new and innovative approaches to engineering education" (ABET (b), p.1). Law calls for schools to address current and anticipated legal problems (ABA, p.13). Education expects that programs will undergo regular change and improvement, designing new programs, phasing others out, and encouraging innovation and experimentation (NCATE, p.12, 49). Architecture notes the changing needs of society, allows for diverse educational

  philosophies and practices, and encourages the development and implementation of innovative and unique learning and teaching strategies, method and materials (NAAB, p.5, 14).

Core Components of Accreditation
Two of the core components of accreditation are the criteria (or standards) upon which accreditation judgments are made, and the role of measurement of outcomes in determining such judgments. The selected criteria and accompanying guidelines for preparation for accreditation were reviewed to determine how the accreditation processes support continual self-improvement by the applicants and member educational institutions, how outcome measurements are used, and what is the balance and flexibility of structure, process and outcome criteria.

Nature of Accreditation Criteria
The degree to which criteria specified by accrediting agencies are prescriptive has been a source of criticism. Increasingly accreditors are making criteria more flexible and allowing variances from standards if an adequate rationale is submitted (CACREP, p.54). Generally, criteria are more extensive and more specific for inputs than outputs. Perhaps the most common quantitative criterion is the number of course and/or practice hours.

As the Task Force studied the various sets of criteria, it looked for wording that would suggest flexibility and encourage creativity. Naturopathic medicine used wording that suggests flexibility. One of its objective is to "ensure that accreditation processes recognize and encourage diversity and innovation in colleges and programs" (CNME, p.3). Some agencies such as Nursing, Speech and Physical Therapy explain their criteria in terms of being competency-based.

All accrediting bodies require programs to notify the agency of an any substantive changes for re-evaluation. Some accrediting bodies require even minor changes to be reported. Health Administration's criteria are fairly prescriptive, yet its site visit procedures are somewhat flexible. Site visits are not granted for a specific time. Instead, the time between visits may be lengthened or shortened depending on the performance of the program as identified through periodic progress reports (ACEHSA (a), p.15).

Nurse Anesthesia writes its criteria in terms of minimums (CANAEP). For example, the duration of an educational program must be at least 24 months. It also uses an asterisk to mark those criteria that critical for accreditation decisions. These criteria exemplify the minimum; if a program is not in compliance with one or more of these minimum standards, then it potentially may not receive accreditation.

Although criteria may be slightly flexible, the policies and procedures of the accrediting agencies appear to be very formal and, at times, rigid. This may be confounded by the multiple levels of decision-making that exist for some accrediting agencies. For instance, within Physical Therapy there are six different governing groups which all play a part in the accreditation process. Although CAPTE is an independent body that makes the final accrediting decisions, the other governing bodies play an integral part throughout the entire accreditation process (CAPTE, p.A5-A7).

Radiologic Technology calls for use of a "currently recognized and accepted curriculum for the profession" and preparation for certain practice areas must be included (JRCERT (b), p.4). Counseling requires providing students with "placement service ... consistent with current recognized professional placement service practices" (CACREP, p.69).

Architecture, Engineering, Law and Music allow for programs to apply for variance from a standard, justifying such exemption. Business interprets their standards based on the institution's chosen mission and goals, and allows for innovation (AACSB (b), p.5). Engineering states that criteria are intended to be flexible, not to restrain creative and imaginative programs, and that they will "give sympathetic consideration to departures from the criteria" (ABET (a), p.5). This further illustrates this agency's acceptance of normal variation.

Some accreditors, such as Law, mandate minimum student to faculty ratios and full-time faculty members out of concern for increasing class size (ABA, p.7-11). Music has explicit criteria regarding library facilities and admission requirements, but most standards are not quantified; rather the criteria specify "as appropriate to meet program mission and goals" (NASM (a), p.54-66). Architecture offers maximum and minimum proportions for areas of study and evidence of adequacy for all other criteria (NAAB, p.11-12). Psychology identifies and describes general "domains", and "does not explicitly prescribe a program's educational goals or the process by which they should be reached" judging instead upon outcomes (APA, p.4). The Computer Science handbook describes the "Intent of Criteria" as "flexible enough to permit the expression of an institution's individual qualities and ideals ... to be applied with judgment rather than as rigid and arbitrary standards ... [and] intended to encourage and stimulate creative and imaginative programs" (CSAB (b), p.11). The phrases "must" and "should" are used to denote the flexibility of specific criteria by Computer Science.
Although many of the key concepts of continuous improvement are implicit in health professions education accreditation, they are not consistently addressed. Since these principles are often not presented in a systematic fashion, they are not easy to recognize. Close investigation, however, does reveal many of these concepts, suggesting that accreditors might find it useful to engage in some structured self-study of their own operations, enabling them to better understand their own systems, variation, understanding of psychology, and applications of theory of knowledge.

Outcomes
Input and process measures have commonly been used in accreditation, because of perceived difficulties in assessing outcomes. The focus on outcome measures has increased in part because of U.S. Department of Education requirements. Although "outcomes" are widely used in accreditation, they are conceived of, and measured, in distinct ways by the different agencies. The Task Force sought to identify how measurable outcomes are incorporated into accreditation standards -- why they are collected and how they are used to stimulate improvement.

Performance-based standards are very evident among the standards reviewed. For example, entry-level competencies for Health Information Management graduates are listed, but the methods to evaluate those skills are left to the discretion of the individual program (AHIMA (b), p.1-3). Dietetics identifies knowledge and performance requirements for professionals (CAADE (a), p.18). The most commonly suggested measures are tests of professional entrance examination results. Dietetics requires a first time pass rate of greater than 80% for the registration exam. Job placement, career development and achievement in further education are other commonly used measures. Surveys of employers are becoming more frequently used methods of collecting data on graduate performance (e.g. Health Information Management, see AHIMA (a), p.21).

Public Health asks for assessment of program objectives throughout the expected documentation. It defines assessment as the extent to which a criterion is met (CEPH, p.11). In its self-study guide, Health Administration presents several templates that detail what outcomes measures are required (ACEHSA (b), p.4-8). The templates include goals, objectives, types of measures, assessment process, and dates to indicate frequency of application of the measure.

The use of outcome measures varies across accrediting agencies. Some state measures explicitly and others only mention that the programs should be evaluated. Dentistry states that programs must focus on outcomes, and describes some quantitative outcome measures such as patient reviews, attrition rates, and student performance on standardized tests (CDA, p.28, 30). In general agencies rely upon quantitative measures. Occupational Therapy requires outcome data such as national certification examination scores and national recognized standardized tests (ACOTE, p.5). Medicine also mentions measures such as national norms to determine student achievement (LCME, p.14).

However, other qualitative data are mentioned by some agencies. For example, it is stated in LCME's accreditation manual that schools include narrative descriptions of student performance and of non-cognitive achievement in supplemental grade reports as measures of outcomes (LCME, p.14-15). Occupational Therapy not only requires salary ranges of graduates but also data from job satisfaction surveys of alumni and interviews of employers, as well as employed graduates (ACOTE, p.5). The NLN gives certain required outcomes such as completion rates and patterns of employment, and some optional outcomes such as organization of work environment and evaluation (NLNAC, p.48). This presents a framework for schools to utilize a range of data types.
Business highlighted the need for outcome measures to judge teaching effectiveness (AACSB (a), p.36). Performance criteria for Architecture call for the evaluation of student work, but not the form the work or method of evaluation (NAAB, p.14). Others also mentioned evaluation to aid in advising and helping students. Music accreditors provide course work guidelines, but only call for a "curricular structure, content and time requirements [that] enable students to develop the range of knowledge, skills, and competencies expected of those holding" a particular degree (NASM (a), p.75). To demonstrate student competencies, a broad range of evaluation techniques are listed, including juries, critiques, course-specific and comprehensive examinations, institutional reviews, peer reviews, and the performance of graduates in various settings (NASM (a), p.127). Music accreditation also stresses that educational programs must analyze and organize the evaluation data to judge if its goals and objectives are being attained, and for planning and projection (NASM (a), p.64).

Psychology emphasizes using outcome data to assess if the goals, model and curriculum are appropriate for local, regional and national needs (APA, p.10). Psychology also notes that "an institution has the right to be evaluated in the light of its own education and training philosophy, model, goals, objectives, and methods, insofar as they are consistent with those generally accepted as appropriate" (APA, p. 3) and that "the review process will place great emphasis on the outcomes or products of a program's training efforts" and therefore describe domains, while avoiding the use of a checklist.

The Pew Health Professions Commission Competencies for the Health Workforce

Another method we used in an attempt to describe and characterize the various sets of accreditation criteria was an analysis of the health professions standards against the Pew Commission competencies. The deliberations of the Pew Health Professions Commission over the past eight years have suggested the need to conduct a careful examination of health professions education accreditation as it exists today. The Commission has also made recommendations to key stakeholders to make improvements in the system of accreditation. The Commission first set out its vision of practice needs (for the year 2005) in a set of seventeen core competencies for the health professions workforce in its first report (Shugars, O'Neil and Bader, 1991). These competencies have been carefully reviewed and incorporated into curricular planning and review procedures by some health professions educators, and offer the unique potential to shape health professions education into an improvement and community-centered model.

The competencies are defined across disciplines, and have been generally well accepted by the health professions education community. They therefore offered a logical and consistent framework against which to compare the multiple sets of accreditation standards in an organized and meaningful way. Given that health professions educators are in general familiar with the work of the Pew Commission, and that its findings and recommendations are widely respected and viewed as innovative and thought-provoking, we hoped a review of standards using the Commission work as a base could provoke similar thought and potentially encourage action. The competencies can also be viewed as one set of benchmarks for curriculum content; by using them in this way, we set out to determine the extent to which curricula prescribed by the current accreditation standards addressed these benchmarks and where there might be opportunities for improvement. We have received some feedback suggesting that the competencies are not an appropriate method for analysis, yet none of this feedback has explicitly addressed which competencies are not relevant for a particular profession. Therefore we continued with the assumption that if the competencies were generally accepted as a model for the future health professions workforce, and if accreditation standards define curricula which prepare the future health professions workforce, then the competencies would in fact be an appropriate model for analysis.

The competencies are listed below; more detail on their content and interpretation may be found in the Commission's third report (Pew Health Professions Commission, 1995):

- care for the community's health
- expand access to effective care
- provide clinically competent care
- emphasize primary care
- participate in coordinated care
- ensure cost-effectiveness and appropriate care
- practice prevention
- involve patients and families in decision-making process
- promote healthy lifestyles
- assess and use technology appropriately
- improve the health care system
- manage information
- understand the environment's role
- provide counseling of ethical issues
- accommodate expanded accountability
- participate in a racially and culturally diverse society
- continue to learn

Process of Review

In December of 1996, a request for a copy of standards/criteria was sent to all specialized accreditation agencies. For the purposes of the analysis against the Pew competencies, only the health-related standards were used. The

definition of health professions included all groups studied by the Pew Commission at one time or another, and generally agreed to be part of the sphere of health professions education (using definitions from the Bureau of Health Professions, for example). The review was restricted to accreditation of programs preparing individuals for a first professional degree, and did not include accreditation of advanced practice programs such as that conducted by the Accrediting Commission on Graduate Medical Education for medical residency programs.

With follow-up, and after elimination of some agencies where standards were in the process of review, there were twenty-two sets of standards to review. A content analysis of key words and concepts reflecting the seventeen Pew competencies was conducted. From the beginning, the task force realized that a review would be inconclusive without feedback from the accrediting agencies. Therefore, the initial findings were sent back to the participating agencies with a request for feedback. Most of the agencies provided citations of their standards to illustrate how the competencies were addressed. The results were modified accordingly.

Findings

The final results of the review are summarized in Table 1. In an effort to present the findings in an organized and meaningful way, the following discussion is presented in order of most frequently cited competencies.

- **Provide clinically competent care**
  This competency seemed to be the clearest and the easiest to pinpoint within all of the reviewed standards. The fact that all applicable standards met this competency was not surprising due to the nature and scope of health professions. *Providing clinically competent care* exemplifies a major strength of the accreditation process for health professions education and is therefore evident in the uniformity across the standards.

- **Providing counseling of ethical issues**
  This competency was addressed explicitly in most accrediting agency standards. For instance, Optometry states that "the optometric curriculum must provide education in areas of public health, ethics, practice administration and jurisprudence that is directly applicable to optometric care" (COE, p.17). Medicine's standards state that "the curriculum must include ethical, behavioral, and socioeconomic subjects pertinent to medicine" (LCME, p.13). In both of these examples, the ethical counseling aspect was explicitly found in the curriculum content section of the standards as it was in all of the other agency standards.

- **Assessing and using technology and managing information**
  Another strength that was evident in the standards was the connection between the standards and the competencies--**assessing and using technology and managing information.** The Pew Commission describes the health care system of the near future as one that is driven by information and the management of this information. In order to educate health professionals to interact in the emerging health care system, the management of technology and information must not be overlooked. Furthermore, the Pew Commission describes in the Third Report that the "practitioners of the future must be able to understand and apply increasingly complex technology in an appropriate and cost-effective manner"(Pew Health Professions Commission, 1995, p.xiv).

  When reviewing the standards these competencies were more evident in the accrediting agency standards that related more appropriately to disciplines that were technology or information-focused. For example, the technically-driven disciplines such as radiologic technology, cytotechnology, and nuclear medicine technology and the information-driven disciplines such as health information management explicitly used terminology that directly related to these competencies. It is not to say however, that those non-technology driven and non information-driven disciplines should be exempt from meeting these two competencies. As

the Pew Commission has pointed out, the health care field focuses more on new technology and depends more on computer applications and information management; therefore, accrediting bodies of health professions education must embrace the assessment of technology and the management of information by reflecting this in their standards.

- **Practice prevention, emphasize primary care and promote healthy lifestyles**
  Interestingly, the competency *practicing prevention* was addressed more often than **emphasizing primary care** and **promoting healthy lifestyles.** Not surprisingly, the majority of standards which met this competency were discipline specific. For example, Medicine, Public Health, Dietetics, Occupational Therapy, and Dentistry were among the accrediting agencies whose representative disciplines included aspects of primary care. Because of this, the wording of their standards reflected the preventative nature of the particular profession.

  The **promotion of healthy lifestyles**, did not explicitly exist as broadly as **emphasizing primary care.** In Criterion I of the Public Health standards, terms like "conditions that protect and promote the health of populations," speak directly to the competency **promotion of healthy lifestyles.** Some agency standards such as CEPH includes words like "ensure public health"(CEPH, p.3), yet are not explicit in including words like the **practice of prevention.** Naturopathic Medicine states in its standard VI, C.2.d. that students must learn to "Practice preventative medicine. Promote wellness" (CNME, p.44). Although, the **promotion of healthy lifestyles** may be implicit in the **practicing of prevention** and the **primary care emphasis** competencies, in order for standards to fully meet this competency, standards will have to employ the use of more explicit verbiage.

- **Care for the community's health**
  A group of competencies that were met by about half of the standards were the following: **care for the community's health, participate in coordinated care, ensure cost-effective and appropriate care, understanding the role of the environment, and accommodate expanded accountability.** Care for the community's health is described by the Pew Commission as meaning the shift of the health care system from an individual focus that centers around acute problems to a community focus that centers around a broader understanding of the determinants of health. Most standards used words like community, the public and society which were sufficient to address the competency **caring for the health of the community.** Standards have the potential to build a higher level of community caring by including the concept of community partnerships. By striving to create partnerships between communities and health professions education institutions or programs, the health of the community can be protected and potentially improved. Certainly, there is improvement work that could center around this competency in health professions education.

- **Understanding the role of the environment**
  As more attention is focused on the impacts of the environment on society and its health behaviors, health professions education needs to integrate into its curriculum content a focus area around environmental issues. Many accreditation agency standards already require the inclusion of environmental issues in their standards. For example, Health Information Management meets this competency with standards in the subdomain identified as the "Legal and Regulatory Environment" (AHIMA (a), p.34). In the Physical Therapy standards under the examination section, test and measures of students will include "environmental, home, and work barriers" (CAPTE (a), p.29). The fact that almost half of the accrediting agencies recognize the importance of the environment in the curriculum by including this in their standards represents an area of strength as well as an area for improvement. Improvement work can be accomplished

by expanding the use of the competency **understanding the role of the environment** across all health professions accreditation standards.

- **Participate in coordinated care**
  As the health care system moves to a more integrated model, health professionals will have to work in coordinated care settings. Coordinated care is exemplified in an integrated team setting that demands organization and effectiveness. In order to prepare students in health professions education to enter the transformed health care system, the competency **participate in coordinated care** can act as an important preparatory tool. If standards can include this competency in an explicit way, teaching institutions will be held accountable for preparing their students to become members of integrated teams who will participate in coordinated care. A good example of a standard that meets this competency is found in Dietetics CD38 which states "coordinate and modify nutrition care activities among caregivers" and in C39 which states, "Conduct nutrition care component of interdisciplinary team conferences to discuss patient/client treatment and discharge planning" (CAADE (b), p.21).

- **Ensure cost-effective and appropriate care**
  The Pew Commission describes this competency as one driven by the consumption of the nation's resources by health care. The Commission recommends that health professionals be able to "utilize resources in a thoughtful and rational manner" (Pew Health Professions Commission, 1995, p.xiii). The emerging health care system demands the management of costs and therefore, health professions education must teach students how to operate within this changing health care system. One example of a standard that addresses this competency is the Dietetics standard CD22 which states that a dietitian must be able to "supervise the integration of financial, human, physical, and material resources and services" (CAADE (b), p.20).

- **Accommodate expanded accountability**
  This competency addresses the ability of health professionals to respond to the public, the political environment and the changing health care system. A good illustration of this competency was found in the Dietetics standard CD5 (CAADE (b), p.19). The standard stated that a program must demonstrate that "participation in legislation and public policy processes as they affect food, food security, and nutrition" exists in the curriculum. Social Work also provides a good example of meeting this competency in their standard B4.1.3 which states that one of the purposes of social work is "the pursuit of policies, services, resources, and programs through organizational or administrative advocacy and social or political action, to empower groups at risk and to promote social and economic justice" (CSWE, p.97).

- **Improve the health care system**
  Some agencies used language that referred to striving to improve the educational institution or program, but few used specific wording on striving to improve the health care system. Only about one-quarter of the standards addressed curriculum content that included improvement methods. The Pew competency -- **improve the health care system** -- becomes most important in an era of change and evolution in the system of health care. The fact that many agencies do not address this area represents a challenge for future attention.

- **Involving patients and families in the decision-making process**
  A smaller number of the reviewed standards met this competency. Some focused on individual patients but did not include the family or caregiver aspect. Physical Therapy uses explicit language to meet this competency within their standards. For example, standard 3.8.3.40 states that measurement techniques

should include the "interaction with patients, clients, family members, other health care providers, and community-based organizations for the purpose of coordinating activities to facilitate efficient and effective patient or client care" (CAPTE (b), p.31). The Pew Commission set out this competency to reflect the changing roles of providers and consumers. The future health professional will need to learn how to effectively interact with the consumer (i.e. the patient and his or her family/caregivers) in treatment choice and other decisions.

- **Participate in a racially, culturally diverse society**
  As the population of the United States continues to become diversified, the health professional will need to appreciate and understand the cultural and racial differences that exist among populations served. This competency reflects the importance of understanding health status and utilization of health services as a function of cultural values. Only a handful of standards addressed this competency explicitly. Almost all stated that the recruitment and admissions of students and the recruitment and employment of faculty will take into account diversity, as required by the Equal Opportunity and Employment Act. A good example of a standard that addressed cultural awareness and diversity training was the Dietetics standard CD33, which states that a student must learn to "manage the normal nutrition needs of individuals across lifespan, i.e. infants through geriatrics and a diversity of people, culture, and religions" (CAADE (b), p.21). Dentistry's standard 2-17 also met this competency by stating that "Graduates must be competent in managing a diverse population and have the interpersonal and communication skills to function successfully in a multi-cultural work environment" (CDA, p.2).

- **Continue to learn**
  Most standards addressed continuous learning for faculty and not for the students. standards that explicitly addressed this competency were seen as benchmarks. For example, Dentistry's standard 2-22 states that "graduates must recognize the role of lifelong learning and self-assessment in maintaining competency" (CDA, p.3). Another example is the Radiologic Technology standard--4.1--which states that the program must "provide a curriculum that promotes professional values and life-long learning" (JRCERT (b), p.4).

- **Expanding access to effective care**
  This competency was least addressed, but some helpful and illustrative examples were found in Social Work, Public Health and Health Services Administration. B4.1.2 of Social Work standards states that "the promotion, restoration, maintenance, and enhancement of the functioning of individuals, families, groups, organizations, and communities by helping then to accomplish tasks, prevent and alleviate distress and use resources" (CSWE, p.97, 135). Interpretative language to Criterion 1 of the Public Health standards calls for public health practitioners to "be able to identify and assess needs of populations and plan, implement, and evaluate programs to address those needs" (CEPH, p.3). Health Administration's standard VIB states that "The Program will have a network of health services agencies and institutions which will enable it to meet its objectives. The Commission will seek evidence that these external resources are appropriately utilized, evaluated, and effectively integrated into program activities" (ACEHSA (b), p.60).

  It appeared from agency responses that accrediting bodies were unclear as to what **expanding access to resources** meant. The Pew Commission's intent is stated in the following description of this competency, "With the demise of a national government-sponsored public policy to provide universal access to health insurance, health professionals will increasingly find themselves called upon to expand access to effective care" (Pew Health Professions Commission, p.xii). The Commission goes on to say that there can be many forms of this competency; these include the ability of a health professional to distribute health resources more efficiently and to act as a community or patient advocate for those individuals with unmet health

needs. The use of words such as advocacy and activism to expand resources for the underserved could demonstrate the intent of this competency.

Challenges Encountered

After conducting this review several challenges became apparent. First, the Pew competencies were seen by some as too prescriptive. In response to this concern, we chose to use the Pew competencies as a guide for improvement, rather than as absolute criteria. Another challenge was that standards may have addressed the competencies with regard to the faculty component but failed to do so in the delineation of the student learning experience. This led us to infer that there may be a need to develop faculty-specific competencies to guide programs.

Some professions have questioned the pace at which competencies such as "expanding access to effective care" can be integrated into clinical training programs. While it is evident that such a competency would be addressed in fields such as public health and health administration, other health professions expressed concern to achieve a balance of social, political and values issues against focused professional knowledge and skill development.

The review also highlighted that some agency standards are written to reflect the development and administration of a program, with the practice content components of curriculum definition found in other documentation -- not the accreditation standards. Speech-language-hearing relies on professional documentation of clinical competencies; nursing relies on similar documentation. In both cases, the practice content is not specified in the criteria, thus making this review more difficult.

This review of accreditation standards against the Pew competencies highlights areas where the competencies were reflected within accreditation criteria. This may be of value to some accrediting agencies as they continue to revise their criteria in the context of the changing health system and the ways these changes will directly affect the professional preparation of new health professionals.

The Facilitation of Accreditation through Self-Study and Standardized Procedures

A final area of review related to the mechanisms in place to support and facilitate programs moving through the accreditation process.The types of tools and activities provided to facilitate the accreditation process, and the self-study in particular, vary greatly.

Dietetics and Speech-language-hearing provide flow charts for the self-study process. Early in the ASHLA procedural section, an organizational chart is also presented (ASHLA, p.4). Although visual aids are not utilized by all agencies, some agencies such as Health Administration provide examples of charts and figures in their self-study guide as a standardized template for programs to complete in preparing their self-studies (ACEHSA (b), p. 1-82). The comprehensive self-study guide aids in the preparation of the self-study, and the samples may be the most helpful for those programs or program leaders new to the accreditation process. Engineering provides an actual form, and applicant schools need only fill in the information collected in the self-study (ABET (a), p.14).

Nursing utilizes a mechanisms called CASS (Computerized Accrediting Self-study), and for a small fee NLN will also send model self-studies to any programs seeking examples of exemplary self-studies (NLNAC, p.20). Physical Therapy provides programs with a template for a timetable for candidacy (CAPTE (a), p.D4-D7). A program can use this timetable to plan for the many stages of candidacy. Within all of the accrediting agencies reviewed, the self-study is an integral part of the entire accreditation process.

The Counseling documentation includes a suggested self-study format and formatting tips, checklists and forms. They also provide for consultation during the accreditation process, from telephone consultations with the

executive director regarding applications and the self-study, to assistance and information about the procedures manual from staff (CACREP, p.5).

Health Information Management calls for involving faculty, staff, advisors and students in the self-evaluation and planning processes, through a permanent committee. The chair of the committee should foster communication and maintain a time schedule (AHIMA (a), p.8). Health Information Management has prepared forms that may be used to fill in required information (available on diskette) and gives guidelines for the creation and work plan of the mandated self-study committee.

Radiologic Technology presents program requirements in outline form. Concise standards and objectives are numbered, key words are underlined, and a guide for planning the program review is included (JRCERT (a)). Dietetics offers several services to assist programs applying for accreditation: a newsletter with updates to processes and procedures, workshops covering the self-study and site visit processes, a handbook on developing a program, and computer disks for preparing a self-study application (CAADE (c)).

Procedures for appeals and complaints are listed in all of the standards as part of due process. Other procedures are in place to facilitate consistent application of standards across programs, and may appear very specific and unyielding because of their very nature. On occasion, there is potential for flexibility in the application of procedures, such as that of Nursing which describes the possibility of coordinating site visits with other agencies for a "joint visit" (NLNAC, p.25); such procedures are also found in other accrediting bodies. However, in general innovation and flexibility were not widely evident in the procedural sections of the reviewed accreditation materials.

Applicants for Architecture accreditation set the agenda for their site visit (a model is provided) and are encouraged to nominate observer(s) to facilitate communication and collaboration (NAAB, p.28-29). Computer Science provides forms on disk including a questionnaire and model correspondence, and applicants are invited to attend evaluator training sessions (CSAB (b), p.2). Programs and team members are given forms to evaluate the site visit team chair's performance and the team's performance (CSAB (b), p.11-12); other agencies also use similar evaluation forms. Music accreditation staff will respond to questions when requested, and consultative visits are encouraged (NASM (b), p.4-5). Consultants are available for Law school accreditation applicants to facilitate the process and answer questions (ABA, p.1-4).

Business offers a comprehensive set of services to support pre-candidate and candidate schools. Business accreditors provide a pre-candidacy advisor, a self-assessment primer for pre-candidates, explicit definitions of the roles of all participants, published guides or forms for each step of the process, applicant workshops on the accreditation process, and an accreditation advisor to be chosen by the applicant program (AACSB (a), p.4-12). When the accreditation plan is approved, the program is granted candidacy status and enters the "Candidacy Partnership program", which provides ongoing assistance including communication, networking, review of annual reports, education, and consultation (AACSB (a), p.17).

The Future

This review of policies, procedures and standards of the accrediting agencies reflects how health professions education and the accompanying system of accreditation are evolving. In response to changes in professional roles, the health system, educational institutions, and student needs, accreditation is beginning to move to a more flexible and responsive model. Accreditation is shifting from a quasi-regulatory function toward a role of peer consultation.

Many agencies perceive such consultation as core to their role in accreditation and improvement of health professions education. While all agencies reviewed provide some general information and help to applicants, some

go beyond this and provide special training for applicants, offer consultation visits, and recommend or assign advisors or mentors. Some agencies have also devoted considerable effort to streamlining the self-study process and report preparation, by providing standardized documentation and/or electronic versions of documentation.

As accreditation moves from a regulatory approach toward a role of peer consultation, agencies might consider some of the following "helpful practices" identified in this review:

- utilize more "minimum" standards in order to encourage flexibility and creativity
- outline "exceptions to the rules" in order to encourage experimentation (substantive changes should not all have to be reevaluated)
- assume more consultative and advisory roles
- provide and promote training to prepare for accreditation
- focus attention on various types of outcome measures, and be flexible to use both qualitative and quantitative measures to determine quality
- provide samples of documentation at minimal cost to promote learning across programs affiliated with an individual accrediting agency
- offer a mentoring program for new programs that are candidates for accreditation
- continue to give considerable attention to the stakeholders of accreditation -- both as participants in governance and on site visit teams
- continue to explore the potential for joint visits among agencies to reduce duplication and increase efficiency
- invest in further development of computer-assisted technology such as the NLNAC's computerized self-study format

The review of the Pew competencies against existing standards also suggests some potential actions by accrediting agencies. First agencies need to determine how the competencies apply to their particular profession. Many accreditors have revised or are in the process of revising their standards both in response to professional changes and to the changing health services environment; the competencies reflect a strategy for preparing to participate in that new environment. The revision process is an opportune time to examine the Pew competencies and other relevant policy documents, in order to utilize such work as a stimulus for improvement. Accreditors may also find it helpful to review standards from other disciplines in order to become familiar with alternate models for review, promotion of change, and stimulation of improvement. As an example, the standards published by the American Assembly of Collegiate Schools of Business provide a framework for the incorporation of continuous improvement into the self-evaluation and peer review process (AACSB (c)).

Regardless of the professional scope of work or the domain of practice, there are basic principles, competencies and attitudes which all new health professionals are likely to need for effective practice. Accreditors can provide a service to the educational programs they work with by ensuring that their frameworks for accreditation are relevant to present practice, and anticipate future practice to the extent feasible. The accrediting agencies have a responsibility to ensure that the purpose of accreditation and the value that it adds to the profession are clear to applicant institutions and to key stakeholders. The agencies are uniquely positioned to bring together the key stakeholders for their profession, and to offer a forum for ongoing assessment of the implications of a changing health system for their profession's practice. Accreditation is one component of the continuing evolution of health professions education; this synthesis of current practices is offered as a means of beginning to identify examples of best practices to better inform agencies and assist in their future planning.

Appendix 1

GLOSSARY

AACSB	American Assembly of Collegiate Schools of Business (International Association for Management Education)
ABA	American Bar Association
ABET	Accreditation Board for Engineering and Technology, Inc.
ACEHSA	Accrediting Commission on Education for Health Services Administration
ACOTE	Accreditation Commission for Occupational Therapy Education
ACPE	American Council on Pharmaceutical Education
AHIMA	American Health Information Management Association
APA	American Psychological Association
ASHLA	American Speech-Language-Hearing Association
ASPA	Association of Specialized and Professional Accreditors
CAADE	Commission on Accreditation/Approval of Dietetics Education
CACREP	Council for Accreditation of Counseling and Related Education Programs
CANAEP	Council on Accreditation of Nurse Anesthesia Educational Programs
CAPTE	Commission on Accreditation in Physical Therapy Education
CDA	Commission on Dental Accreditation
CEPH	Council on Education for Public Health
CNME	Council on Naturopathic Medical Education
COE	Council on Optometric Education
CSAB	Computing Sciences Accreditation Board, Inc.
CSWE	Council on Social Work Education
JRCERT	Joint Review Committee on Education in Radiologic Technology
LCME	Liaison Committee on Medical Education
NAAB	National Architectural Accrediting Board, Inc.
NASM	National Association of Schools of Music
NCATE	National Council for Accreditation of Teacher Education
NLNAC	National League for Nurses Accreditation Commission

Pew Competency	ACE HSA	ACO TE	ACPE	AHI MA	ASLH A	CAA DE	CANA EP	CAPTE	CDA	CEPH	CNME	COE	CSWE
Care for the Community Health		X		X		X	X	X	X	X	X	X	X
Expand Access To Effective Care	X									X			X
Provide Clinically Competent Care	X		X	X	X	X	X	X	X		X	X	
Emphasize Primary Care	X	X	X		X	X		X	X		X	X	
Participate in Coordinated Care	X	X	X			X		X		X		X	X
Ensure Cost-Effective And Appropriate Care	X	X	X	X		X		X		X	X		
Practice Prevention	X	X		X		X		X	X	X	X	X	
Involve Patients and Families in Decisions		X				X		X	X		X	X	X
Promote Healthy Lifestyles						X		X	X	X			X
Assess & Use Technology	X	X	X	X		X	X	X	X				
Improve the Health Care System	X			X		X		X					
Manage Information	X	X		X		X	X	X	X	X			
Understand the Environment's Role	X	X				X		X		X	X	X	X
Provide Counseling Of Ethical Issues	X	X	X	X	X	X	X	X	X	X		X	X
Accommodate Expanded Accountability		X		X		X		X		X			X
Participate in a Racially/culturally Diverse Society		X	X		X	X		X	X				X
Continue to Learn			X						X	X		X	X

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STRATEGIES FOR CHANGE AND IMPROVEMENT: NATIONAL FORUMS ON THE FUTURE OF ACCREDITATION

Two forums were held to engage a wide variety of stakeholders in the deliberations of the Task Force on Accreditation of Health Professions Education to identify and address community needs and current priority issues in professional accreditation. The first forum took place in Chicago, IL on May 1, 1997, and the second in Washington, DC on May 2, 1997. Approximately 75 participants attended the forums, including representatives of accrediting organizations, accredited institutions, professional associations and other interested parties responding to public advertisements.

The forums began with an overview of the changing health services system and current issues in accreditation to set the context for break-out sessions. The following are the summarized notes from the interactive sessions in which participants defined the essential values of health professions accreditation, discussed core topics that were identified in advance by participants, and developed recommendations and possible actions to improve accreditation. Opinions and ideas expressed do not necessarily reflect those of the Task Force, the UCSF Center for the Health Professions, or the Pew Charitable Trusts.

Essential Values of Accreditation
Accreditation usually works, but we lack studies or other proof of added value.

Five key values of accreditation were identified by participants through the discussions: continuous self-improvement; flexibility and relevance; issues of civic responsibility and professional excellence; peer review and collaboration; and serving the interests of the public. Specific comments about these values are listed below.

Continuous Self-improvement

- Need to have on-going, comprehensive self-study, not just point in time review
- Self-study value decreases with repetition, information not applied to improvement
- Self-study sometimes for compliance only
- Temptation to copy an approved program; limits innovation
- Competencies are important, but difficult to measure
- Experiential opportunities and assessment

Flexibility and Relevance

- Want non-prescriptive, fluid standards/criteria
- Accredit program, not documentation; rigidity and limited formulae stifle creativity
- Need flexible criteria, not mandated methods of teaching
- Respond to unique and individual programs

Civic Responsibility and Professional Excellence

- Venue for identifying best practices
- Provides professional identity to people, program
- Collegial consultation or external evaluation?
- Help programs prepare for evaluation
- Some standardization; issues of inter-rater reliability
- Danger of streamlining, consolidating: lose curriculum content, limit professional preparation

Peer Review and Collaboration

- Peer review provides opportunity to share ideas, information
- Increases involvement of participants (faculty, students, practitioners, community)
- Increase coordination with other organizations to increase efficiency
- Integrate, avoid duplication in accreditation, reduce competition between accreditors
- Train site visitors to be consultants

Public Interest Served

- Standards must be clear
- Process should be consultative and developmental
- Serve profession or public?
- Accountable to profession and patient, but accountability not tested, displayed
- Measures within and throughout the educational process

The Potential Added Value of Accreditation
Given these values, the participants then discussed the potential added value contributed to higher education through the systems of accreditation.

For Accredited Programs

- Professional development opportunity and validation for faculty
- Gateway to licensure, financial aid, eligibility for entitlement programs
- Competitive advantage for program (status, recognition)
- Promotes quality, encourages improvement and creativity, with on-going, open self-evaluation
- Increases faculty awareness and responsiveness
- Heightens awareness of system, provides objective assessment of strengths and weaknesses
- Forces re-evaluation and focus on future
- Promotes stability
- Helps student recruitment (although many potential students do not ask about accreditation)

For a Profession

- Accreditation offers opportunity to influence process, build consensus on standards
- Promotes consistent outcomes, accountability
- Assures competent practitioners
- Link between academics and practitioners
- Provides coherent, efficient way to define and evolve the profession

For Students/Graduates

- Ensures eligibility for licensure/certification
- Assists employers who seek graduates from accredited programs
- Offers avenue for redress for students
- Provides useful information for career and education decision making
- Creates career ladder

For Public/Employers

- Helps assure competent practitioners
- Viewed as assisting in protecting the public welfare and safety through preparation of competent practitioners

Minimizing Duplication and Waste

One of the topics of discussion among participants was the issue of duplication and waste which is a frequent criticism of accreditation. The points below outline some of the identified areas of duplication and waste; some possible strategies to address these concerns follow, as well as some potential models/alternatives to the present.

Issues

- Overlap between regional and specialized accreditors
- Institutions and programs are subject to multiple standards and multiple visits, which require substantial time and money
- Same data is reported in different formats
- Difficult to account for shared facilities
- Some requirements do not add value
- Difference between initial and re-accreditation

Possible Strategies

- Common instrument for data collection, common language, and centralized database of institution/program information
- Coordinate outcomes with certification/licensing boards
- Coordination among accrediting bodies (cooperative site visits, single report for multiple programs)
- Decrease the number of site visits and time on campus of each accreditor
- Discussion/problem-solving across programs and faculties
- Discontinue standard forms, allow program to decide how to report
- Computerize information transfer, training and information
- Integrate program accreditation and professional licensure/certification processes

- Reprogram specialized accreditation to continuous improvement and competency assessment
- Increase dialogue among accreditation agencies, certification/licensure agencies, professions, employers
- Assure common understanding of standards content and nature of process

Models/Alternatives

- Collaborative
- Multi-skilling -- what is appropriate? Community colleges have responded with training packages produced for employers; concern of loss of identity of individual profession(s); turf wars likely
- Self accreditation -- based on student, employer and patient satisfaction, licensing/certification rates; may be perceived as self-serving
- Certified private sector accreditation as alternative

Linkage of Regulation and Accreditation
A second area of discussion is the potential to build greater linkage between regulation and accreditation. The discussion addressed barriers to such linkages, issues related to multi-skilling, and some advantages and disadvantages of increased linkages across these systems.

- Accreditation evaluates educational programs, licensing evaluates individual competency
- Possible to link if both are focused on the same outcomes (e.g. competency-based performance assessment)

Barriers

- Varying role of regulation across professions, and varying impact of licensing
- Disagreement over control of curriculum
- Differences in payment structures between professions
- Lack of connection between accreditation and state licensure, despite baseline relationship
- Missing link between curriculum and necessary skills and relevant knowledge for employment
- Territorial issues

Multi-Skilling Issues

- Doesn't necessarily increase effectiveness
- Need to maintain procedural skills
- Potential for overlap within teams could cause problems
- Possible decrease in salary

Advantages and Disadvantages of Linkage

- Save program and regulator/accreditor time and resources (share training)
- Produce a clearer, more objective standard for entry to a profession
- Avoid defining equivalents

- Eliminate geographic barriers
- Possible conflicts of interest
- May limit alternative education opportunities
- Potential barrier for new graduates (increased competencies for practitioners?)
- Eliminates checks and balances, creative tension

Making Exceptions to Standards
Accreditation is based on evaluation against accepted and published standards. Yet situations frequently arise where there appears to be a need or demand for an exception to the standards. This discussion addressed whether accreditation can adapt to make exceptions, the issues arising from exceptions, and some lessons from distance learning that may be applicable to accreditation.

Is Accreditation Adaptable?

- Standards are based on facts, and facts change -- must not reward "nit-picking"
- Curricula are over-burdened; need to be more creative, flexible
- Some models are available (e.g. we can learn from service-centered model)
- Exceptions should be viewed as essential, not negative--a learning opportunity
- Need to account for context (e.g. rural or urban)
- Must balance process and outcomes standards

Issues

- Pressure for change is coming from the bottom up
- Should be patient-centered, promote patient as partner
- Assure minimum interpersonal skills
- Must prepare students to be adaptable
- Move toward general education standards, minimum standards (eliminate interpretation questions)
- Evaluators need more training
- Standards are increasingly specific because of legal pressures

Lessons from Distance Learning / Education

- Has pushed the discussion of balance between standards of processes and outcomes
- Presented a challenge--inevitably it will be followed
- Need to think of new ways of addressing needs while ensuring standards are met

Accreditation and Interdisciplinary Education
As models of health practice and professional education increasingly adopt an interdisciplinary approach, there is concern that accreditation is not adapting to these models. The discussion on this topic addressed questions/issues, the drivers of interdisciplinary accreditation, barriers, and some potential action strategies.

Questions/Issues

- How do we train individuals to work effectively together, gather information from related professionals?
- What should standards look like to train students, faculty and site visitors?
- Interdisciplinary education is not the same as multi-skilled (learning and understanding values versus learning skills)

Drivers

- Need for cost-effective, coordinated care
- Population-based teams
- Demand for integrated work (managed care organizations)
- Outcome orientation
- Future learning needs, respond to change

Barriers

- Resistance to change: turf protection, fear of losing professional identity, lack of understanding of other professions
- Specialization: increased knowledge base in individual disciplines could lead to curriculum overload
- Lack of incentives (decreasing employment base)
- Rigidity of current structure (education, practice, reimbursement, accreditation)
- Lack of interdisciplinary models, core curriculum or competencies
- Funds to facilitate change are not readily available

Action Strategies

Professional Programs

- Increase problem-based teaching format
- Develop core curriculum with branches for discipline-specific emphases
- Involve community and practicing professionals
- Reward faculty efforts
- Begin cross-disciplinary teaching, experiences and dialogue early in program
- Set standard of certain proportion (e.g. 20%) of faculty from outside discipline
- Increase flexibility of system; incorporate interdisciplinary concepts in mission

Accreditors

- Increase flexibility, encourage innovation, involve communities of interest (e.g. payers, large employers, practitioners)
- Communicate among accreditors in reviews and standard setting (e.g. physical and occupational therapy; public health and health administration)
- Incorporate interdisciplinary concepts in standards and competencies
- Hire certain proportion (e.g. 20%) of staff from outside discipline
- Train cross-disciplinary site visit teams

Programs and Accreditors

- Develop measures of interdisciplinary competency
- Cultivate links at all levels: accreditors, faculty, professionals, students

Areas for the Future

- Self-study as process and product (standards that reduce barriers, are outcome-focused and interdisciplinary; process with compliance and improvement roles)
- Team training (interdisciplinary teams, unit accreditation)
- Collaborative visits (one self-study, one well-thought out visit to maintain quality)
- Streamline process to reduce costs and faculty/institution burden

Accreditation as Model for Assessment and Improvement

The Task Force has spent considerable time discussing how accreditation might be reconceptualized to be viewed in future as a model for self-assessment and continual improvement, as compared to current perspectives of accreditation as a quasi-regulatory periodic evaluation. This discussion at the Forums addressed the role of accreditation agencies in such a reconceptualization, potential outcomes, criteria, and key questions.

Role of Accreditation Agencies

- Currently are not change leaders, but are driven by the market
- Academics dominate some agencies and only allow slow change
- Gatekeepers
- Enforcer/sustainer of quality -- provide students with consistency and standards across schools
- Guard against cost-cutting or catering to market
- Consult with and assist programs
- Teach educators about models and process for assessment and improvement (most faculty do not fully understand them)
- Serve as an assessment model
- Assist programs to better manage selves (particularly with information/data management)
- Provide change dynamic through assessment requirements
- Train site visitors to be consultants -- assure inter-rater reliability
- Provide consultation and mentoring to new programs, those with problems and new faculty
- Should be leaders, reflect practice realities, provocative

Outcomes

- Most accreditors do not know how to use outcomes, lack clear idea of goals
- Lack of good models -- most do not require data to be used
- Lack of quality indicators
- Need to emphasize product and balance structure with process
- Base measures on competencies for practice (easier for specialized accreditors)

Criteria

- Because based upon consensus, cannot be too radical or adapted quickly
- Department of Education forces some specificity
- Input limited to perceived stakeholders
- How can improvement be encouraged without rewriting standards constantly
- Standard of practice can be useful (e.g. information technology)

Questions

- How can any model respond to issues of diversity between professions, institutions, programs and accreditating bodies?
- How can the need to change or "fix" the system be communicated?
- Should programs prepare students for entry to practice or for life-long learning? Or both?
- To whom is the accrediting agency accountable? Is this truly self-regulation?
- Should there be separate processes for compliance and improvement?
- What have accreditors done to address social issues?

What to Change to Improve Accreditation

Following the group discussions, a synthesis of the comments generated in the small groups was prepared and presented back to the participants. This synthesis identifies four sets of change factors: social, governance, structural, and process.

Social

- Greater appreciation of value
- Recast accreditation to enhance experimentation
- Clarify purpose
- Improve public understanding

Governance

- Resolve ongoing control conflicts
- Clarify roles of Department of Education (DOE), Council on Higher Education Accreditation (CHEA), Association of Specialized and Professional Accreditors (ASPA)

Increase mutual respect, trust and cooperation

Promote cooperation between institutional and programmatic accreditation

Structure

- Enhance professional qualities of site visitors
- Clarify guidelines
- Provide forums for exchange
- More core curricula
- Develop national database for information and accreditation decisions
- Expand use of technology
- Globalize accreditation
- Encourage innovation
- Update standards to reflect changing health systems
- Create core, uniform, evidence-based standards

Process

- Provide support for improvement, common methodology
- Focus on outcomes
- Streamline process
- Focus on broad themes, not narrow compliance

Is There a False Dichotomy?

- Compliance (basic floor needed to protect public) vs. improvement (process valued by consumer to make program more competitive)
- Do not need to resolve issues, but must manage these conflicts
- Developmental steps in accreditation process need to be reconsidered: entry/initial review, problem identification, regular review, improvement, exit

Possible Next Steps for the Task Force

As a result of these forums, the following list of possible next steps for the Task Force was generated.

- Provide forums for constructive conversation among accreditors, certifiers, licensers and professionals
- Continue and broaden interdisciplinary dialogue (beyond health community) around accreditation issues and possible solutions
- Partner with other higher education and health system accreditation reform efforts
- Work with regulation reform efforts
- Expand and update competencies for health practice for next century
- Consider different mechanisms or strategies to facilitate accreditation reform
- Assess self-study as process and as product
- Focus on assessment of outcomes as a change strategy
- Identify agents for change, promote pockets of innovation, influence decision-makers
- Help clarify issues that inhibit collaboration among stakeholders in accreditation
- Write "issues" paper(s) to communicate system problems, promote discussion, pose solutions, articulate values
- Disseminate information, produce a resource guide, illustrate innovate efforts

- Foster experimentation to evaluate innovations (e.g. create a demonstration project -- a successful model that could be applied across the board)
- Offer training on change management, continuous improvement strategies, assessment techniques, leadership development, institutional use of improvement data

Intentional Improvement:
The Deliberate Linkage of Assessment and Accreditation

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Assessment, accreditation, improvement: these are three terms well known to the higher education community, and all are capable of provoking responses ranging from religious fervor to extreme distaste to complete cynicism. Rarely are they mentioned together. Ask a group of educators to define any or all of these terms, and one will get a range of interpretations. Yet the activities represented by these three terms -- assessment, accreditation, improvement -- are increasingly assuming more prominent roles in higher education in a time where social forces require us to do more, do it better, and do it with less, as we 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
- an evolving policy domain shaping and redirecting higher education goals and initiatives

Higher education is frequently declared to be "in crisis", government is concerned with reinventing itself, our health system is changing every day (despite the supposed failure of national health reform), and in general society seems to be concerned with doing better with less. There is a lot of tension in the system -- and when we try to address these tensions we recognize that there is an urgent need to do something. This is commencement time across the country, and we could look at any set of graduates and ask whether they are prepared and positioned to deal with this tension-filled environment -- are the new teachers prepared for the challenges of the diminishing funding of the public school system? Are the new doctors ready to work in a managed care environment? Do the new public administration graduates understand what public service means today? Do public health graduates really understand the "public" part of health? We want to do better at what we do, but we are not necessarily sure of how to approach the improvement.

This is an era of change. We see tensions for change in higher education, and tensions for change in accreditation. I presently serve as Project Director for the Task Force on Accreditation in Health Professions Education, supported by The Pew Charitable Trusts, and based at the Center for the Health Professions at the University of California at San Francisco (1). Some of you may have encountered the work of the Pew Health Professions Commission, also based at the Center, which has been studying health professions education and workforce issues in this country for the past nine years and has made a series of policy recommendations, many of which have already been implemented (2). As part of our Task Force work, we have attempted to articulate some of these tensions in the system as follows (3):

Tensions in Higher Education

Degree focus	<-------->	Lifelong learning
Campus setting	<-------->	Computer network
Classes	<-------->	Individualized learning
Lecture pedagogy	<-------->	Multimedia presentations
Reputation	<-------->	Price
Traditional students	<-------->	Adult learners
Western culture	<-------->	Multicultural
Homogeneous student body	<-------->	Diverse student body
Unidisciplinary	<-------->	Multidisciplinary
Unrestricted giving	<-------->	Targeted giving

Complementing these tensions in higher education are a similar set of tensions in accreditation. Few topics in higher education engender as much debate and emotion as that of accreditation. There has been extensive debate for many years in higher education circles about the role and value of accreditation. At the same time, there has been nearly constant study of accreditation, and frequent organization and reorganization of the systems for monitoring, evaluating, recognizing, certifying, and accrediting educational programs, resulting in a continuing state of unrest and discontent. We have identified this set of tensions in accreditation (3):

Tensions in Accreditation

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

In the accrediting community, there has been additional dissonance since the early 1990's, beginning with concerns raised during the reauthorization of the Higher Education Act, and continuing through the dissolution in 1993 of the Council on Postsecondary Accreditation. During this time, many of the specialized and professional accreditors came to realize that they had professional and organizational needs that would not be met with the disappearance of COPA. Under the leadership of the elected officials of the Assembly of Specialized Accrediting Bodies within COPA, a new organization was established in 1993 to address specifically the needs of specialized and professional accrediting agencies. This new organization, the Association of Specialized and Professional Accreditors, became an important facilitator for developing common practices for specialized and professional accreditation and for sharing information within this community (4). Today, ASPA continues to be an effective resource for the specialized accrediting community, and is working with the new Council on Higher Education Accreditation (CHEA) to address common visions for accreditation.

This turbulent environment suggests the need to do something -- and one part of doing something is thinking about how we do a better job of knowing what we are doing in higher education. My professional career has been spent working in the health system, so I will rely heavily on this background to make general illustrations of how our system today positions us to think about improvement.

How can we move to our desired future for higher education? I do not presume to be able to make a diagnosis and recommend a treatment plan which will solve all the ills of higher education; my charge in this talk is to introduce the strand of this AAHE meeting that will focus on accreditation, and to suggest ways in which accreditation and assessment might be more closely integrated to achieve what I am calling "intentional improvement" -- improvement which is the result of a clear plan, and results in desirable changes.

My intent is to explore the following points:

- the relationship of assessment and accreditation
- whether accreditation is in fact a structured process of assessment
- what is the linkage to an ongoing and deliberate strategy for improvement
- the perception that accreditation is disconnected from improvement
- accreditation/assessment process as fundamental component of ongoing program development and review
- reconceptualization of accreditation as an intention to improve

Assessment, Accreditation and Improvement: The Concepts

I assume a high level of understanding in this audience of these basic concepts, but it might be useful to set a context. Assessment programs enable academic units to focus on indicators and measures such as student learning outcomes, program evaluation and institutional effectiveness, n order to improve the quality of teaching and learning (5). Accreditation is used for purposes of external recognition, eligibility for federal support, and articulation with professional regulation. Assessment may be driven by internal mandates, with no clear standards or framework of activities; accreditation assures minimum standards of performance, to ensure practitioners are capable of meeting at least the minimum threshold of acceptable practice. Improvement allows us to reframe assessment and accreditation as activities of intentional improvement -- we engage because we have a clear aim of improvement. Assessment offers internal systematic analysis of activities; accreditation validates the standards of performance and assures a baseline level of uniform quality across comparable programs or institutions. When viewed as linked activities that are part of intentional improvement, we can begin to work on setting and achieving "stretch" goals that move us towards excellence and link activities with our overall aims (6).

Assessment

In talking about assessment, I believe we are addressing three major concepts:

- a process of collecting, organizing and interpreting data
- the determination as to what degree the educational program meets the established mission, goals and objectives
- measurement and evaluation of outcomes related to performance, efforts or accomplishments

We often speak of assessment strictly in terms of assessment of student outcomes; I have found it valuable to consider a broader approach where we consider assessment as a global process that can also be applied to faculty, to programs, and to institutions (7). In 1991, Pat Hutchings, Ted Marchese and Barbara Wright commented that assessment should be valued not only for the data it produces, but also for the processes it fosters and stimulates (8). I wish we could say the same of accreditation -- but there are few opportunities to do this.

Accreditation

I could assume a common understanding of what is meant by "accreditation", but often find there are mixed perceptions of what accreditation is and how it works in the U.S. system of higher education. Accreditation exists as a means of assuring the public of educational program quality, and of promoting continuing review and self-improvement by educational units in preparation for accreditation reviews and more importantly as an integrated means of continuous assessment, evaluation and improvement (9).

In general, accreditation:

- is a voluntary, non-governmental process
- based upon guided self-evaluation and self-improvement
- relies upon peer review which in turn stimulates evaluation and program management
- judges effectiveness of the academic unit against a set of predetermined standards

Accreditation as we know it consists of a series of common activities:

- Self-study
- Preparation of documentation
- On-site peer evaluation
- Report
- Accreditation decision
- Periodic review and reporting

Variation across the accrediting agencies is evident when one looks at specific procedures -- length of time between site visits, composition of the site visit team, expectations of documentation -- but in general all of the recognized agencies (both regional and specialized) employ these common activities. The system of guided self-evaluation and self-improvement stimulated by accreditation is central to this voluntary effort of self-regulation. The primary value of accreditation can be found not in the outcomes, but rather in the process of evaluation and program management stimulated by this peer review (10). The effectiveness of accreditation may be judged by its ability to encourage and promote programs and institutions to evaluate their educational activities and to use the evaluation results for ongoing improvement to better need customer needs.

As a point-in-time review, accreditation as we know it today has difficulty accommodating the natural process of program evolution. The difficulty is perceived by some as being a barrier to innovation and creativity because of the rigidity of the accreditation format, and the need to keep procedures consistent for at least a period of years in order to ensure comparability of reviews across academic units over time. This rigid application of standards and procedures may not be in tune with current educational methods or professional practice. As a result, the perception exists that accreditation limits changes and innovations in curriculum and program delivery (11).

Accreditation thus provides benefits to various "publics", including the following (4):

- advances/enhances the profession or discipline;
- supports access to the profession or discipline;
- facilitates professional mobility;
- supports individual credentialing processes;
- provides consumer protection; and
- affords opportunities for educational funding.

Improvement

The third major concept is that of improvement, and understanding the difference between traditional improvement and continual improvement. Traditionally we assumed professional knowledge of the subject, the discipline, and its related values, and worked on traditional improvement. Continual improvement is based on Deming's theory of profound knowledge -- knowledge of systems, understanding of variation, application of psychology, and a theory of knowledge (12). It is the linkage of traditional improvement and continual improvement which provides leverage for conceptualizing our work -- in particular when we are assessing professions or disciplines and need that expert knowledge base as well as improvement knowledge. Improvement comes from the application of this knowledge. The "Model for Improvement" proposed by Langley, Nolan and Nolan (13) provides a framework to gain and apply knowledge to the improvement of a wide variety of endeavors -- processes, products, services, programs, work patterns, personal life, etc. It consists of three fundamental questions derived from the work of W. Edwards 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?

These questions help us to focus our efforts on thinking about learning as our primary aim. But we need to recognize that there are different types of learning and different contexts for learning. The university is given responsibility by society to foster and stimulate learning as the primary focus towards which all efforts are concentrated. Thus the emphasis is on the student who is learning, on faculty who are learning and contributing to new knowledge, on institutional learning, and on learning with the community to ensure that learning is relevant to the local context. I am constantly reminded of these differences as I work in an urban university where teaching is the primary mission, and compare this environment to those universities where I studied which were driven by the academic health center and its research mission. I also see the differences in learning when considering undergraduate general education programs, as compared to graduate professional programs. Our common aim is learning, but how the learning occurs may vary.

Systematic improvement efforts incorporate the documentation of the strength and vitality of programs. Well-designed and executed assessment programs, which may be part of self-study efforts in preparation for accreditation or may be routine program monitoring, will yield information about the strengths and weaknesses of academic units and the relationships among structures, processes and outcomes (7). The information obtained from such assessments yields information to assist in identifying opportunities, dealing with challenges, revising aims and goals, and wisely allocating resources. Conducting such appraisals from a systems perspective attends to both

outcomes and processes -- so that linkages can be made to environmental factors as well as to internal issues. Integrating assessment, evaluation and improvement can help to build a common, shared educational vision whereby participants -- both the providers and the consumers of the educational products -- collectively embrace the organizational goals.

Accountability

What drives us to commit so much energy to thinking about mechanisms for improvement such as assessment and accreditation? Demands for accountability are increasing in the higher education community. Self-regulation, which is one of the essential foundations of the U.S. system of accreditation in higher education, may need to be redefined in the context of its mission of consumer protection. Peter Ewell (14) has advocated assurance to the community of academic quality; this requires a focus on the assessment of outcomes and the active use of results, with particular attention to evaluating a student's competencies in order to assure the knowledge, skills and other attributes students seek from their academic experience. Ewell suggests that greater attention to the use of results may be needed not only for accreditation, but also to regain public confidence in higher education. Accrediting agencies need to be acutely aware of the need to maintain public confidence given that accreditation is "voluntary", and to ensure that they enjoy the continuing confidence of its many publics. Higher education institutions face the same issue of confidence.

When considering educational improvement, we need to assume the perspective of the customer -- and there may be multiple customers. Some of my favorite examples of applying the customer perspective come from health services. For example, many of you will have been a patient in a health care organization at some point, and have been frustrated by the experience -- dealing with multiple hand-offs, an endless stream of different specialized providers -- each responsible for only a small portion of your care, a lack of information, unnecessary waits and delays, rude service. We often see the greatest improvements in patient care when we ask primary care providers and administrators to live the experience of the patient. Another example is the person who comes to the hospital for a treadmill test, and walks more miles through the hospital in the various steps of pre-test screening before the test than when they are actually on the treadmill (15). The frustrations of these experiences clearly identify opportunities for improvement. In education, we can play the role of the student and see what the process is like -- whether it is admissions, advising, career counseling, preparation for graduation -- and then be convinced of the need for more experimentation with changes to improve processes, consume less time, use fewer forms, and generally enhance process flow.

Moving to Improvement

The model for improvement provides a useful framework for thinking about the reconceptualization of assessment and accreditation as improvement activities -- what is the purpose of the work, where should the focus of these reviews be, how might we make change, how might these changes be tested, and what opportunities can be created for experimentation with minimal risk? Change takes months in industry, but it can take years in academe -- so can we create opportunities to use the model for improvement and implement rapid change? This should be possible, if we use improvement knowledge to accelerate our work based on the subject knowledge of our professions and our disciplines.

The model allows tests of change while accommodating the need to gain more knowledge before developing a change. The third question sets up the opportunity for tests of change -- to demonstrate the improvement, increase knowledge to develop a change, make tests, and then implement the change (13). It uses the Plan-Do-Study-Act approach, sometimes called the Deming or Shewhart cycle, and consists of the following:

- Plan: state the objective of the test; make predictions; develop a plan to carry out the test (who, what, where, when, how)
- Do: carry out the test; document problems and unexpected observations; begin analysis of the data
- Study: complete the analysis of the data; compare test data to predictions; summarize what was learned
- Act: what changes are to be made? what will be the objective of the next cycle?

We can run these small tests of change in our daily work, and readily integrate improvement, let alone building it into more long-term assessment activities. We conduct organizational assessments -- but how do we know that the standards we have set are the right ones? We engage in more deliberate review and inquiry, such as through the Baldrige self-assessment process. The PDSA approach can become the model for assessment of routine, ongoing activities that are part of our daily work. Preparation for accreditation then becomes a summation of the multiple tests of change, with documented evidence of what has been done, why, what improvements have been made, and what is the focus for subsequent work.

Change is helpful, but at the same time needs to be made in a controlled manner. The traditional lengthy diagnostic journey of quality improvement, which many of you may have engaged in at your institutions, is increasingly viewed as excessive in today's world -- spending months in diagnosis with no improvements. We cannot afford that sort of expenditure of time today -- the problems just will not wait. It is like conducting a course evaluation at the end of the course -- useful for the professor for the next offering of the course, but there is no opportunity to make improvements that will benefit the current students. Rapid cycle tests of change would allow the professor to make improvements throughout the course and benefit current students, as well as developing knowledge for future courses. Some of these approaches may be familiar to you under the term of "classroom assessment techniques" -- strategies articulated by colleagues such as Tom Angelo and Pat Cross which have accelerated learning in the application of improvement theory in higher education.

The Need for Articulation of Assessment and Accreditation

Can accreditation become a model for assessment and improvement? I believe it can -- and that a closer articulation of assessment methods and accreditation will greatly enhance our efforts in educational improvement. The focus on improvement is not intended to suggest that there is nothing good in accreditation today, but rather to focus attention on how it can be better. Why has there not been more reform in the systems of accreditation of education? Perhaps because accreditors and educators have been reluctant to experiment and take risks, given the attacks on accreditation which have been prevalent in higher education for the past two decades. Why is there so much discontent and resistance to change by the stakeholders in accreditation? Perhaps because those working in accreditation on a day-to-day basis are consumed with detail and routine tasks, and are unable to free themselves for long-range strategic thinking about the overall process of accreditation. Similarly, for many assessment is a new concept, and they are just beginning to

embark upon comprehensive assessment programs. Together this creates an atmosphere where there has been little effort devoted to thinking about how to articulate assessment and accreditation. How, then, can improvement and change be accomplished?

A Model for Implementing Change in Education

In most industries, change happens regardless of whether one is eager for, or resistant to, it. In education and in accreditation, resistance to change is often sufficiently intense to inhibit or actually stifle new ideas. Yet successful change can be a positive activity. To champion change in the face of resistance requires commitment and energy. In preparing for this presentation, I studied some recent work on change and improvement, and have applied it to thinking about assessment and accreditation. One particularly useful resource was The Improvement Guide, authored by Langley, Nolan, Nolan, Norman and Provost (16).

Any approach to improvement must be based on building and applying knowledge; actual improvements will only happen as a result of that application of knowledge. If one applies the Model for Improvement, described earlier, we need to answer the basic questions of the model. What are we trying to accomplish -- what is the aim of the improvement effort that will guide and keep the assessment and accreditation effort focused? The aim is to respond to many of the issues raised as weaknesses of the current accreditation process -- cost, duplication, excessive focus on inspection, limitation on innovation, redundancy of the processes built into the accreditation system.

How will we know that a change is an improvement? One measure will be increased satisfaction of the customers of education -- whether these are students, community members, institutional administrators, faculty, professional leadership, or other concerned individuals and groups. A second measure might relate to changes in the political climate such that there are fewer perceived "attacks" on accreditation and more support for the concepts and principles advocated by accreditation. In general, the effectiveness of the change will be judged by the ability to determine criteria for success and to measure the impact of the change. Perhaps the most evident change would be when individuals engage in assessment on a routine basis and anticipate accreditation eagerly because it is a value-added activity that enhances their work, rather than a burdensome exercise that consumes resources with little return.

Finally, what changes can be made that will result in an improvement? There are many possibilities for change, but they will require new ways of thinking about how we evaluate higher education and how we approach our daily work -- and they will challenge the current system. These changes will demand that leaders in higher education, including accreditors and their key stakeholders, begin to operate in a mode of flexibility and adaptability, rather than rigidity and conformance to history.

Strategies for Supporting and Sustaining Improvement

The Task Force on Accreditation of Health Professions Education has generated a series of questions that we feel need to be answered in order to consider reforms in accreditation, and its role as a mechanism for assessment and improvement (3). Some key questions to be addressed in developing strategies include:

- To whom are accreditors accountable?
- Does accreditation promote improvement or does it focus solely on compliance?
- Does accreditation facilitate effective working relationships among stakeholders?

- Does accreditation provide the assurance of quality education that it is expected to provide?
- Does accreditation really make a difference?

The following discussion highlights some key areas where new strategies for accreditation might move us to a system of "intentional improvement", where the assessment system accommodates the current realities of a resource-constrained environment, uses data wisely and frugally, is based on an understanding of the systems of education and accreditation, acknowledges inevitable variation, and fosters innovation and creativity. The intent is not to denigrate the many positive aspects of accreditation as it exists today, recognizing the individual strengths and the variability across different accrediting agencies, but rather to build upon the community's collective wisdom to strengthen accreditation and make it a more effective force in promoting the quality of higher education. Perhaps these strategies will stimulate thought about actions that are realistic and practical, and will seed changes and improvements.

Utilization of Data

Many accreditation systems are consumed with collecting data but have no system for synthesizing and analyzing the data once collected. This constrains improvement efforts, because there are no possibilities to test changes and demonstrate the effects of these changes. There is little, if any, precedent for experiments in accreditation; what if the experiment fails? What would be the implications for the program/school in terms of accreditation status, professional stature, eligibility for federal funding, etc.? This is a risk accrediting agencies have been unwilling or unable to take. Unfortunately an inspection mentality has perpetuated in some accreditation systems, looking at lists, numbers, and quantitative measures; what do these tell us about quality?

Frequently data is collected because it is a historical practice. Accreditation could help academic units by focusing on the assessment process whereby goals, objectives, and desired outcomes are clearly articulated; only then should measures be developed and data collected which becomes the means for assessing achievement of outcomes. Simply setting out to collect data can cause change to occur, because of the inevitable awareness of a process that develops from trying to measure it. The act of measurement can be the trigger to move a process toward the desired results. This brings the work of routine assessment in line with information collection necessary for accreditation, and permits ongoing consideration of the information, rather than periodic review in the midst of a flurry of activity as a self-study is prepared.

One of the tasks for our task force on health professions accreditation has been to review many of the sets of accrediting standards from a range of accreditors (17). Our findings illustrate the continuing dependence on data -- reams of paper, pages of tables, and uncertain utility of this information. Each data item suggests that we ask questions such as:

- what difference does it make if we have this piece of information?
- how much effort is required to collect it?
- will it be used?
- what does it really tell us?

The uses of information collected in the accreditation process also merit attention. Academic units collect extensive data, present it in various formats depending on the requirements of the accrediting (or other evaluating) entity, and often do not revisit the information. Given the extensive effort needed to assemble this information, it would seem logical that academic units would then collect

and update this information on a regular basis in order to use it for routine program monitoring, evaluation and improvement. Yet this does not happen. Perhaps this is because the data collection format is cumbersome, or because there is no person or other mechanism to routinely collect and document the information, or because decision-makers do not know what to do with the information. This suggests a need for greater articulation between the "evidence collection" aspect of accreditation and routine program assessment and improvement on the part of the academic units. This also lends credence to the argument that accreditation systems should coordinate their data collection needs, and streamline their formats to permit a unified information base at each university from which the data necessary for a focused accreditation review can be extracted. This would require collaboration between the institutional and specialized accreditors; it might decrease the reporting burden and increase overall satisfaction with the multiple accrediting processes taking place on individual campuses.

Understanding the Systems of Education and Accreditation

A frequent complaint about accreditation -- and particularly about specialized and programmatic accreditation -- is that the focus on a specific profession or discipline is presented as being self-serving and myopic, and that there is no recognition of the larger system in which the specialized program operates. Accreditors have been known to demand changes in institutional policies which are not within the purview of the individual program. This leads to questions of the relevance of the individual review if it does not acknowledge the larger governing system. Professions have an established body of knowledge, and as a result some translate this professional domain into a tightly constrained approach to accreditation, not taking into account that there may be considerable diversity across institutions in how they deliver their educational programs. The concern for the accreditor should be less focused on the process (which may reveal innovative ways of overcoming barriers) and more focused on the outcomes, asking questions such as: Is the graduate competent and prepared to enter professional practice in the specific field? Yet accreditors devote enormous resources to examining discrete aspects of the process, and often appear to be less concerned with graduate competencies and other program outcomes. This suggests a need for accreditation evaluations to be vested in examining programs in the context of specific institutional and programmatic missions, and to emphasize outcomes and competencies, rather than structures and processes. Again, this presents an opportunity to link assessment and accreditation practices.

Concepts of Variation

Accreditation is ill-equipped to deal with normal variation, yet variation exists in all aspects of any process. There are variations in systems, in processes, in institutions, and in people. Similarly, the means by which a specific activity will be conducted and completed will vary across individuals and organizations leading the activity, no matter how tightly proscribed. Variation in an activity may reflect a fundamental change, or may be a normal occurrence that reflects a random change, leaving the underlying systems intact. Problems occur in the accreditation process when such random change is viewed as a fundamental change, causing extensive effort -- effort to remedy the situation when in fact no effort is necessary other than understanding that such variation does occur from time to time, and dealing with the immediate consequences. Accreditors would be well-served if they could be prepared to identify such random variation, and to learn from these events without imposing punishment or additional reporting on the academic unit. This variation should not be ignored, but needs to be recognized and accommodated.

Innovation and Creativity

Critics of accreditation would suggest that the term "accreditation innovation" is an oxymoron. Yet the study of creativity and creative thinking reveals some practical applications that could reform systems of accreditation and approaches to accreditation without much effort (16). The following are some suggestions to stimulate accreditation innovation:

- 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 the individual 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, and it may be possible 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 -- as stated above, much of the accreditation process is accepted because of historical process or because it has never been questioned. A careful examination of the reasons for the various inputs, processes and outputs of an accreditation system may reveal steps which can be eliminated if they are not vital to the purpose.
- visualize the ideal -- accreditors and the accredited should engage in discussions about the ideal situation for accreditation. The Task Force has asked some audiences whether health professions education could exist without specialized accreditation. Similar discussions could take place to help concerned stakeholders articulate the true value of accreditation, and 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 a viable alternative, there will be no choice but to identify new ways to conduct accreditation. Exploring such alternatives may 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. Some accreditors have viewed themselves only as evaluators and standard-setters; their role as consultants, peer coaches, and advisors has been minimal -- driven perhaps by the need to maintain objectivity and fulfill the "separate and independent" requirement from the Department of Education. Others have been able to engage in considerable consultation, and thus demonstrate value to their constituents in ways in addition to evaluation.

How Might We Make Change

Change concepts have recently been introduced into the improvement literature by Langley et al. (16) as a lever to provoke new ideas, new methods, and new approaches. By themselves they do not suggest the strategies for improvement. Rather, they serve as the basis to consider a situation -- in this context, accreditation of higher education -- and from there can be turned into ideas which can be made operational in order to achieve improvement. Langley et al. suggest an initial list of 70 change concepts, derived from their work on improvement in a variety of industries. These concepts can be grouped into nine categories of change; for each, a sample change concept relevant

to accreditation is presented:

- focus on the product of service -- differentiate product using quality dimensions
- design systems to avoid mistakes -- use reminders
- 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
- change the work environment -- give people access to information
- enhance the producer/customer relationship -- focus on the outcome to a customer
- optimize inventory -- reduce multiple brands of same item

The intent of thinking about change concepts is to stimulate thinking about improvement in a new way. Instead of focusing on what is "wrong" with accreditation, these categories of concepts help us to focus on areas where change might be feasible. Accreditors can benchmark their efforts for change and improvement against other industries where such efforts have been successful, can learn from experiences in other contexts, and then apply the lessons in a manner relevant to their specific activities. However, to successfully benchmark one needs to understand one's own organization as a basis for comparisons. Change is not impossible in accreditation, but there needs to be a ground swell of interest in order for change to be stimulated, to be forward-thinking, and to come from within rather than being imposed by an external body.

Some Practical Ways Of Thinking About Change

I have recently had the opportunity to work with a new tool called the "value compass" as a way of considering an activity to help assess its value, identify areas for improvement, and focus improvement activities to ensure they address value. Just as a traditional compass is used to verify location and identify the direction in which you want to travel, the value compass assists us in assessment and identification of opportunities for improvement. This tool is modified from the clinical value compass developed by Eugene Nelson and Paul Batalden in the Center for the Evaluative Clinical Sciences at Dartmouth Medical School (18) it is now being tested in applications for education through early work of Linda Norman at the Vanderbilt University School of Nursing (19) and the participants in the Community-Based Quality Improvement in Education for the Health Professions collaborative, sponsored by the Institute for Healthcare Improvement and by the Bureau of Health Professions of the U.S. Public Health Service.

Consider an educational program or experience which you want to assess. Begin to the west with learning objectives/ course outcome -- accomplishment of the desired outcomes would be your entry on the compass. Then move north to overall professional competencies/outcome -- here your measurements could include student perception of level of accomplishment, as well as faculty perception, with respect to terminal competency. To the east is satisfaction -- how satisfied are faculty, students, or employers with the student outcomes? Finally, move south to cost -- costs of faculty and student time, resources used, credit hours or tuition generated. Put this information together and you begin to see relationships among the components, which quickly leads to identification of opportunities for improvement.

Another useful way of thinking about a problem and trying to identify the leverage points for improvement is to use the concept triangle, one of the tools for creative thinking offered by Edward

DeBono (20). The three points of the triangle are identified as problem, idea, concept. Once again a health care illustration is useful. A major problem in hospitals relates to the management of operating rooms, which are frequently plagued by delays in start times for surgery which then back up the subsequent schedule. The problem is delays in start times; the idea is to provide a beeper to the surgeon to ensure he or she comes to the operating suite when the surgery is ready to begin; the concept is to synchronize the work of all the players involved. The challenge is that there are multiple perspectives of the concept -- the nurse believes the activity starts when he or she begins to set-up the operating room, the anesthesiologist believes the activity starts when he or she starts the flow of anesthetic, and the surgeon believes the activity starts when he or she makes the first incision. For all three, the problem and the idea are the same, but the concept is different. Think of the graduate student who is processing their paperwork for graduation and experiences what appear to be unexplained delays in the process. The student thinks the process its done when they submit their graduation papers; the advisor thinks it is done when they sign off on the forms; the department administrator thinks it is done when she sends it to graduate studies; but the office of graduate studies doesn't even think the process has begun until they receive the paperwork -- which has already been processed by multiple individuals. If we put this in perspective looking at the concept triangle, we begin to see how various attempts at improvement may make no difference until we deal with the fundamental concept that is the issue.

Conclusion

There are many opportunities for improvement in higher education, and we can streamline some of this work by more carefully articulating the evaluative activities we conduct under the auspices of both assessment and accreditation. This effort can be enhanced by drawing upon improvement knowledge, and by adapting some of the methods being used in other industries to identify opportunities for improvement, develop tests of change, run small experiments, and use the resulting knowledge to make lasting improvements. We need to create a culture where innovation is rewarded, and where creative change in short time frames is encouraged. Through closer alignment of our internal assessment systems, and the external reviews conducted by various accrediting agencies, we can consolidate many of our efforts and focus our work -- and our utilization of precious resources -- on making incremental changes to improve our systems of higher education and better prepare our graduates for productive roles in our society.

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A THIRTY-YEAR PERSONAL PERSPECTIVE ON ACCREDITATION: Quality Assurance in Education

Arthur C. MacKinney, PhD

Summary
This paper, based on over 30 years experience in accreditation involving five accrediting commissions, examines the U.S. accreditation system with five basic questions. What are the major issues facing accreditation? What are the myths confounding accreditation's perception and functioning? What are the several models or approaches for carrying out accreditation? What are the processes that might substitute for accreditation as we know it? And finally, What revised system of accreditation seems to have promise as an improvement in what we now have?

Introduction
Any responsible person wants to know, am I doing a good job? Similarly, any responsible educational institution or program wants to know, are we doing a good job?

That's what this paper addresses: quality assurance in education. There have to be ways that a society or a consumer can assess how good a job is being done on their behalf. Since we're putting limited resources into the enterprise, we've got both a right and a responsibility to know whether our money is being spent wisely.

One problem is, society at large doesn't seem to be accustomed to asking quality assurance questions about educational programs. But, it is an entirely legitimate and important exercise to ask whether any kind of intervention is actually working the way it is advertised. Is this training program any good? Is this personnel selection system really valid? Is my new organizational form really an improvement? The methods might vary, but the goal with all these questions is really pretty much the same. Are we doing an acceptable job?

This is why the U.S. accreditation system exists. It is supposed to be the set of processes by which the society satisfies itself that a decent job is being done on its behalf. But it isn't that at all! The unfortunate fact is that educational quality assurance in the public's mind is pretty elusive stuff, made up of some mysterious combination of athletic reputation, campus esthetics, hearsay, and articles in the popular press. Accreditation, other than some vague reference that every institution has to "be accredited", hardly enters the equation at all. For this reason, even if for no other, we, the higher education professionals, simply must take a hard look at how we can make our rather elaborate system of accreditation (1) work better for us, and (2) take its rightful place among public decision processes.

Does this mean that U.S. accreditation is seriously broken? No, absolutely not! Is it improvable? Certainly! I am convinced that it is much in need of substantial improvement.

Okay, you ask, what do you base this on? Well, the answer to this one is, lots and lots of relevant experience, which, when combined with several soon-to-be-obvious biases, makes me think that my observations might be useful. First, there's the 40+ years in higher education, including virtually all roles from graduate assistant to president/CEO. But maybe more to the point, there's 30+ years experience in accreditation, involving hundreds of reviews and site visits with five accrediting

commissions, plus work with several special accreditation committees and task forces. That kind of experience has an influence on how one thinks about things. I most sincerely hope you will agree that the exercise is worthwhile.

Major Issues in Accreditation

What I propose to do in this section is to present what I see as the big issues facing our accreditation system. There is no significance to the order of presentation.

Issue 1: Audience

Who does accreditation speak to? The historic answer has been, ourselves! Accreditation has been a peer review system speaking only, or primarily, to peers. Accreditation began this way, certifying to each other the quality of the education and thus the acceptability of students receiving it. But this limited view couldn't survive.

Following World War II, when federal money began to be made available to higher education, the money sources wanted to know which programs and institutions might be good investments. To cite one interesting example, when the Veterans' Administration wanted to spend money on doctoral programs in clinical psychology as a means of getting more qualified practitioners, the V.A. asked the American Psychological Association to help identify the worthwhile programs. As most of us now know, the A.P.A. soon got into accreditation, speaking to an audience substantially larger than peers alone.

More recently, the consumers of education, our customers if you will, have begun asking quality assessment kinds of questions. . For years, as we noted earlier, the public has been assessing education in some highly limited ways. I hope that the public will come to rely more and more on our accreditation system for their decision making, and that we, the higher education professionals, will help them. We're not there yet, but the audience is growing.

The states are also part of accreditation's audience. Later we will go into the constitutionally mandated role of the states in education and how our accreditation system has interacted with their processes.

Issue 2: Control

Historically, in the U. S. voluntary self and peer evaluation have been primary, and most of us are convinced that this is a system very worth preserving. There are alternatives, of course.

One of these alternatives clearly seems to be "the law". Of course, this is pretty much the same as saying, "the public", whereby authority emanates from those ultimately consuming these services. Most of us won't argue against this source of control.

Another is clearly money. Authority or control emanates from payment; customers, grantors, taxpayers, benefactors. Also hard to argue with.

Still another, and the one closest to the mark overall, is shared control. The faculty bring expertise, the directors represent ownership, the money sources have a legitimate role, etc. All are reasonable, have a legitimate voice, and should share control.

Issue 3: Who pays?
There is a partial answer to this just above, but maybe it's useful to break it down further.

- The customers pay. This says that those being served should pay the bill through their dues and fees. This isn't new; we've pretty much always had dues and fees.

- The profession pays. It's common for the appropriate practitioner professionals to help with accreditation costs via their contributions or via their organizational dues.

- The public pays. If you agree that the public is the ultimate consumer of educational services, then it would make sense to ask the public to share costs. Of course, the mechanism probably would have to be taxation, and we all know the problems with this approach.

So what's the answer? Like the question of control above, the answer is sharing. I see little alternative to asking the customer, the professional, and the public to each contribute.

Issue 4: Cost
What does accreditation cost? The general opinion is that accreditation is quite costly, although interestingly there seems to be very little hard data to base a definite opinion on. Direct costs are the easy part. These include what the institution or program pays in dues and fees. The cosmetology accrediting commission (the National Accrediting Commission of Cosmetology Arts and Sciences, NACCAS), which is at or close to the least cost of all (personal communication), charges the smallest accredited schools (fewer than 40 students) about $2,000 per year. Direct costs for other accrediting groups go upward from there.

But the indirect costs are an entirely different matter. These are very difficult, and maybe impossible, to specify. They include such things as the self-study, meetings, decisions, printing, shipping, data collection, travel, out of pocket costs, etc.

The general opinion is probably very close to correct; accreditation is costly. I estimate, for a large institution, costs may run to hundreds of thousands per year if not more.

At one time years ago, I made a stab at a study of the costs of accreditation. However, I ran into so many problems, including stonewalling from some accreditation agencies, that I abandoned the study. It seems a pity that we have little to base cost figures on except impressions, but that seems all there is for now.

Issue 5: Model or Approach
Obviously, there are different ways accreditation can be carried out. Later, there will be a more detailed discussion of this highly central topic. For now, maybe it's sufficient to note that historically there have been three basic models: resource based, process based, and output based. We will look at the pros and cons of each when we come to it.

Issue 6: Role of Government
This has been a nuisance issue! We educators like to think we're in charge and we favor a self and peer review system. But we also know that both state and federal government have a large role to play.

- **States.** The Constitution assigns education to the states, and the states regulate, control, authorize, evaluate, etc., by various means. In my experience in five states, none do their evaluation functions very well. They tend to be bureaucratic, slow, unimaginative, and even pedestrian. However, the states with which I am most familiar vary, so it may be reasonable to hope that there is a state somewhere that does it well. I haven't seen it.

- **Federal.** We have already noted that the federal influence is substantial, due to their funding role and perhaps most directly due to student financial aid. The role and influence of the Department of Education is very substantial, and the influence of other federal agencies such as Defense, Labor, and NSF, is nearly as large. My experience has been that the federal role is entirely legitimate (monitoring the use of public funds) but very often trivial and petty. And, sadly, it isn't uncommon for government employees to be negligent.

Issue 7: Voluntary Nature
Is accreditation really voluntary? Some, such as Lenn and Lenn (1990), argue that it is not. I agree. Accreditation cannot be considered voluntary, they argue, when it is tied so closely to money and to regulation. One can say that programs and institutions can "volunteer" not to accept aid, but it is very difficult to do.

Issue 8: Level/scope
Accreditation applies basically at two levels: institution wide via the regional accrediting associations, and professional/program specific. The distinction gets fuzzy when we consider the single purpose institution, but by and large the difference holds.

There has been recent interest in reducing the program specific, especially from the major research institutions. Some have sought to reduce the number of program accreditations by arguing that the program level of accreditation imbalances the pressure for resources within the institution. Sometimes they even use the word "blackmail", forgetting that it is the responsibility of university administrators to make difficult resource decisions regardless of pressures.

In any event, both levels of accreditation are inevitable. There continues to be a need for both. At the same time, there also continues to be a need for some coordinating agency or agencies for accreditators themselves. The demise of the Council on Postsecondary Accreditation (COPA) was a serious step backward.

Issue 9: Proliferation
There are a large number of accrediting agencies; seventy plus at my last count. Their growth in numbers is 1argely a historical accident, resulting partly from tradition and partly from self-interest. Establishment of each met a felt need of the time, with some interest in self-protection from within the institutions or programs. Accreditation does reduce the chances for external encroachment, and it may make an institution or program eligible for new funds. All this is attractive to a prospective recipient.

I have to believe, however, that there are more accrediting agencies than we really need. The public interest would be served by mergers. Increased coordination and cooperation would be helpful. Again, I see the demise of COPA as a real negative.

Myths of Accreditation

Accreditation, like many institutions, has accrued several reputations, some of which are untrue and unwarranted. What I propose here is to review those I believe to be the most problematic.

Myth 1: Accreditation is voluntary
It isn't voluntary, of course, as I hope has been sufficiently documented in the discussion above. It's true that an entity seeking accreditation has to apply, and it can resign. Thus accreditation is voluntary to this extent. But when you attach dollars, status, recognition, etc., it becomes much less so. And, of course, in regard to state mandated evaluation, it isn't voluntary at all. In fact, as Lenn and Lenn (op cit) argue, little if any of it is truly voluntary.

Myth 2: Accreditation is Empirical
Accreditation is in part observational, so it is empirical to that extent. But it is more accurate to say that accreditation is heavily judgmental, based on observation that usually is not systematic. It is a positive development that accreditation is becoming more and more empirical particularly as it becomes more and more reliant on outcomes assessment. As we will review in more detail below, accreditation originally assumed that resources and processes reflected quality well enough. We now know that isn't necessarily so. They are better thought of as prerequisites to quality.

In recent years, in one of the most positive developments to impact accreditation, there is increasing recognition that empirical proof, using applied research methodologies, is the way of the future. We are a long way from universal acceptance of this idea, and therefore, from universal use. But accreditation is clearly moving in this direction.

Myth 3: Accreditation is Valid
We assume it is! We hope it is! But do we know for sure? Unfortunately, the answer is no, we don't know for sure.

Here, as so often with accreditation, we assume, we guess, we rely on judgment. If the experts say it's valid, we tend to accept the argument. Obviously this isn't proof, until considerably more hard data are amassed, we won't really know. We can safely say, "I think"; we can't really say, "I know".

Myth 4: Accreditation is non-governmental, self regulation
This is nonsense, of course. I hope the reviews of both state and federal involvement have already proven the point.

Myth 5: Accreditation is quality assurance
Accreditation is OUR system for quality assurance. In this sense this is not a myth.

But, is it the Country's system for quality assurance? Actually, there isn't much apparent impact from accreditation on the public's perception of educational quality. The accreditation system has traditionally been reluctant to reveal much to the public. Lists of accreditation actions are published occasionally in obscure places, but that isn't much. As a result, several popular publications have filled this niche. This leads me to an examination of possible accreditation models or approaches below.

Accreditation Models / Approaches / Methods

There are different ways to carry out quality assurance in education.

Method 1: Reputational Model
This model represents the public's perception of what accreditation is, and thus how educational quality assurance is carried out. Publications such as *Newsweek* and *Business Week* publish the results of their reputational surveys annually. In recent years, these surveys have been improved substantially by better sampling, by assessing multiple factors, and by grouping institutions by type. Thus these surveys seem to have become more subtle and multidimensional, and therefore more useful to the consumer. Besides, they are so much a part of the popular view of educational quality assurance, they are not going to go away.

There are substantial problems with this approach. Surveys, even surveys of people presumed to be well informed, reflect a great deal of extraneous information. The classic misperception revolves around cost; if the tuition is high, the quality must be excellent. Another problem is reputational lag. Changes in actual quality often take a long time to become generally known.

But the main point, of course, is that an institution's or program's reputation isn't the same as true measured quality, as documented by well executed assessment of outcomes. While improvements in reputational ratings can be done, and in some instances have been done, they remain limited. But because they are popular and likely to remain so, it might make sense for us to take them into account in our regular accreditation processes.

Method 2: Resources model
This is how accreditation started. The original assumption was this: if the appropriate resources are available, the educational results must be pretty good. Most thoughtful people would probably say that this assumption is neither all right nor all wrong. Clearly resources have to be prerequisites for good education. At the same time having the resources in place is no guarantee.

What resources are we talking about? First, people are fundamental. The educational enterprise must have at least minimally competent faculty, staff, students, and administration. This is a base line; without them education is going nowhere. And this in turn means that accreditation has ample justification for incorporating resumes, vitae, transcripts, and the like into the review processes.

But people are not all. One has to also have at least minimally adequate learning resources such as libraries, AV materials, computers, syllabi, exams, and the like. Similarly, physical resources, including such items as classrooms, laboratories, and buildings, have to be present.

So to reinforce the point, resource review is important and maybe essential, but over reliance on resources is a mistake. Resources are pre-requisites, nothing more.

Method 3: Process Model

Early in accreditation's history, there was recognition that educators had to do the right things for good education to take place. Millard (1993) attributes this development to the medical fields, which early began to assess specifically what experiences were being incorporated into the students' education. What was in those lectures? What exercises were included in the labs? And so forth.

The logic of this is very compelling. One has to do the right things--bring students through the right educational experiences--for good education to result. The emphasis is on what students, with faculty guidance, actually carry out both in and out of classes, including study, lab work, practical library work, research, writing, whatever.

Like evaluation of resources, process evaluation rests on expert judgment. There has been little research on specifically what processes are needed and how processes vary in impact on learning and other outcomes. Nevertheless, most of us accept the assumption that the right processes are essential for educational quality.

Method 4: Output Model

This is the most recent and the most definitive of all the approaches to evaluation. It refers to the empirical assessment of the degree of achievement of objectives, using applied research methods. It's a form of applied research, which is often called by other names such as "program evaluation", "training evaluation", "validation", "outcomes assessment". All these mean pretty much the same thing. All seek to find hard data answers to such questions as: Do students learn and retain what we say they should? Do student attitudes shift as desired or expected? Do the careers of graduates proceed as our objectives say they should? And the like.

Clearly the output model is based on objectives and empirical assessment of whether they have been achieved. The objectives have to be specifically articulated and defined; a very careful statement of objectives is an essential starting point. In some fields, the objectives will be oriented to specific professional applications. In other fields, the applications and thus the objectives will be wider and more inclusive. The subject experts have to say what their educational outcomes are intended to be.

My bias is probably obvious. I believe that accreditation must put more and more emphasis on this model in the future. I view it as the fundamental way accreditors are going to be able to carry out the kind of definitive evaluations that are clearly needed and that will be highly convincing even to a skeptical audience.

Method 5: Combination Model

It seems only realistic to assume that: (1) some use of the reputation model is probably inevitable, given its wide acceptance and use among the public; (2) the use of the resource model is also firmly entrenched and it is buttressed by a strong logic; (3) similarly, the logic of the process model is strong and its use is nearly universal; and (4) the logic of the output model is strongest of all and it

alone provides hard evidence. Thus, when you put all four of these together, it seems to point to the need for a model that combines the best features of all. That, of course, is what a combination model attempts to do, and you will not be surprised to learn that the approach I will outline later in this paper attempts to do that.

Before we go into what I think are the optimal processes, I think it would be advisable to consider whether there are reasonable alternatives to the present system of accreditation.

Alternatives to Accreditation

There may be alternatives, and it seems to me that the critics of the U.S. accreditation system need to consider what might supplant what we do at present.

Alternative 1: Self Evaluation

There is an important distinction between self evaluation and a completely hands off process. Alternative 1 uses an internal review process. The idea would be to start with a searching self study, including evaluation of resources, processes, and, most important of all, empirical evidence of outcomes. But the problem, obviously, is who evaluates all the evidence. One unfortunate possibility is that it is just put on the shelf. Obviously this would not be acceptable and thus some form of searching internal review of the process results are necessary.

Alternative 1 does not seem like accreditation to me, although the results of an internal review can be readily incorporated into external accreditation reviews.

Alternative 2: Reduced Scope

An alternative argued particularly by the most prestigious institutions is to eliminate professional or programmatic accreditation and retain only the institution wide (regional) kind. The idea would be to put the evaluative focus on the entire institution and remove all program by program reviews.

This argument has the appeal of simplicity and economy. Most of the regional associations do a good job. The problem is that there is no possibility of bringing it off. It is an impractical suggestion. Program-level accreditation is well established, by and large well done, important, and it isn't going to go away.

Alternative 3: Levels of Accreditation

I call this the "Four Star" system, and it has a lot of appeal. The idea would be to create levels or grades of achievement in the accreditation system, with the four stars going only to the very best of whatever is being accredited. Beginners, perhaps similar to what some call ìcandidacy statusî, could be One Star, and the other levels yet to be defined could be Two or Three.

There would have to be some kind of "payoff" for achieving the higher star standings; perhaps longer periods to re-review, perhaps marketing applications, or access to special funds. It might help in faculty attraction and retention. I suspect that the media would find interest in publicizing the Four Star status.

Alternative 4: Government Accreditation
This could be an option. It is one that is in use in nearly all other nations. In addition, there is something akin to it in some states in the U.S.; state agencies charged with educational oversight may carry out what they call accreditation. And, as we all know, the U.S. Department of Education has a "recognition" process whereby it approves accrediting agencies as gatekeepers for federal financial aid. So government involvement in educational quality assurance is very much with us.

However, my experience, as noted earlier, leads me to doubt whether government agencies are capable of any genuine accreditation functions.

Alternative 5: The Present System
This is the best option. In fact, it is difficult to imagine alternatives to the present system, and I have to conclude that some variation of what we now do is the only practical route to improvement.

But, to repeat an earlier point, I do think that the present system as currently operating, is inadequate. I propose now to discuss what I see as the best set of changes. What I am going to propose is a revised system, with some different emphases, drawing on the strength of what we now do, eliminating some weaknesses, and putting first priority on hard evidence proof.

A New Approach to Accreditation

What I envision is an input-output model like this:

Step 1.
Careful and detailed articulation of goals. The goals have to be stated very specifically. No more goals such as "preparation of an informed citizenry", although that may be laudable. We would need to know precisely what the student is to learn, what skills he/she should develop, how he/she is expected to think, what attitudes we expect to engender, what jobs we expect graduates to fill, how we expect careers to develop, and so forth. I canít specify all this here; the subject experts have to do this job and it is big and key one.

Step 2.
Identify in detail what resources must be present in order for the goals above to be achieved. First concentration would probably have to be on people resources, and these would need to be described in quite specific ways. What kinds of faculty backgrounds would be needed? What level of student is required? What attitudes and values must the student bring? In addition, what physical resources must we have to carry out the educational program(s)? Again, I can't specify all the resources that would have to be identified. That would require work from the subject experts.

Step 3.
Careful statement of the educational processes needed to achieve the goals stated in Step 1 above. What can be learned in lecture sessions? What has to be learned in labs? From books? In practice? In internships? By observation in real life settings? By real life practice? By computer? In the library? And so forth. Again, as before, judgments from the experts would be needed.

Step 4.
Most important of all, we must have a research-based system for evaluation of outcomes. Step 1 above says what the outcomes should be. Now someone, perhaps an applied behavioral scientist or an institutional research specialist, needs to design outcome studies, probably dozens of them, to assess the degree to which each of the goals is being achieved. If you are looking for learning, you must measure it in ways that have demonstrated validity. Similarly, if you are looking for development of values, you must measure values in ways that really measure values. And so it goes. This isn't a place to try to discuss applied research methods. But for this approach to be successful, someone who knows the procedures must design and carry out genuine hard headed assessment research.

Step 5.
Review of all of the above, by a group of expert, outside, impartial reviewers and reporters. I see this as the role of those we now call site visitors. Their job wouldn't be so much site visiting any more, although they might visit the site. Rather, it would be to review all the materials generated by steps one through four above, and pronounce whether they demonstrate adequate educational quality, whether the entity deserves a One Star or a Four Star or whatever, and recommend to the head decision makers who would make the final pronouncement.

This final step isn't totally different from what we do now, but that it is more data oriented rather than site review oriented. It still looks at what has been produced, makes a judgment, and recommends an action.

Conclusion

This paper has critiqued the U.S. accreditation system by examining (1) the major issues, (2) the myths, (3) the models, methods, or approaches, (4) the alternatives, and (5) recommendations for a revised system. Our present system was found to have some serious but correctable deficiencies in nearly all areas, but the modern movement toward the use of applied research methods for outcomes assessment provides genuine promise for the future.

The revised accreditation process envisioned in this paper utilizes an input-output model which begins with careful delineation of goals and objectives, moves through examination of both resources and processes, and culminates with multiple research-based assessments of outcomes.

The fundamental conclusion to be drawn is that the U.S. system for educational quality assurance, while clearly containing some serious defects, has a distinguished history, a great deal of value, and deserves much greater use by the public at large. A revised system, based on some of the ideas presented in this paper, has even more potential for social utility.

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