

**THE FINAL REPORT
OF THE
BLUE RIBBON TASK FORCE©**

September 12, 2003

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Accrediting Commission on Education for Health Services
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EXECUTIVE SUMMARY

The Blue Ribbon Task Force was created by the National Center for Healthcare Leadership (NCHL) and the Accrediting Commission on Education for Health Services Administration (ACEHSA), in June 2002. The Task Force was formed in response to the need to ensure that health services education accreditation is relevant and responsive to the changing needs of the broad range of stakeholders in the healthcare industry.

The Blue Ribbon Task Force was made up of representatives of the practice and academic community, who were jointly appointed by ACEHSA and NCHL. The Task Force was charged with seven tasks:

1. Conduct an analysis regarding the definition and scope of *health services administration*.
2. Conduct and present a comprehensive literature search on accreditation.
3. Conduct and present results of a survey of accreditation best practices.
4. Conduct an analysis of relevance, application, and/or essentiality of accreditation regarding graduate programs in health services administration.
5. Define the process for incorporating educational outcomes as developed by the Council on Core Competencies into the ACEHSA accreditation criteria.
6. Develop and publish a paper on current expectations and requirements for health services administration accreditation, to serve as a guideline for the transformation of accreditation processes and criteria.
7. The Final Report will address and recommend future roles, relationships and activities.

The work of the Task Force had two focuses. The first focus was information gathering and analysis, which helped provide intelligence to the Task Force's deliberations. The second focus was the deliberations by the Task Force to formulate the conclusions and recommendations about the future directions for health services administration education accreditation.

The information gathering and analysis included commissioning three consulting studies that were designed expressly to obtain background information for the use of the Task Force. The studies included: obtaining background information on the historical and current definitions and scope of health services administration; developing an analysis of models of accreditation relevant to health services administration education; and conducting a survey of stakeholders to obtain their perceptions of accreditation.

The Blue Ribbon Task concluded that:

- Accreditation overall is considered an important factor in maintaining standards of education programs.
- The processes and criteria for accreditation are influenced by the disciplines involved, the mission of the specific program, where it is located and how close the

program is to the field of practice. These influences vary and are particularly important in education for health services administration. At the same time, commonalities among the education programs are essential for public understanding and accountability.

- Accreditation for education programs in health services administration is valued by many individuals, programs and experts. There is a consistent opinion across all groups, however, that the processes for conducting accreditation reviews and assuring standards are met can, and must, be improved.
- It is time for action to make improvements quickly especially to decrease the administrative burden of accreditation.
- Accreditation processes should promote continuous quality improvement in programs. To achieve this, there needs to be greater emphasis on performance measurement, benchmarking and public reporting.
- Some changes are beyond the scope of the Task Force and need broader discussion with the multiple stakeholders in health services administration and education.

The Task Force makes recommendations that create a renewed vision for ACEHSA, clarify the definition of health services administration, identify core competencies for graduates, increase accountability for outcomes and quality, streamline the accreditation process, and incorporate core competencies into the accreditation criteria.

The Task Force believes that ACEHSA, and related stakeholders, are at a critical crossroads, and have a unique opportunity to make changes in the field of health services administration education that will have far-reaching implications for students, graduates and the future leadership of healthcare. The Task Force believes that ACEHSA's leadership is committed to a process of change, and is poised to debate and address the kinds of strategies recommended in this Report.

NCHL has the opportunity to provide strong support to ACEHSA in developing its new directions. It is essential that the linkages developed and the spirit of collaboration achieved, partially through the work of the Task Force, be sustained and further promoted.

INTRODUCTION

BACKGROUND

The Blue Ribbon Task Force was created by the National Center for Healthcare Leadership (NCHL) and the Accrediting Commission on Education for Health Services Administration (ACEHSA) in June 2002. The Task Force was formed in response to the need to ensure that health services education accreditation is relevant and responsive to the changing needs of the broad range of stakeholders in the healthcare industry.

NCHL was formed in November 2001, as a result of extensive discussions between representatives from practitioner organizations and universities, offering education programs in health services administration, culminating in a Summit Conference in February 2001 on the transformation of the education of future leaders for health services administration.

NCHL is a not-for-profit organization whose mission is:

To be a catalyst for industry-wide collaboration to assure that high-quality, relevant, and accountable health management leadership is available to meet the needs of 21st century healthcare.¹

Collaborating with a broad base of industrial stakeholders, including educational and professional organizations, NCHL's goal is to improve health system performance and the health status of the entire country through effective healthcare management leadership.

ACEHSA is an interdisciplinary group of educational, professional, clinical, and commercial organizations devoted to accountability and quality improvement in the education of healthcare management and administration professionals. ACEHSA was formed in 1968, and is formally recognized by the United States Department of Education (DOE) as the only organization to accredit master's level health services administration programs in the US. ACEHSA's accreditation program is designed to foster high quality professional education for *health services administration*. All programs seeking accreditation by ACEHSA, regardless of setting, such as a School of Business, Public Health or other school or department, are subject to the Criteria for Accreditation.

ACEHSA's mission is:

Serving the public good through promoting, evaluating, and improving the quality of graduate health services administration education in the United States and Canada. Through our partnership between academe and the field of practice, ACEHSA serves universities and programs in a voluntary peer review process as a means to continuously improve graduate education. In so doing, ACEHSA accreditation becomes the benchmark

¹ www.nchl.org.

by which students and employers determine the integrity of health services administration education and the standard of measurement for the world community.²

In addition to the important work of NCHL and ACEHSA, the Task Force recognizes the important and associated work of the Association of University Programs in Health Services Administration (AUPHA). Indeed, the missions of AUPHA, NCHL and ACEHSA are closely related. AUPHA's vision is to:

- Be the global leader in curriculum development, reflecting the changing needs of an integrated healthcare delivery system, educational reforms and technological changes.
- Be the principal advocate for research on management and the organization and delivery of health services and to be a major resource for translating health services management practice and research into teaching materials and strategies.
- Be an indispensable resource to faculty and programs in health management education and to the health management practitioner community.

AUPHA's mission is to:

- Promote graduate and undergraduate curriculum reforms and faculty development, which respond to the changing needs of the health services delivery system, so as to improve the health of communities;
- Promote the application of research findings to the educational setting and to the field of practice;
- Be a leader in transferring new pedagogical techniques and technology to health management education;
- Provide student support, including scholarships, fellowships and other support which strengthen a diverse workforce;
- Provide faculty with career enhancement activities and the skills required for effective teaching and continuing education efforts.³

THE BLUE RIBBON TASK FORCE

The Blue Ribbon Task Force was made up of representatives of the practice and academic community, who were jointly appointed by ACEHSA and NCHL. Members are listed in Appendix A. The Task Force held its first meeting on September 27, 2002, and met five times in person and 17 times by conference call over the course of its work.

The Task Force was charged with seven tasks:

1. Conduct an analysis regarding the definition and scope of *health services administration*.⁴

² www.achesa.org.

³ www.aupha.org

⁴ The term *health services administration* is used throughout this Report as the single term that includes health administration, healthcare administration, health services management, hospital or other healthcare organization-specific administration and management, health planning and evaluation, health policy, and other related activities.

2. Conduct and present a comprehensive literature search on accreditation.
3. Conduct and present results of a survey of accreditation best practices.
4. Conduct an analysis of relevance, application, and/or essentiality of accreditation regarding graduate programs in health services administration education.
5. Define the process for incorporating educational outcomes as developed by NCHL's Council on Core Competencies into the ACEHSA accreditation criteria.
6. Develop and publish a paper on current expectations and requirements for health services administration accreditation, to serve as a guideline for the transformation of accreditation processes and criteria.
7. The Final Report will address and recommend future roles, relationships and activities between NCHL and ACEHSA.

The Task Force was accountable to both ACEHSA and NCHL in the fulfillment of its charge. The work of the Task Force incorporated the charge of an NCHL Council on Accreditation, which had included achievement of a set of strategies, outcomes and deliverables defined in the grant proposal to The Robert Wood Johnson Foundation (November 1, 2001). It was expected that these strategies and outcomes would be further refined through discussions of the Task Force.

Concurrent with the work of the Task Force, ACESHA has been reviewing its accreditation criteria, as defined in its bylaws and as required by DOE. The work of the Task Force was coordinated to assure that timelines were met, and that its work would inform the work of the ACESHA Criteria Review Committee. The intentional overlap of membership on the Task Force and the ACEHSA Criteria Review Committee facilitated this objective.

The Task Force also recognized that NCHL has spent the last two years carefully crafting a vision for its role in the development of health management leadership for the future. ACEHSA and AUPHA are currently conducting separate processes to strategically plan their future. The Task Force wanted to ensure that its recommendations would complement and be sensitive to these processes. It was recognized that the missions of the three organizations (and others) are closely related, and require close inter-relationships and collaborative approaches.

FOCUS OF THE WORK

The work of the Task Force had two focuses. The first focus was information gathering and analysis, which helped provide intelligence to the Task Force's deliberations. The second focus was the deliberations by the Task Force to formulate the conclusions and recommendations about the future directions for health services administration education accreditation.

The information gathering and analysis conducted for this review were extensive. The Task Force commissioned three consulting studies that were designed expressly to obtain background information for its use. The final reports of these studies included the observations, conclusions and recommendations of the authors, and do not necessarily represent the views of the Task Force. The three studies in their entirety are included as appendices:

- *Definition and Scope of Health Services Administration: Background Paper for the Blue Ribbon Task Force on Accreditation.* Authors: James W. Begun, Ph.D., and Amer Kaissi, Ph.D. September 5, 2003. (See Appendix B.)

This paper analyzes the definition and scope of “health services administration.” Begun and Kaissi reviewed the literature for major definitions of health services management and scope of the field, considered scope as reflected in job market estimates and graduate program location, and raised three key questions relevant to the work of the Task Force.

- *Contemporary Models for Accreditation: Lessons for Health Services Administration Education Accreditation.* Authors: Ronald Andersen, Ph.D., Cynthia Carter Haddock, Ph.D., Eugene Schneller, Ph.D. July 8, 2003. (See Appendix C.)

This paper explores the role that accreditation plays in assuring educational quality, and identifies progressive accrediting practices in other fields that can improve health services administration education accreditation and increase the probability that graduates will meet future leadership challenges. Andersen, Haddock and Schneller reviewed the accreditation literature, conducted focus groups, interviewed experts in the field, and analyzed accrediting practices in business, medicine, public administration and public health.

- *Stakeholder Satisfaction with the Accreditation Process: A Report to the Blue Ribbon Task Force.* Authors: Sherril B. Gelmon, Dr. P.H., with Khalid Wahab and Kathi Ketcheson, Ph.D. July 2003 (final report). (See Appendix D.)

This study assesses stakeholder satisfaction with, and expectations of, accreditation of graduate and certification of undergraduate health management and policy educational programs. Gelmon, Wahab and Ketcheson obtained the opinions of multiple stakeholder groups on questions that were not being addressed by other NCHL or ACEHSA initiatives or research studies.

In addition to these three studies, the Task Force considered ACEHSA's ongoing review of its accreditation criteria for the US Department of Education.⁵ Since 1968, ACEHSA accreditation criteria have been reviewed and revised a number of times in response to changes in the healthcare field.

In June 2002, the National Advisory Committee on Institutional Quality and Integrity recommended that ACEHSA be granted “continued recognition” for five years. This recommendation was approved by the Secretary in October 2002. The Committee further recommended that ACEHSA submit an interim report demonstrating full compliance with the Criteria for Recognition. The National Advisory Committee noted two areas that were to be addressed in the interim report:

⁵ Sources include: Accrediting Commission on Education for Health Services Administration. *Interim Progress Report to the Department of Education* (June 2003). Accrediting Commission on Education for Health Services Administration. *Accreditation Philosophy Embodied In Proposed Criteria for Accreditation Changes* (June 2003).

- A written policy enabling ACEHSA to initiate adverse action as circumstances warrant; and
- Revised policies to incorporate all of the requirements of section 602.21. In this instance, ACEHSA was required to document and report on the results of a full review of its criteria prior to proposing and seeking input on the changes.

Accordingly, in the Fall of 2002, ACEHSA launched a full review of the accreditation criteria for the conduct of graduate education for health services administration under the leadership of Robert Hernandez. The first step in this process was to determine the extent to which the current ACEHSA criteria signal academic quality, are relevant to the changing needs of the field, reflect the changing nature of the field of higher education and different methods of education delivery, and are in need of revision.

The ACEHSA Criteria Review Committee set about revising the criteria based on the feedback received from academic programs and the field in early 2003. Draft revised criteria were reviewed by ACEHSA at its May 2003 meeting and forwarded to the field for further review and comment, as well as presented at the AUPHA Annual Meeting in June 2003. ACEHSA has taken the suggested changes under advisement, has been finalizing the criteria over the summer of 2003, and will distribute them to the field in the early fall of 2003 for implementation in the fall of 2004.

The Blue Ribbon Task Force has been following the work of ACEHSA's Criteria Review Committee including proposed changes to the accreditation criteria and the underlying accreditation philosophy (See Appendix E.)

OVERVIEW OF THE TASK FORCE REPORT

The Task Force Report is organized according to the seven tasks with which the Task Force was charged.

Part One summarizes the findings of the four tasks that focused on information gathering and analysis for the purpose of providing intelligence to the Task Force's deliberations. The Task Force's general observations on the findings of each task are also included. The tasks were:

- An analysis of the definition and scope of *health services administration*;
- A literature search on accreditation;
- A survey of accreditation effective practices; and
- An analysis of the relevance, application, and/or essentiality of accreditation regarding graduate programs in health services administration.

Part Two presents the results of extensive deliberations and the recommendations of the Task Force, which address the remaining tasks:

- Addressing current expectations and requirements for health services administration accreditation;
- Making recommendations for future roles, relationships and activities between NCHL and ACEHSA; and

- Defining a process for incorporating educational outcomes as developed by NCHL's Advisory Council on Healthcare Leadership Competencies into accreditation criteria.

PART ONE: INFORMATION GATHERING AND ANALYSIS

AN ANALYSIS OF THE DEFINITION AND SCOPE OF HEALTH SERVICES ADMINISTRATION⁶

The central focus of the field of health services administration in the mid-1900s was quite narrowly defined as hospitals. In 1975, the Commission on Education for Health Services Administration reinforced the expansion of the field well beyond this narrow definition. This national commission developed formal definitions of health services administration and health administrators, outlined the scope of the field which included organizations and services, and specified the educational content for health services administration.

Along with a broadened focus of health services administration, there has been extensive growth of healthcare systems and job opportunities. These include new and more specialized jobs for health administrators, as well as increasingly diverse opportunities in healthcare consulting and supplier organizations (e.g., medical devices, information technology and pharmaceuticals). The demand for health services administration training is currently being met by accredited and unaccredited programs located in a wide variety of departments and schools. The most common school settings are public health and business, with no consensus on the ideal setting.

Definitions of health services administration and its scope will vary depending on the needs of the definers, and the uses to which the definitions are put. Job placement professionals may define the field broadly to maximize job opportunities for graduates, but accreditors may choose to define the field more narrowly to standardize content. There has been pressure to expand the domain of health services administration as defined by accrediting organizations.

Begun and Kaissi identified three key issues regarding definition and scope that must be considered in relation to accreditation processes and the role of accreditation in health services administration education. Potential options, as defined by Begun and Kaissi, for resolving each issue are also noted:

Issue 1: Does the accreditation community need a formal definition (or an explicit working definition) of health services administration?

Option 1A: Yes, a definition is needed. An explicit definition would clarify whether programs meet an initial screening criterion, would help identify which segments of the industry share the values and interests of health services administration, and would help accreditors define required content or competencies.

⁶ This section is an adapted summary of Begun and Kaissi, *Definition and Scope of Health Services Administration: Background Paper for the Blue Ribbon Task Force on Accreditation* (September 5, 2003). The reader is encouraged to refer to Appendix B for the complete text and references.

Option 1B: No, a definition is not needed. The lack of an explicit definition would enable flexible and ad hoc decision-making, would support speed of response by accreditors, and would create a more inclusive atmosphere.

Issue 2: If a definition is needed, how broad and inclusive should it be? What segments of the field or roles of administrators should be explicitly listed?

Option 2A: Develop a definition with a narrow scope. A narrow definition would create focus and help build a strong core of central competencies in graduates. It would raise quality rather than lower or widen its definition, and would speak clearly to the field and its stakeholders.

Option 2B: Develop a definition with a moderate scope. A definition of moderate scope would be a compromise between an exclusive focus on healthcare financing and delivery, and a broad definition that diffuses the identity of the field.

Option 2C: Develop a definition with a broad scope. A definition with broad scope would maximize the attractiveness of the field to new entrants (students and programs) and the mobility of current members. The field needs to grow and have powerful allies. Insurers, supplier companies, consulting firms and others are powerful allies. A definition of the field should explicitly include these segments.

Issue 3: Do existing labels appropriately convey the identity of the field?

Labels of professional associations, educational programs, regulatory bodies and other organizations are powerful, symbolic ways to establish identity, appeal to legitimacy, and convey change when altered. There is wide diversity among the labels of organizations and activities involved in the accreditation community. The accrediting body for the field is labelled the Accrediting Commission on Education for Health Services Administration. The accrediting body needs to reflect the domain of its work. Labels other than *health services administration* that have been suggested include: health administration, healthcare administration, health management, healthcare management, health sector management, health industry management, health services administration and policy.

The Blue Ribbon Task Force's Observations on the Definition and Scope of Health Services Administration

Job opportunities for master's degree graduates with a "health services administration" concentration have become more diverse, well beyond the narrow hospital administration foundation from which the field grew in the mid-1900s. Concurrent with this expansion in job market diversity has been pressure to expand the domain of health services administration as defined by the accrediting organization. For example, some business schools have sought to accredit health services administration programs that prepare students for the broader "health sector" or "health industry." Some schools of public health have sought to accredit health services administration programs that prepare students for health policy staff and leadership positions. In such cases, accreditors are challenged to justify content and competency requirements that apply most directly to students preparing for jobs in healthcare delivery organizations (as opposed, for

example, to jobs in the broader “health sector” or in health policy agencies). Accreditors are pushed to broaden standards, based on the different job market targets of the programs.

- The definition and scope of health services administration needs to be clarified.
- The Task Force recognised the variety of terms and labels used for the profession to be defined, but has chosen to use the term *health services administration* throughout its Report.
- As the field of practice changes in response to the changing needs of health systems, it is essential that the domain of health services administration be defined.
- The unique characteristics that set health services administration apart from other types of administration should be clarified, so that appropriate competencies can be defined and curriculum standards developed appropriately.
- The Task Force discussed the extent to which the scope of health services administration should be defined with a “moderate” and/or “broad” scope, and concluded that this issue should be debated by multiple stakeholders.
- Health services administration education accreditors are increasingly being challenged to justify content and competency requirements, as well as demonstrate what value accreditation processes add.
- As the domain is clarified, there may be a need to re-title the name of the field from *health services administration* to another name. A change in name would have implications for the name of ACEHSA.

A LITERATURE SEARCH ON ACCREDITATION⁷

During the process of gathering background information through consulting reports and discussions with experts, published and unpublished literature was reviewed to guide the deliberations of the Task Force. Much of the general literature was incorporated into the Anderson et al. paper, a summary of which is provided below.

Accreditation is a process of self and peer review that requires institutions or programs to meet certain defined standards or criteria for structure, process and outcome of the educational endeavor. Since the 1980s, accreditation has increasingly sought to promote continuing improvement of quality in colleges, universities and educational programs.

In the United States, accreditation has the following specific purposes:

- Fostering excellence through the development of criteria and guidelines for assessing effectiveness;
- Encouraging improvement through on-going self-study and planning;
- Ensuring external constituencies that an educational endeavor has clearly defined goals and appropriate objectives, maintaining faculty and facilities to attain them, and demonstrating it is accomplishing them and has the prospect for continuing to do so;

⁷ This section is an adapted summary of Andersen, Haddock and Schneller, *Contemporary Models for Accreditation: Lessons for Health Administration Education Accreditation* (July 8, 2003). The reader is encouraged to refer to Appendix C for the complete text and references.

- Providing advice and counsel to new and established programs in the accrediting process; and
- Ensuring that programs receive sufficient support and are free from external influence that may impede their effectiveness and their freedom of inquiry.

Accreditation serves a variety of constituencies by providing information about an educational institution or program. Accreditation serves to notify:

- Prospective students that an institution or program has met minimum standards of educational quality;
- Academic administrators, deans, and faculty members of an institution's or program's strengths and areas for improvement;
- Potential employers that an institution's or program's graduates are prepared for a job and/or professional practice; and
- Taxpayers and the public that taxes and contributions are well spent, and that graduates are prepared to use their education in a way that serves the public good.

Accrediting bodies face a number of challenges today. Anderson et al. noted the following challenges in their consultations with experts in the accreditation field:

- There are pressures for educational accountability (particularly in light of the impending re-authorization of the Higher Education Act).
- There is a need to demonstrate cost-effectiveness and “value-added” (in response to criticism from academic administrators).
- There are calls for a move from an input-driven to an educational outcomes or education effectiveness approach to accreditation.
- There is tension between the rapidly changing “practitioner world” and the more slowly moving world of higher education and accreditation.
- There is a need for specialized accrediting bodies to deal with increasingly sub-specialized or “niche” programs.

Anderson et al. conducted a focus group of leaders from several accrediting agencies. The leaders included representatives from the Accrediting Board for Engineering and Technology Education, Accreditation and State Division Liaison, US Department of Education, the Commission on Collegiate Nursing Education, The National League for Nursing Accrediting Commission, the Teacher Education Accreditation Council, a Commission on Health Education Accreditation board member, and ACEHSA. The focus group identified several key points about current accreditation practices:

- ***Movement to general criteria:*** Outcomes are the principal focus of change in accreditation. There is a very strong focus on “general criteria” and a “blurring” of disciplinary lines. What a graduate should be able to do is of importance. Consequently, accreditation boards have spent a good deal of time visioning about the workplace and the nature of the field. Fields that are fairly technical in nature have begun to move away from a “micro” listing of criteria to more global single criteria related to training a competent practitioner. Such fields

give strong billing to criteria and competencies that may lead to success in practice beyond field technique.

- ***Entry into practice:*** Focus group members agreed the role of accreditation is to prepare graduates for entry into practice. Depending on the selection of students, different programs within a field may face different problems as students seek employment.
- ***Focus on outcomes:*** Many accrediting agencies regard the measurement of outcomes as a very difficult task.
- ***Easing the bureaucratic burden:*** There is a movement to ease the bureaucratic burden of the accreditation process (e.g., surveys have become substantially shorter). At the same time, there appears to be consensus to move away from a universalistic set of standards and criteria, to ones that are linked to the program having carefully crafted its own mission, goals and objectives in concert with the practice world.
- ***Changing the role of faculty:*** The new accrediting environment is placing more demands on faculty. Faculty members must be engaged at every step of the process, shape their courses in response to lessons gained from practice community, and have a broader understanding of the entire curriculum and how the curriculum builds graduate competencies. Continuous quality improvement activities require faculty to participate in evaluation and change between accreditation visits.
- ***Responding to accrediting review bodies:*** Tensions appear to exist between accrediting agency strategy and new Department of Education requirements that all deficiencies be corrected in a two-year period. This will lead to accrediting agencies being “guarded” in their language regarding program deficiencies and expected progress.
- ***The contested terrain of accreditation:*** Some fields, such as nursing, are experiencing competition between accreditation agencies. It is not clear how this will affect accreditation.

Health services administration education programs have a variety of school and department “homes” within universities including business, medicine, public administration and public health, among others. Anderson et al. explored accreditation processes and recent developments for accrediting bodies in these areas, and identified observations to consider for health services administration education accreditation. Briefly:

Authors' Observations From Business Accreditation for Health Services Administration⁸

- There is a focus on mission that is reflected in programs, characterized by very different career destinations for graduates in very diverse university settings.
- An emphasis on benchmarking will potentially shift accreditation far along the continuum from an “audit” model of program criteria toward a model characterized on quality improvement. Programs will be required to be explicit about what they do and to collaborate in the metrics that provide evidence for progress.
- Benchmarking information on graduates is reviewed, and there is an emphasis on preparing leaders and change agents. However, issues pertaining to accreditation of colleges of business are not linked to mid or later-career development.
- Schools are encouraged to innovate, they choose among a variety of accreditation criteria, and there is an emphasis on the “iterative” nature of accreditation (e.g., teams work closely with schools under scrutiny, with site visits when improvement or elaboration is necessary).

⁸ The Association to Advance Collegiate Schools of Business (AACSB) is the accrediting body for business.

Authors' Observations From Medicine Accreditation for Health Services Administration⁹

- General education outcomes/competencies, shared across specialties and programs, are used in competency-based accreditation.
- The Accreditation Council for Graduate Medical Education's accreditation effort will be implemented over several years. It has included cross-specialty cooperation and development of standards, processes, and assessment tools.
- Generally, accreditation processes continue to include structure and process measures, even in light of the focus on outcomes.
- The Liaison Committee on Medical Education has made efforts to streamline its processes, reducing costs and the administrative burden on accredited schools of medicine.
- Medicine has and continues to attempt to engage the full field – undergraduate medical education, graduate medical education and continuing medical education – in thinking about accreditation, and how common themes and competencies can run across these different career stages, while maintaining each level of accreditation in its appropriate role.

Authors' Observations From Public Administration Accreditation for Health Services Administration¹⁰

- Accreditation uses a mission-based competency approach, where each program develops a set of graduate competencies in light of its own mission.
- The accreditation process does not have guidelines or standards for sub-specialties or concentrations within accredited programs. However, the number of sub-specialties and concentrations is growing, and consideration is being given to developing guidelines by the accrediting body.

Authors' Observations From Public Health Accreditation for Health Services Administration¹¹

- Accreditation is increasingly emphasizing leadership, and is moving toward competency-based criteria for accreditation. There continues to be ambivalence as to how far the Council on Education for Public Health (CEPH) has moved and what the criteria should be. For example, the Association of Schools of Public Health believes that standards should be changed even more to emphasize competencies of graduates.
- While there is general support for movement toward competency-based criteria, there is also support for a continued role for structure and process measures in the accreditation process.
- The role of CEPH is being debated: should the role be limited to enforcing standards or should it include setting standards?

⁹ The Accreditation Council for Graduate Medical Education (ACGME) is the accrediting body for medical residency (graduate medical education). The Liaison Committee on Medical Education (LCME) determines the accreditation status of educational programs leading to the MD degree.

¹⁰ The National Association of Schools of Public Affairs and Administration (NASPAA) is the accrediting body for masters programs in public affairs.

¹¹ The Council on Education for Public Health (CEPH) accredits schools of public health, as well as community health education and community health/preventive medicine programs located in other college and university settings. The accreditation practices of CEPH are especially relevant to health services administration accreditation, since the CEPH provides more general institutional accreditation for a major proportion of the ACEHSA accredited programs.

- There seems to be general agreement about the value of having the membership organization that provides services to its members (e.g., schools or programs) be independent from the one that accredits them.
- There is strong support for making the accreditation process less onerous.
- The CEPH site visit teams contact the school before the visit.

The Blue Ribbon Task Force's Observations on the Literature Search on Accreditation

- The processes and criteria for accreditation vary depending on the accrediting body. School level accreditation varies in processes and criteria by type of program (i.e., public health, medicine, public administration, business).
- There are few common approaches between the criteria and processes used to accredit schools of business, public health, medicine or public administration.
- There is an increasing trend in all the schools to be mission-driven, and to use competencies and outcomes as a basis for accreditation.
- There is increasing emphasis on measuring performance, and documenting and publicizing performance achievements.
- As accreditation processes focus more on competencies, the role of faculty members changes to greater involvement with the curriculum as a whole and greater coordination across courses.
- Where graduation from an accredited school is a requirement for license to practice (at an entry level), accreditation is ascribed a higher value.
- Some accrediting bodies are accountable for more than one program including for example, undergraduate and graduate programs.
- Residency programs in Medicine (post-graduate programs) are accredited by ACGME according to 26 programmatic areas.
- Accreditation status may be awarded according to different types – initial or provisional or full.
- Having both school and program-specific (specialized) accreditation adds a burden to the extent that many programs question the added value of specialized accreditation.
- A recurrent theme is mechanisms must be developed to reduce the administrative burden and/or coordinate the two levels.
- Some accrediting bodies have moved to a problem-based or quality improvement type of process.
- An accrediting body is typically organized and managed as a separate entity to a professional membership organization.
- Accrediting organizations work in close collaboration with the professional organizations and the field of practice.

A SURVEY OF ACCREDITATION EFFECTIVE PRACTICES¹²

While some of the effective practices for accreditation were described in the Anderson et al. paper, important information on perceptions of the value of accreditation processes was obtained through a survey of stakeholders.

Gelmon et al. conducted a survey to assess and monitor changes in stakeholder satisfaction with, and expectations of, accreditation of graduate and certification of undergraduate health management and policy educational programs. All stakeholders were asked three broad, overarching questions about accreditation in general:

- What is the value-added/benefit of accreditation/certification?
- Is the "product" (i.e., the graduate) prepared and competent for the work environment?
- How could systems of accreditation/certification of health management and policy educational programs be improved to better serve the needs of stakeholders?

The key stakeholder groups that were surveyed included:

- Faculty and program directors from ACEHSA-accredited programs and others affiliated with AUPHA (graduate and undergraduate);
- Program directors of comparable programs offering an emphasis in health services administration and accredited through public health, business and public administration;
- A sample of current students and recent alumni from ACEHSA-accredited programs;
- Key informants from major stakeholder organizations (professional associations, trade associations, membership groups); and
- Employers and other stakeholders in positions that influence the hiring of health services administration graduates.

A series of surveys, customized for each stakeholder group, included common questions as well as specific questions addressing each stakeholder group's interests in health management education. The Task Force gave final approval of the surveys at the end of February 2003. The surveys were administered via the Web.

Limitations and assumptions of the survey included a short time frame for survey completion, resource limitations, no advance notice to potential respondents, self-identification leading to potential bias, presumed knowledge of health services administration education, and exclusive Web-based survey administration. All feasible actions to account for these limitations were incorporated into the study methodology and interpretation of the findings.

¹² This section is an adapted summary of Gelmon, Wahab and Ketcheson, *Stakeholder Satisfaction with the Accreditation Process: A Report to the Blue Ribbon Task Force* (July 2003 final report). The reader is encouraged to refer to Appendix D for the complete text and references.

Profile of Respondents

There were 534 completed surveys, for an overall response rate of 42%. Response rates for each major category of respondents were 34% alumni, 56% students, 56% faculty and 28% employers. The varying response rates for each group presented some limitations to the generalizability of findings from the survey. In particular, the number of respondents from undergraduate programs was so small that their responses could not be included in the analysis. As well, the employer response rate was low (n=104). Because the sample of employers may have been subject to selection bias, it was not considered to be representative of the population. Consequently, the survey results for employers should be interpreted with caution.

What is the Value-Added/Benefit of Accreditation/Certification?

The survey findings suggest that accreditation of health services administration programs is valued by many constituencies – faculty and program directors, students, alumni, employers, and other key stakeholder groups. There is a widespread perception that accreditation benefits the field, with support across most constituencies. Accreditation is perceived to advance and enhance the profession of health services administration and is a mechanism that confirms program quality to multiple stakeholders. For the individual student or graduate of an accredited program, accreditation gives recognition from the field at large, and supports individual access to the profession. It is also seen to aid in student recruitment and career progression over time. However, as has been demonstrated in other surveys by ACEHSA and other accreditors over the past few decades, the interpretation of the value of accreditation varies among different “publics” suggesting a need for more information and public education.

The survey results offer an endorsement of the benefits of programmatic accreditation. In particular, these benefits include stimulating routine and ongoing program review and improvement, clarifying program mission and goals, and fostering ongoing planning. There is also agreement with the core principles of the Association of Specialized and Professional Accreditors “Code of Good Practice,” particularly the principles that accreditation offers a trustworthy external peer review, promotes integrity and professionalism, and respects institutional autonomy.

Students and alumni indicated that the accredited status of a program was important in their decision to apply to programs. Over 90% of students and 85% of alumni indicated that accreditation had an impact on the quality of the education they received. Students and alumni felt that the accredited status of their program helped them in searching for field experiences and internships, and in their job search upon completion of their academic program.

Is the "Product" (i.e., the Graduate) Prepared and Competent for the Work Environment?

Fifty six percent (n=58) of the employers indicated they have a preference for hiring graduates of an accredited program. Employers indicated preferences for certain settings and certain kinds of expertise related to the nature of the degree held by the potential employee. Employers are concerned about the degree and the institution from which the potential employee received that

degree; faculty perceive that employers hire based on traditions of hiring practice and alumni affiliation.

Respondents were asked to rank graduates according to their perceptions about the extent to which graduates met the draft competencies (March 2003) of NCHL (learning and performance improvement, professionalism, personal and community health systems, leadership, collaboration and communication, and management practice). The highest overall rankings by employers on the draft competencies were for professionalism and collaboration/communication, whereas the lowest overall rankings were for personal and community health systems, and management practice. Students and alumni ranked themselves more highly prepared than the assessments made about their preparedness by faculty or employers.

Faculty ranked graduates highest on the competency of management practice and lowest on leadership. Employers ranked graduates highest on professionalism and lowest on leadership. Alumni and students ranked themselves highest on professionalism and lowest on management practice. Thus there are considerable differences between the perceptions of the various stakeholders about the competencies of graduates.

How Could Systems of Accreditation/Certification of Health Management and Policy Educational Programs be Improved to Better Serve the Needs of Stakeholders?

There was consensus among faculty respondents on the role of accreditation as a mechanism to assure quality and accountability, promote program improvement and identify important issues.

When asked to rate the level of influence of a number of trends in higher education on the future directions of accreditation of health services administration education programs, employers gave the highest rankings to the expanding use of the Internet/computer technology and increasing demands for accountability, whereas faculty gave the highest rankings to dwindling financial resources followed by the expanding use of the Internet/computer technology and increasing demands for accountability. Faculty saw accreditation as being influenced more by increasing competition for students, whereas employers saw attention to the quality of teaching and learning as the influence. Faculty in ACEHSA-accredited programs emphasized the influence of dwindling financial resources and increasing demands for accountability. Changing methods of paying for higher education and the increase in numbers of accredited programs in a geographic region were seen as having the least influence on accreditation.

The Blue Ribbon Task Force's Observations on the Survey of Accreditation Effective Practices

- Most respondents from each stakeholder group appear to value accreditation because it can increase the recognition of the field and advance the profession.
- Most respondent groups appear to endorse programmatic accreditation.
- There is a variation in perception of competencies of graduates between employers and faculty and students. Competencies where programs are perceived to be most successful are related to professionalism, collaboration and communication, but less success is evident with specific management practices.

- The results of the survey should be interpreted with caution because of the limitations in sample size and selection processes. Further discussion and interpretation of the results of the survey are needed.

AN ANALYSIS OF THE RELEVANCE, APPLICATION, AND/OR ESSENTIALITY OF ACCREDITATION REGARDING GRADUATE PROGRAMS IN HEALTH SERVICES ADMINISTRATION¹³

There is a need for individuals with health services administration skills who can lead and manage:

- Large, complex, multi-institutional organizations that have resulted from mergers and other forms of consolidation;
- Health service organizations with a specialized focus; and
- The growing number of non-delivery health organizations that support the health services delivery system (e.g., consulting, insurance and managed care, biotechnology, pharmaceuticals).

Accreditation in health services administration must function as a process that:

- Establishes and assures minimal levels of program quality;
- Is responsive to the diversity of existing and emergent program missions;
- Successfully meets the needs of the field of practice for employers in program targeted settings;
- Provides students with competencies that will promote mobility across and within sectors for career advancement and progression;
- Assures that those engaged in the educational enterprise continue to develop the intellectual capital associated with health management education and practice and import into academia the intellectual capital that is produced outside of the academy;
- Is sufficiently flexible to meet the managerial needs for a wide range of health-related organizations and aspirants for entry at various career stages; and
- Is not burdensome beyond what is necessary to achieve the above goals.

Accreditation cannot completely assure that all stakeholders' needs are adequately met. For example, accreditation cannot assure that the pool of individuals aspiring to be health sector leaders will grow larger and more diverse, or that universities will value and invest more in health services administration education over others in periods of constrained resources. However, accreditation is relevant and essential, particularly to assure quality and public accountability in post-secondary educational institutions and programs.

As of November 2002, there were 68 accredited graduate health services administration programs in the United States and Canada. These programs are located in a variety of

¹³ This section is an adapted summary from Andersen, Haddock and Schneller, *Contemporary Models for Accreditation: Lessons for Health Administration Education Accreditation* (July 8, 2003). The reader is encouraged to refer to Appendix C for the complete text and references.

institutional homes including schools of business, public health, allied health and medicine, with most accredited programs in schools of business and public health.

Anderson et al. postulate a model that includes four potential forces driving the criteria used for health services administration accreditation and four types of accreditation criteria. The relative importance of the four potential forces or influences on accreditation criteria varies at any point in time and changes over time.

The four potential forces driving the criteria used for health services administration accreditation are:

- **Discipline:** This force leads to criteria stressing the importance of basic disciplines such as economics, management science, information science, political science or sociology.
- **Mission of Program:** ACEHSA has traditionally relied upon a program's statement of its mission which has meant that the mission, goals and objectives of individual programs serve as a basis upon which the criteria are applied.
- **Location:** The type of school or program can influence accreditation criteria, the general accreditation requirements for that type of school, and type of degree program.
- **Connection With the World of Practice:** This is the link between health services administration education and the field of practice.

The four types of accreditation criteria postulated by Anderson et al. are:

- **Inputs:** These include the characteristics of students entering programs, the bases upon which they are admitted, the characteristics of schools and universities in which programs are located, and program links to the surrounding community and healthcare industry.
- **Structure:** These include the traditional criteria for accreditation including characteristics of faculty, curriculum, facilities, finances and ties to practice.
- **Process:** These include characteristics that define the way education and learning take place in the program.
- **Outcomes:** Outcomes can be short-term (e.g., does the graduate possess the competencies, skills, knowledge, and abilities deemed necessary for career success, and does the graduate obtain a suitable entry level job?) or long-term (e.g., does the graduate achieve career advancement and become a leader in the field?).

The Blue Ribbon Task Force's Observations on the Relevance, Application, and/or Essentiality of Accreditation Regarding Graduate Programs in Health Services Administration

- Accreditation overall is relevant and considered an important factor in maintaining standards of education programs.
- The processes and criteria for accreditation will be influenced by the disciplines involved, the mission of the specific program, where it is located and how close the program is to the field of practice. These influences are varied and hence particularly important in education for health services administration.

- Accreditation for education programs in health services administration is valued by many individuals, programs and experts, but opinion was consistent across all groups that the processes for conducting accreditation reviews and assuring standards are met can and must be improved.
- Accreditation should include a set of core health services administration competencies that all program graduates are expected to master. Examples include the important ongoing work of the NCHL's Advisory Council on Healthcare Leadership Competencies and the related work being done by other professional societies and organizations such as the five core competencies for all health professions providing direct care identified in a 2003 Institute of Medicine report. These may be applicable for health services administration: providing patient-centered care, working in interdisciplinary teams, employing evidence-based practice, applying quality improvement, and utilizing informatics.
- Accreditation processes should promote continuous improvement. To achieve this, there needs to be greater emphasis on performance measurement, benchmarking and public reporting.
- It is time for action to make improvements quickly especially to decrease the administrative burden of accreditation.
- Some changes need broader discussion with multiple stakeholders.
- Greater collaboration and partnerships are needed between education and practice communities.

PART TWO: DELIBERATIONS OF THE TASK FORCE

Part Two of the report outlines the conclusions and recommendations emerging from the deliberations of the Task Force. It includes the Task Force's recommendations regarding:

- Addressing current expectations and requirements for health services administration accreditation;
- Making recommendations for future roles, relationships and activities; and
- Defining a process for incorporating educational outcomes as developed by NCHL's Advisory Council on Healthcare Leadership Competencies into accreditation criteria.

CURRENT EXPECTATIONS AND REQUIREMENTS FOR HEALTH SERVICES ADMINISTRATION ACCREDITATION

The Blue Ribbon Task Force carefully considered the background information and analysis in its deliberations about the expectations and requirements for health services administration education accreditation. Based on these studies, the Task Force came to two major conclusions:

- Health services administration education accreditation is valued.
- In the spirit of continuous quality improvement, there is an ideal opportunity for some new directions to improve and strengthen accreditation and to make it more relevant and responsive to the changing needs of the broad range of stakeholders in the healthcare industry.

The Task Force has identified a number of new directions supported by action-oriented recommendations. It is recognized that some changes will occur more quickly whereas others will require broader discussion with multiple stakeholders. Success will be assured if there is greater collaboration and strengthened partnerships between the education and practice communities.

As a critical first step, the Task Force believes that this is the time to frame a new vision for the future of ACEHSA. This section begins by proposing some key elements for a new ACEHSA vision statement, followed by new directions that will move ACEHSA toward that vision. These directions include the definition of health services administration, core competencies and values, accountabilities for outcomes and quality improvement, streamlined accreditation processes, and policy considerations.

SOME ELEMENTS FOR A NEW ACEHSA VISION STATEMENT

The Task Force believes that a new vision should be developed for the future of ACEHSA. This will build upon the strategic planning currently underway at ACEHSA, and complement the planning taking place at AUPHA and the current vision for NCHL.

As a starting point, the Task Force believes this vision might be:

“ACEHSA will be recognized and respected as a premier accreditation agency in the field of higher education.”

The vision also needs to incorporate the following elements:

- The educational programs that ACEHSA accredits, the universities in which these programs are located, and the practitioner community will view the ACEHSA accreditation process as highly efficient, effective, and valuable.
- The priorities of ACEHSA and the educational programs that it accredits will demonstrate a strong commitment to improving the health of individuals, communities and population through improving the organization, management, financing, and delivery of healthcare services and products.
- There will be tangible evidence to show that ACEHSA is contributing more significantly than in the past to improving the quality of health management leadership in North America, with measurable benchmarks against which progress can be assessed and performance improved.
- ACEHSA will be known as an innovator and actively promote quality innovations in learning, such as distance and experiential learning and other pedagogical developments.
- Through a combination of accreditation fees, grants, philanthropic gifts and sponsorship support, ACEHSA will have a solid financial foundation and sound financial operations.

It is vital to build on stakeholder support for the new vision. ACEHSA's strategic and operational plans should focus on the vision with clear benchmarks to assess progress.

The Task Force recommends that:

- R1 ACEHSA craft and frame a new vision that incorporates elements identified in the Report, and that will enable ACEHSA to implement the Report's recommendations.

DEFINITION OF HEALTH SERVICES ADMINISTRATION

Currently, a wide array of terms is used to refer to *health services administration* including health services administration, health administration, healthcare administration, health management and healthcare management, to name a few. This plethora of terms has resulted in a lack of clarity, unity and understanding within the field and in the minds of the public.

The Task Force believes that it is important for the accrediting body for health services administration to clarify the definition and scope of the field to assure effective accreditation. The goal in defining health services administration is to identify those characteristics that are unique to this field, specifically the unique contributions to be made to the health of individuals and communities.

The Task Force concluded that the scope of health services administration should be defined more broadly than narrowly, while recognizing a unique and foundational core in the management and leadership of healthcare delivery organizations. Such a definition would recognize the realities of the changing job market (i.e., new organizational settings and new health industry sectors), and the response of academic programs to the changing job market for graduates. As previously noted the term *health services administration* is the term that the Task Force has chosen to use for consistency throughout this Report.

The Task Force recommends that:

- R2 A broader definition of *health services administration* be developed that incorporates the application of specialized management knowledge, skills and attitudes to the improvement of individual and community health, and healthcare delivery.

The Task Force recognized that health services administration knowledge, skills and attitudes are valuable in a wide range of organizational settings, and that the roles for graduates of health services administration programs span a wide range of opportunities. Organizational settings include those involved in the direct delivery of healthcare services (e.g., hospitals, health systems, physician organizations, public health departments, nursing homes and home health agencies), health insurance organizations, health planning organizations, healthcare regulatory bodies, healthcare supply organizations (e.g., pharmaceutical, medical device, and biotechnology companies) and healthcare consulting organizations. The wide range of roles for graduates of health services administration programs include policy analysts, consultants, and staff and management roles in units, departments, divisions and organizations including specialized departments/divisions such as information technology, human resources, marketing, quality improvement and finance. Each of these roles emphasizes a narrower set of competencies. The implication of using a broad overarching definition, with perhaps explicit sub-categories, is that it assists in identifying and separating core competencies that are needed by anyone working in the broad health sector while, at the same time, recognizing "customization" of competencies for those pursuing careers in a specific sub-category.

Since ACEHSA is the official and only accrediting agency for graduate programs in health services administration education, changes in the definition of *health services administration* may require using an alternative label for the field and changing the name of the accrediting body. Possible alternative terms for *health services administration* that have been suggested include healthcare administration, health management, health administration, health sector management and health industry management.

The Task Force recommends that:

- R3 ACEHSA consider the value of changing its own name should all stakeholders reach a consensus about the name of the domain other than *health services administration*.

CORE COMPETENCIES AND VALUES

The Task Force believes that ACEHSA needs to adopt accreditation criteria that:

- Incorporate a set of core health services administration competencies that all program graduates are expected to master while, at the same time, respect diversity among the programs in terms of their educational mission, target markets and priorities: and
- Expect all programs to systematically examine societal, organizational and personal values in their curricula, and encourage students to clarify their own values in the process.

Core health services administration competencies should be reviewed and revised on an ongoing basis as experience is gained with the use of competencies and new evidence becomes available. When adopting and refining the core competencies, ACEHSA should give careful consideration to the ongoing work of the NCHL Advisory Council on Healthcare Leadership Competencies, related work being done by other professional societies and organizations, as well as the five core competencies for all health professions who are direct care givers (2003 IOM) – providing patient-centered care, working in interdisciplinary teams, employing evidence-based practice, applying quality improvement, and utilizing informatics.

Once core competencies have been defined, a more detailed approach may be necessary for programs to describe competencies tailored to the roles identified in their mission.

As reflected earlier in this Report, the use of competencies changes the roles and expectations for faculty members in how they communicate, educate and evaluate learners and graduates' behavior. Attention must be given to educating faculty members to facilitate their transition to the new expectations.

The Task Force recommends that:

- R4 ACEHSA adopt accreditation criteria that incorporate a set of core health services administration competencies that all program graduates are expected to master.
- R5 ACEHSA work with other stakeholders, such as AUPHA, to develop strategies for facilitating faculty members' adaptation to competency and outcome-based learning.

ACCOUNTABILITIES FOR OUTCOMES AND QUALITY IMPROVEMENT

The Task Force deliberated the importance of accreditation in increasing accountability of programs to a broad range of stakeholders. The Task Force concluded that there are two primary areas where increased accountabilities could be achieved: 1) a commitment to ongoing evaluation of educational outcomes; and 2) an enhanced commitment to continuous quality improvement.

Commitment To Ongoing Evaluation Of Educational Outcomes

The Task Force believes that the leadership of ACEHSA, AUPHA, participating programs, and practitioner organizations need to collaborate in developing workable and valid methods for assessing student learning in relation to the core health management competencies. This includes defining consistent evaluation criteria and methods to assess students' learning across all program settings, and defining outcome measures that can be used to evaluate the performance of graduates. In addition, each graduate program should adopt methods to assess their students' learning in relation to the core health services administration competencies and to the competencies that are unique or specialized to their particular mission and curriculum. Objective assessment of student learning and post-graduate performance should include ongoing efforts to obtain the input and advice of preceptors and employers.

Demonstration programs should be encouraged, where multiple programs collaborate to identify common outcome measures that assess student learning and performance. Sharing best practices openly and widely will enhance overall progress in the field.

The Task Force recommends that:

- R6 ACEHSA, AUPHA, participating programs, and practitioner organizations develop reliable and valid methods for assessing student learning in relation to the core health management competencies, including criteria and methods to assess students' learning across all program settings in specialized areas.
- R7 ACEHSA, AUPHA, participating programs, and practitioner organizations develop reliable and valid methods to define outcome measures for evaluating the performance of graduates.

An Enhanced Commitment to Continuous Quality Improvement

The Task Force believes that accreditation criteria need to be adopted that expect programs to demonstrate a commitment to ongoing evaluation and continuous improvement in all facets of their activities. This commitment must be supported with objective measures of progress in relation to established goals. Examples include sharing performance information with other programs and sharing selected indicators with the practitioner community and the public-at-large as part of a unified effort to enhance public accountability. There would be advantages to the development of a "report card" approach, where a relatively short and precise set of indicators of a program's performance was available and used, perhaps, in annual reports (the Task Force recognizes that some of this type of reporting is already in place). Comparative analysis of programs' achievements and public reporting would promote performance improvement among programs, and would clearly demonstrate ACEHSA's commitment to the value of openness in communications.

New understanding and approaches to higher education and, consequently, to health services administration education are evolving. Indeed, many programs have moved to "executive" models, are experimenting with new technologies for distance education and are using problem-based learning techniques. ACEHSA has a unique opportunity to observe these developments in programs during site visits and regular program communications. ACEHSA, along with other

stakeholders such as AUPHA, should actively promote this type of innovation and develop a more aggressive approach to sharing these types of experiences, to enhance excellence in education methodology.

The Task Force recommends that:

- R8 ACEHSA adopt accreditation criteria that require programs to demonstrate a commitment to ongoing evaluation and continuous improvement in all facets of their activities that impact on outcomes. Program information must be made available for benchmarking purposes and to be shared, with the goal of improving both the education process and outcomes.
- R9 ACEHSA actively and aggressively promote and communicate new and innovative approaches in executive and distance learning methodologies to enhance best practices.

STREAMLINED ACCREDITATION PROCESSES

The Task Force believes that, in the short term, ACEHSA needs to take a fresh and innovative look at current accreditation processes and efforts, with the goal of simplifying and streamlining the accreditation process. The Task Force recognises that considerable effort has been made in the past, but concluded that this effort must be revisited and redoubled to stimulate new thinking and approaches. There are a number of positive changes that can be made quickly with little or no cost, whereas others will take more time and effort. The Task Force identified a number of areas where improvements should be made.

Improve the Efficiency and Reduce the Administrative Burden of Accreditation Processes

Paperwork requirements can and should be reduced dramatically. Paper copies of documents should be reduced to a minimum. Processes could be streamlined if electronic tools were used to regularly report and communicate between ACEHSA and the programs. Electronic communications should be used for programs to report a key set of indicators annually to ACEHSA. In terms of site visits, these could be simplified and more effective if, for example, key materials were on display at a site visit rather than incorporating them into the written self-study reports. The expectation should be to conduct “paperless” site visits. The process could also be streamlined if key “problem areas” were identified and provided in advance to the program before a site visit. The site visit would then focus on exploring input, process and/or structural causes of why a program was not achieving its established outcome objectives, goals and standards.

The Task Force recommends that:

- R10 ACEHSA examine operating strategies with the goal of streamlining to reduce or eliminate paperwork and other administrative costs to programs. For example, ACEHSA should:
- Develop a template of information/indicators that would be reported upon electronically by programs on a regular basis;

- Develop a “problem-based” approach to site visits where areas for further exploration are identified and communicated in advance, so that site visits can focus on clarification and advice in these areas; and
- Assess the quantity and quality of material that is needed for the self-study reports to identify information that is redundant or could be available at the time of a site visit.

Examine, Identify and Adopt Effective Ways to Coordinate ACEHSA Accreditation Processes with School-Level Accrediting Agencies (e.g., CEPH and AACSB)

ACEHSA needs to identify ways to reduce duplication of time, effort and costs. For example, the Task Force observed that present ACEHSA procedures request significant amounts of information from programs that is already required by school-level accrediting agencies. One approach is to launch demonstration projects to test out mechanisms to improve coordination and reduce duplication between school and program levels of accreditation. While it is recognised that similar efforts have been tried in the past, strategies must be found to prevent programs from experiencing accreditation “burnout.”

The Task Force recommends that:

- R11 ACEHSA examine, identify and adopt effective ways to coordinate its accreditation processes with school-level accreditation. For example, identify baseline data and information facts about the university and school that would be acceptable for both school and program accreditation processes.
- R12 ACEHSA develop a proposal with one or more school-level accrediting agencies for a demonstration project that can test out a simplified set of accreditation documentation and site visit requirements.

Recognise the Broad Range and Stages of Development of Programs Seeking ACEHSA Accreditation

The programs that seek ACEHSA accreditation represent a continuum of programs that vary greatly in their missions, populations being served, scope of activities, organizational location, and in many other ways. For example, ACEHSA serves organizations that range from comprehensive entities actively engaged in education, research and public service, to smaller programs that focus primarily on teaching a single curriculum.

The Task Force believes that the effectiveness of ACEHSA could be maximized if it recognized the different types and levels of accredited organizations and developed approaches appropriate to each type or level. There is precedence for this elsewhere. For example, the Carnegie methodology categorizes universities according to their scope. In a similar manner, ACEHSA could have one set of criteria for more comprehensive programs with deep engagement in research, and another set for those whose mission focuses primarily on teaching. To be accredited, all programs would need to assure that core health services administration competencies were addressed.

Mechanisms are in place for programs to receive provisional accreditation through ACEHSA. It is possible that this model could be extended and refined to accommodate programs, at different or more advanced stages, that might receive a different type of accreditation process.

The Task Force recommends that:

- R13 ACEHSA recognize the different levels and types of accredited programs and consider developing accreditation approaches for each level and type.

POLICY CONSIDERATIONS

The Task Force identified a number of policy considerations in the areas of scope of accreditation activities, sponsorship, and a new federal grant program to support health services administration education.

Scope of Accreditation Activities

The Task Force believes that ACEHSA needs to examine the scope of its present and future activities. ACEHSA currently accredits master's level programs that vary widely from programs offering different degrees, to programs aimed at entry-level graduates, to programs aimed at individuals in "executive-type" programs. Some programs may grant the same degree to both entry level and executive graduates.

In examining the scope of ACEHSA, the following questions need to be explored:

- What types of educational programs should be eligible for accreditation in the future?
- Should ACEHSA continue to focus only on masters-level programs?
- Should ACEHSA assume responsibility for the certification of undergraduate programs, a responsibility currently held by AUPHA?
- Should ACEHSA narrow or expand its present focus and, if so, in what way(s) and why?

These questions need to be answered in partnership with the practitioner community.

The Task Force recommends that:

- R14 ACEHSA examine the scope of programs that it is responsible for accrediting, and develop a rationale for maintaining the status quo or for expanding its scope.

Sponsorship

The Task Force believes there is an opportunity to strengthen ACEHSA's relationship with its sponsorship base. For example, current sponsorship arrangements could be improved by clearly defining the roles and duties of sponsors in relation to the Board of Commissioners. Greater clarity in roles and functions would simplify communications and enhance effectiveness. In

addition, the ACEHSA Board of Commissioners and staff should regularly provide the sponsors, and other key stakeholders, with evidence-based reports that document the contributions that its accreditation activities are making to improving the quality of health services administration education and practice. Communicating and clarifying output would help demonstrate ACEHSA's value to the field it serves and could further strengthen its sponsorship base.

The Task Force also believes there is an opportunity to expand ACEHSA's sponsorship base. There has been expansion in the number and types of ACEHSA's sponsors in recent years, resulting in invaluable input into accreditation processes. Further expansion may be warranted as the definition and scope of health services administration expands to include new groups of stakeholders. For example, having NCHL as an ACEHSA sponsor would further strengthen the collaborative relationship between NCHL and ACEHSA. There may be other health-related organizations and associations that might be considered to further strengthen ACEHSA's sponsorship base.

The Task Force recommends that:

- R15 ACEHSA, as part of its ongoing strategic planning process, examine its patterns and methods of communicating with current sponsors to improve its effectiveness.
- R16 ACEHSA invite NCHL to be a sponsor of ACEHSA, so as to enhance further collaboration and communication between the two organizations.

A New Federal Grant Program to Support Health Services Administration Education

The Task Force believes that effective management and leadership are essential to achieving organizational effectiveness. Given national and international pressures for critical improvements in the health industry, this would be an ideal time to make the case for a new federal grant program to support health services administration education. Funds should be provided for carefully targeted purposes such as defining competencies, improving curriculum content, developing new pedagogy, and evaluating outcomes in areas such as informational technology, developing clinical and organizational performance measurement, and promoting clinical improvements through evidence-based healthcare.

The Task Force believes that there are Congressional leaders who would be willing to explore such a grant program. If this initiative were linked closely to the core health management competencies that are recommended earlier in this Report, it would be possible to focus the grants on accredited programs. In governmental terms, relatively small amounts of money could make a big difference in health services administration education programs. A new grant program could simultaneously strengthen education for health services administration as well as create an additional incentive for programs to seek accreditation.

The Task Force recommends that:

- R17 AUPHA with ACEHSA, NCHL and other stakeholders develop a proposal for a federal grants program that would provide funding for an innovative program of educational research and development for health services administration education.

FUTURE ROLES, RELATIONSHIPS AND ACTIVITIES

As one of its mandates, the Task Force examined the future roles and potential interrelationships between ACEHSA and NCHL, with a view to maximizing the strengths of each organization and identifying areas of synergy. While AUPHA was not specified as part of the mandate of this work, the Task Force included AUPHA in its analysis of relationships because of AUPHA's historic and central role in health services administration education.

ROLE OF NCHL IN ACCREDITATION

The role of NCHL in accreditation should be to promote the improvement of accreditation processes to strengthen the field of health services administration and health services administration education. NCHL has a very important role to play enhancing and supporting ACEHSA's accreditation process for master's programs, by advocating for the types of changes in health services administration education and accreditation recommended in this Report. To this end, NCHL should be supportive of ACEHSA, and its mission and goals for master's level training for health services administration. NCHL can demonstrate its active support by participating in efforts to obtain funding for, and conduct, research that will contribute to improving the effectiveness of accreditation processes and outcomes. Examples of this type of support include the initiatives recently conducted for this Task Force, namely the background paper on models of accreditation, the survey of stakeholders, and the paper on the definition of health services administration.

The Task Force believes that NCHL should build upon its ongoing work with practitioners and assist in the inter-linkages between universities and practitioners. NCHL has demonstrated its ability to convene forums that bring together health services administrators and academics to debate important strategic issues for health services administration education. NCHL has demonstrated a philosophy of engagement with AUPHA and ACEHSA and of sharing information that should be maintained. Currently, the President, Board Chair and several commissioners of ACEHSA are board members of NCHL. Such inter-relationships should continue. Further communication and collaboration would be enhanced with NCHL as a sponsor of ACEHSA.

The Task Force recommends that:

- R18 NCHL assume an active role in supporting the work of ACEHSA in refining its approaches to accreditation. The experience of this Task Force has shown that NCHL and ACEHSA can work collaboratively and productively. Other stakeholder organizations

might build upon this experience of collaboration to ensure that processes are in place to enhance collaboration and undertake joint projects in the future.

Recognizing that a stimulus for the creation of this Task Force was NCHL's initial proposal for an NCHL Council on Accreditation, the Task Force deliberated the benefits and limitations of forming a Council at this time. The Task Force concluded that the collaborative relationship that now exists between ACEHSA and NCHL makes the formation of an NCHL Council redundant. The current and proposed structural arrangements – with key ACEHSA leaders as board members of NCHL and with NCHL as a sponsor of ACEHSA – create ample opportunities for sharing and debating accreditation issues of common interest. Further, the Task Force believes that future education and accreditation issues for NCHL can be directed to, and incorporated into, the role and functions of the existing NCHL's Advisory Council on Healthcare Competencies and NCHL's Advisory Council on Research and Continuous Improvement.

The Task Force recommends that:

R19 NCHL not form a Council on Accreditation, and that education and accreditation issues be incorporated in the roles and functions of existing NCHL Advisory Councils on Healthcare Leadership Competencies, and Research and Continuous Improvement.

ACEHSA ROLES AND RELATIONSHIPS

A key element of ACEHSA's success will be to demonstrate its impact on improving the level of competencies in health services administration, with the ultimate outcome of improving the health of individuals and communities. To this end, ACEHSA should move towards a more precise, outcome-driven, mission-sensitive and improvement-oriented focus.

Currently, ACEHSA focuses on master's level education that includes learners from a variety of backgrounds, who are at different stages of their careers. The Task Force believes that ACEHSA needs to continue to recognize this diversity while, at the same time, adopting reliable and valid competencies that incorporate core competencies and encourage programs to define additional competencies tailored to their missions.

The recommendations in this Report identify an enhanced vision and a strong and vital role for ACEHSA. Recognizing the ongoing strategic planning process underway, the Task Force encourages ACEHSA to move forward aggressively with this new agenda.

The Task Force recommends that:

R20 ACEHSA move quickly to debate and act upon the recommendations outlined in this Report concerning its future role and relationships.

AUPHA RELATIONSHIPS

Historically, due to a variety of factors especially financial constraints, AUPHA and ACEHSA have been obliged to share physical and administrative resources as the organizations have evolved. The end result, not surprisingly, has been considerable confusion by organizational members, programs, practitioners and other stakeholders about the unique roles and responsibilities of each organization.

It is important that AUPHA and ACEHSA maintain both the appearance and reality of the arms-length relationship between a professional association and an accrediting agency. Through their respective planning processes, the Task Force has anticipated that AUPHA and ACEHSA will take these factors into consideration. Clearly a close working relationship is necessary. ACEHSA needs to be supportive of AUPHA's developing role in relation to designing and testing new curriculum and pedagogy.

The Task Force recommends that:

- R21 During its strategic planning process, ACEHSA explore its relationship with AUPHA and clarify for all stakeholders their different roles and responsibilities.

PROCESS FOR INCORPORATING COMPETENCIES INTO ACEHSA CRITERIA

ACEHSA has excellent formal and informal approaches to regularly consider and review changes in the criteria for accreditation (e.g., identification of key competencies). Given the unique and specific responsibilities that ACEHSA has for master's level education, the Task Force believes that ACEHSA should become the repository for core and specialized competencies for master's level preparation for health services administration education as they are developed. The pioneer work on core competencies, currently being developed through NCHL's Advisory Council on Healthcare Leadership Competencies, is one major starting point.

ACEHSA's repository should also be the recipient of competencies developed, validated and perceived to be of relevance by other groups including other professional organizations. Recognizing the excellent work done by many organizations in the health field – including the Institute of Medicine 2003 report on the health professions – the repository could include a variety of competencies for core roles in health services administration as well as competencies developed by individual programs.

ACEHSA has an important role to play in supporting the work of other organizations that are in the process of developing and validating competencies. ACEHSA, with AUPHA and NCHL and other interested organizations, could support pilot projects for a program or clusters of programs that are experimenting with developing and testing competencies (e.g., AUPHA is currently proposing to conduct background research in relation to pedagogy). ACEHSA should collaborate with other organizations to help secure funding and play an active part when the content of projects have implications for accreditation.

ACEHSA should establish a review process for the receipt and evaluation of competencies on a regular basis, which will make recommendations to ACEHSA about incorporating new or revised competencies into the accreditation criteria. Similar processes would be necessary should ACEHSA decide to expand the scope of accreditation responsibilities to other health services administration education programs beyond master's preparation.

During site visits for accreditation and regular progress reports, ACEHSA has the unique opportunity to see first hand the progress that is being made by individual programs in developing and validating competencies. These experiences can be summarized by ACEHSA and distributed broadly for individual programs to use as benchmarks.

The Task Force recommends that:

- R22 ACEHSA establish a repository for review, critique and communication of core competencies for the graduates of master's degree programs in health services administration.
- R23 ACEHSA promote the development, innovation and testing of core competencies for health services administration among education programs and other stakeholders.

FINAL OBSERVATIONS

Throughout the Task Force's process of information gathering and deliberations, it became clear that accreditation processes are valued, and have the potential to improve education processes and, ultimately, the health of individuals and communities in North America. We are not there yet, even though the Task Force heard commitment from a wide array of organizations and individuals to improving both processes and outcomes of accreditation.

ACEHSA and related stakeholders are at a critical crossroads, and have a unique opportunity to make changes in the field of health services administration education that will have far-reaching implications for students, graduates and the future leadership of healthcare. The Task Force believes that ACEHSA's leadership is committed to a process of change and is poised to debate and address the kinds of strategies recommended in this Report.

NCHL has the opportunity to provide strong support to ACEHSA in developing its new directions. It is essential that the linkages developed and the spirit of collaboration achieved, partially through the work of the Task Force, be sustained and further promoted.

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SUMMARY OF RECOMMENDATIONS

CURRENT EXPECTATIONS AND REQUIREMENTS FOR HEALTH SERVICES ADMINISTRATION ACCREDITATION

Some Elements For a New ACEHSA Vision Statement

The Task Force recommends that:

- R1 ACEHSA craft and frame a new vision that incorporates elements identified in the Report, and that will enable ACEHSA to implement the Report's recommendations.

Definition of Health Services Administration

The Task Force recommends that:

- R2 A broader definition of *health services administration* be developed that incorporates the application of specialized management knowledge, skills and attitudes to the improvement of individual and community health, and healthcare delivery.
- R3 ACEHSA consider the value of changing its own name should a consensus be reached about the name of the domain other than *health services administration*.

Core Competencies and Values

The Task Force recommends that:

- R4 ACEHSA adopt accreditation criteria that incorporate a set of core health services administration competencies that all program graduates are expected to master.
- R5 ACEHSA work with other stakeholders, such as AUPHA, to develop strategies for facilitating faculty members' adaptation to competency and outcome-based learning.

ACCOUNTABILITIES FOR OUTCOMES AND QUALITY IMPROVEMENT

Commitment To Ongoing Evaluation Of Educational Outcomes

The Task Force recommends that:

- R6 ACEHSA, AUPHA, participating programs, and practitioner organizations develop reliable and valid methods for assessing student learning in relation to the core health management competencies, including criteria and methods to assess students' learning across all program settings in specialized areas.

- R7 ACEHSA, AUPHA, participating programs, and practitioner organizations develop reliable and valid methods to define outcome measures for evaluating the performance of graduates.

An Enhanced Commitment to Continuous Quality Improvement

The Task Force recommends that:

- R8 ACEHSA adopt accreditation criteria that require programs to demonstrate a commitment to ongoing evaluation and continuous improvement in all facets of their activities that impact on outcomes. Program information must be made available for benchmarking purposes and to be shared, with the goal of improving both the education process and outcomes.
- R9 ACEHSA actively and aggressively promote and communicate new and innovative approaches in executive and distance learning methodologies to enhance best practices.

STREAMLINED ACCREDITATION PROCESSES

Improve the Efficiency and Reduce the Administrative Burden of Accreditation Processes

The Task Force recommends that:

- R10 ACEHSA examine operating strategies with the goal of streamlining to reduce or eliminate paperwork and other administrative costs to programs. For example, ACEHSA should:
- Develop a template of information/indicators that would be reported upon electronically by programs on a regular basis;
 - Develop a "problem-based" approach to site visits where areas for further exploration are identified and communicated in advance, so that site visits can focus on clarification and advice in these areas; and
 - Assess the quantity and quality of material that is needed for the self-study reports to identify information that is redundant or could be available at the time of a site visit.

Examine, Identify and Adopt Effective Ways to Coordinate ACEHSA Accreditation Processes with School-Level Accrediting Agencies (e.g., CEPH and AACSB)

The Task Force recommends that:

- R11 ACEHSA examine, identify and adopt effective ways to coordinate its accreditation processes with school-level accreditation. For example, identify baseline data and information facts about the university and school that would be acceptable for both school and program accreditation processes.

- R12 ACEHSA develop a proposal with one or more school-level accrediting agencies for a demonstration project that can test out a simplified set of accreditation documentation and site visit requirements.

Recognise the Broad Range and Stages of Development of Programs Seeking ACEHSA Accreditation

The Task Force recommends that:

- R13 ACEHSA recognize the different levels and types of accredited programs, and consider developing accreditation approaches for each level and type.

POLICY CONSIDERATIONS

Scope of Accreditation Activities

The Task Force recommends that:

- R14 ACEHSA examine the scope of programs that it is responsible for accrediting, and develop a rationale for maintaining the status quo or for expanding its scope.

Sponsorship

The Task Force recommends that:

- R15 ACEHSA, as part of its ongoing strategic planning process, examine its patterns and methods of communicating with current sponsors to improve its effectiveness.
- R16 ACEHSA invite NCHL to be a sponsor of ACEHSA, so as to enhance further collaboration and communication between the two organizations.

A New Federal Grant Program to Support Health Services Administration Education

The Task Force recommends that:

- R17 AUPHA with ACEHSA, NCHL and other stakeholders develop a proposal for a federal grants program that would provide funding for an innovative program of educational research and development for health services administration education.

FUTURE ROLES, RELATIONSHIPS AND ACTIVITIES

Role of NCHL in Accreditation

The Task Force recommends that:

R18 NCHL assume an active role in supporting the work of ACEHSA in refining its approaches to accreditation. The experience of this Task Force has shown that NCHL and ACEHSA can work collaboratively and productively. Other stakeholder organizations might build upon this experience of collaboration to ensure that processes are in place to enhance collaboration and undertake joint projects in the future.

R19 NCHL not form a Council on Accreditation, and that education and accreditation issues be incorporated in the roles and functions of existing NCHL Advisory Councils on Healthcare Leadership Competencies, and Research and Continuous Improvement.

ACEHSA Roles and Relationships

The Task Force recommends that:

R20 ACEHSA move quickly to debate and act upon the recommendations outlined in this Report concerning its future role and relationships.

AUPHA Relationships

The Task Force recommends that:

R21 During its strategic planning process, ACEHSA explore its relationship with AUPHA and clarify for all stakeholders their different roles and responsibilities.

PROCESS FOR INCORPORATING COMPETENCIES INTO ACEHSA CRITERIA

The Task Force recommends that:

R22 ACEHSA establish a repository for review, critique and communication of core competencies for the graduates of master's degree programs in health services administration.

R23 ACEHSA promote the development, innovation and testing of core competencies for health services administration among education programs and other stakeholders.

APPENDIX A

MEMBERS OF THE BLUE RIBBON TASK FORCE

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APPENDIX B

DEFINITION AND SCOPE OF HEALTH SERVICES ADMINISTRATION: BACKGROUND PAPER FOR THE BLUE RIBBON TASK FORCE ON ACCREDITATION

James W. Begun, Ph.D., and Amer Kaissi, Ph.D. September 5 2003.

Definition and Scope of Health Services Administration

Background Paper for the
Blue Ribbon Task Force on Accreditation

September 5, 2003

This paper was prepared in order to assemble resources and facilitate discussion in response to the charge to the Blue Ribbon Task Force on Accreditation to “conduct an analysis regarding the definition and scope of ‘health services administration.’” It was prepared by James W. Begun, Ph.D., and Amer Kaissi, Ph.D. It does not represent the views of the Blue Ribbon Task Force.

The authors conducted a search of the literature for major definitions of health services administration and/or scope of the field. Scope of the field as reflected in job market estimates and graduate program location also is briefly considered. The paper ends by raising three questions relevant to the Blue Ribbon Task Force charge.

HISTORICAL DEFINITIONS OF THE FIELD

The field of health services administration began with its central focus being the hospital. The first national initiative to standardize the educational content of hospital administration dates back to 1945-48 with the report of the Joint Commission on Education, also known as the Prall Report (Joint Commission on Education, 1948; Loeb, 2001). The mission of the Commission “was to make over hospital administration in such ways as to permit it a place among the professions” (Prall, 1959, cited in Neuhauser, 1983:104). Based on a national survey of practicing health administrators, a recommendation was made that hospital administration training programs include coursework in the following areas: medical staff, personnel

management, hospital departments and department functions, medical care programs, business and financial management, and community relations.

In operation from 1952-54, the Commission on University Education in Hospital Administration expanded on the Prall Report with a new study, also referred to as the Olsen Report (Commission on University Education in Hospital Administration, 1954). The Olsen Report argued that the central core of hospital administration should be oriented towards business and administration, and the report recommended placement of programs in schools of business. At the same time, the uniqueness of health care administration education was recognized and endorsed. Students were expected to learn to apply generic analytical skills with careful attention to the social and environmental context in which hospitals exist (Loebs, 2001).

While the above-mentioned reports were key markers in the field of health (or more specifically, “hospital”) services administration education, it was not until 1975 that a formal definition of health administration was promulgated, along with roles, organizations and services that are part of the field (Commission on Education for Health Administration, 1975a, 1975b). At that time, the Commission on Education in Health Administration, chaired by James Dixon and directed by Charles Austin, defined health administration as “*planning, organizing, directing, controlling, coordinating, and evaluating the resources and procedures by which needs and demands for health and medical care and a healthful environment are fulfilled by the provision of specific services to individual clients, organizations and communities.*” This definition implied “leadership in community policy decisions as well as organization and management of resources gathered together in increasingly complex organizations.” Health administrators were defined as the “directors of public and private institutions, agencies, and programs involved in the planning and delivery of personal or community health and medical

care services, and other personnel in such organizations who aspire to become executives.” The organizations in the field were listed as “group clinics, small and large hospitals, long-term care and mental health services, health departments, voluntary health agencies, comprehensive health planning agencies, insurance plans, and numerous additional specially-designated agencies and programs” while the services were identified as follows: “Personal and community health and medical care services include those provided to individuals by physicians and other health care professionals on a one-to-one basis, plus one-to-group services, provided to population groups and communities, such as collection and dissemination of health information, environmental management, planning and regulation of health services, and provision of medical care insurance.” Moreover, the educational content for health administration was specified as 1) “information on health and disease, health and medical care organization, and environmental management,” and 2) “administrative theory and skills and applied behavioral science content, particularly that relating to social organizations and political processes” (Commission on Education for Health Administration, 1975a:2-3,8,15,149).

The Commission on Education for Health Administration definition is significant not only in its precedence, but because it remains the only definition of scope promulgated by a nationally legitimated commission. The definition reinforced the expansion of the field well beyond the hospital, as was noted by a task force of the American College of Hospital Administrators that reviewed the Commission's report (Neuhauser, 1983:115). Importantly, the definition of scope also explicitly recognized health planning and regulation in the listing of services and organizations included in health services administration, following increased government involvement in healthcare delivery from the 1960s forward. In addition, “insurance plans” and “the provision of medical care insurance” were included in the listing of services and

organizations in the field of health administration. While the work settings and roles for graduates included these more diverse arenas, the specified content remained focused on healthcare delivery and administration.

MORE RECENT DEVELOPMENTS

Following these early attempts to specify the boundaries of health services administration, the field continued to evolve in several new directions. The growth of healthcare systems led to new, more specialized roles within healthcare systems for health administrators. Today, these more specialized tracks include management roles in healthcare systems in information technology, marketing, and finance. The need for administrators of medical group practices led to increased job opportunities in that sector, as did similar needs in nursing homes. Because of a physician surplus and the growth of managed care, an increasing number of physicians started to seek graduate degrees in health administrations and to pursue managerial roles. Therefore, programs became more physician-friendly in matters of student recruitment and the integration of clinical and managerial instruction (Levey, Battistella and Weil, 2001). Managed care organizations became job settings for some health administration graduates.

Opportunities in healthcare consulting and in supplier organizations such as medical device, information technology, and pharmaceutical companies also grew in the 1980s and 1990s, further diversifying the job markets of health services administration program graduates.

Some career guides (e.g., Haddock, McLean and Chapman [2002]) note that the title “administrator of a healthcare facility” is a catch-all category that includes many positions, and they emphasize the diversity of work settings for healthcare administration (also see Filerman, 1989). Others (e.g., Kovner and Channing, 2000) focus on delivery organizations only. The

U.S. Department of Labor, Bureau of Labor Statistics, narrowly defines the field, stating that medical and health services managers “Plan, direct, or coordinate medicine and health services in hospitals, clinics, managed care organizations, public health agencies or similar organizations” (U.S. Department of Labor, 2002). This definition refers specifically to administrators of organizations, and thus excludes such areas as consulting, device manufacturing, and policy making, although it does encompass managed care organizations.

Estimates of the health services administration job market vary from lows of around 100,000 to a high of 750,000, depending on the horizontal scope (across types of organizations) and vertical scope (across hierarchical levels of the organization) of the boundaries of the field. Illustrative of the low end of the range, the AUPHA *Directory of Programs* (2000:xiv) reports that “an estimated 100,000 people serve in health management positions, ranging from middle management to CEO positions...” The U.S. Department of Labor (2002) states the “Medical and health services managers held about 250,000 jobs in 2000.” Aggregation of management positions across several U.S. Department of Labor categories, including drug manufacturing, medical equipment, health insurance, and home health services (but excluding consulting) results in an estimate of 750,000 management positions in health services administration (Rice, 2003).

Reflecting these diverse job markets as well as contributing to their further diversification, existing programs in health services administration, both accredited and unaccredited, are located in a wide variety of departments and schools. Schools of public health and schools of business are the most common school settings, with no consensus that one setting is ideal. Illustrating this ambivalence, Levey, Hilsenrath and Hill (1998:81) suggested that “Perhaps those trained in schools of public health can better match price and ‘value’ than those trained in schools of business,” while Levey, Battistella and Weil (2001:469) a few years later

stated that "...to ensure that every health services management program has a solid foundation in the core curriculum of management, the business school is, in theory, the best location for instruction..."

ISSUES FOR DISCUSSION

Definitions of health services administration and delineations of its scope will vary depending on the needs of the definers, and the uses to which the definitions are put. For example, job placement professionals may define the field broadly to maximize job opportunities for graduates, but accreditors may choose to define the field more narrowly to standardize content. We end by broaching three issues for discussion that relate to definition and scope as they specifically affect accreditation processes and the role of accreditation in the field of health services administration. The three issues are: does the accreditation community need a formal definition of health services administration; if so, how broad should the definition be; and, what label should the field adopt?

Issue 1. Does the accreditation community need a formal definition (or an explicit working definition) of health services administration?

There are several reasons that an explicit definition of health services administration would be desirable. An explicit definition clarifies to programs whether or not they meet an initial screening criterion. It appropriately directs new programs to apply or not apply for accreditation. An explicit definition brings to the surface an underlying, "wicked" question -- what segments of the industry truly share the values and interests of health services administration and should be part of the professional community? It would be healthy to surface the issue and make a decision instead of avoiding the question. Symbolically and strategically, it is important for accreditors to draw a line in the sand and show leadership. Another key

argument for an explicit definition is that accreditors cannot define required content or competencies without knowing the scope of work settings and roles for which graduates are being prepared.

Arguments against an explicit definition include the following. First, an explicit definition forces decisionmaking by rule where no rule is needed. Issues around definition and scope can be appropriately finessed or decided *ad hoc*. Second, lack of explicit definition allows for flexibility and speed of response by accreditors. Explicit definition would forestall change and innovation. Third, there is no strategic value to the field in being exclusive; it only creates animosity from those groups defined as outside the community. Finally, it is the role of accreditation to mirror changes in the profession, not to lead change or to alter its direction. The lack of clear definition merely reflects current reality.

Issue 2. If a definition is needed, how broad and inclusive should it be? What segments of the field or roles of administrators should be explicitly listed?

We present briefly the rationale for and examples of definitions of narrow scope, moderate scope, and broad scope.

The case for a definition of narrow scope is that a narrow definition would create clarity and focus on building a strong core of central competencies in graduates. A narrow definition could raise quality of graduates by leading to depth of preparation in the specified range of competencies, as has been argued by some for the field of business education (Trank and Rynes, 2003:198-199). A narrow definition would speak clearly to the field and its stakeholders. The definition used by the U.S. Department of Labor (2002) is an example of a definition with narrow scope: health services administration is “*planning, directing, or coordinating health services in hospitals, clinics, managed care organizations, public health agencies or similar*

organizations.” The narrow focus is on health services delivery, with possible, indirect extension to health services financing (via the reference to managed care organizations) and public policy (via the references to planning, coordinating, and public health agencies). The implied roles of graduates prepared for the field would be as managers or management staff in healthcare delivery organizations and managed care organizations.

A definition of moderate scope would represent a compromise between an exclusive focus on healthcare financing and delivery, and a broad definition that conceivably could diffuse the identity of the field. While considered a broad definition at the time, the definition promulgated by the Commission on Education for Health Administration (1975a) can be considered one of moderate scope in light of changes in the field since 1975. Health services administration is “*planning, organizing, directing, controlling, coordinating and evaluating the resources and procedures by which needs and demands for health and medical care and a healthful environment are fulfilled by the provision of specific services to individual clients, organizations and communities.*” Roles for graduates implied by the moderate scope definition add to those implied by the narrow definition, as policy staff, evaluators, and consultant roles, and the organizations that provide those roles (policy agencies and consulting firms) would seem to fall within the boundaries of the definition.

The rationale for a definition with broad scope includes the argument that a broad definition would maximize the attractiveness of the field to new entrants (students and educational programs) and the mobility of current members. The field could more easily grow and encompass powerful allies. Insurers, supplier companies, and consulting firms are among those powerful allies, and definition of the field could explicitly include those segments. Commenting on the size issue, Levey, Hilsenrath and Hill (1998) write that “health management

education lacks the cohesiveness and critical mass that many other fields enjoy and this fractures efforts to become a more powerful national force.”

A definition of broad scope would implicitly or explicitly include roles across a wide range of organizations, including those involved in the direct delivery of services, health insurance companies, health planning organizations, health care regulatory bodies, health care supply organizations (e.g., pharmaceutical, medical device, and biotechnology companies), and companies engaged in health care consulting. An example of a definition with broad scope is the following: Health services administration is “*the application of specialized management knowledge, skills, and attitudes to the improvement of individual and community health and health care delivery.*” This particular example leaves open the specification of roles and organizations that contribute to the goal of “improvement of individual and community health and health care delivery,” while retaining the principle that the field has a “specialized” body of knowledge, skills and attitudes.

Issue 3. Do existing labels appropriately convey the identity of the field?

Labels of professional associations, educational programs, regulatory bodies, and other organizations are powerful, symbolic ways to establish identity, to appeal to legitimacy, and, when altered, to convey change. There is wide diversity among the labels of organizations and activities that are involved in the accreditation community. Among labeling choices that have symbolic and strategic implications (and which rapidly escalate in permutation and combination) are the following:

- 1) Is the field “health services” administration or “health” administration?
- 2) Is the field “administration” or “management”?
- 3) Should “policy” be included in the field’s label?

- 4) If the label includes “health care” rather than “health” or “health services,” should “health care” be one word or two words?

Illustrating extant variety, high-profile labels include those of academic departments housing health administration graduate programs, some of which carry the label “Health Policy and Administration”; the professional association of university programs, the Association of University Programs in Health Administration; the 2001 conference, National Summit on the Future of Education and Practice in Health Management and Policy; the *Journal of Healthcare Management* (until 1998 known as *Hospital and Health Services Administration*); and the National Center for Healthcare Leadership [underlining is added].

The accrediting body for the field is labeled the Accrediting Commission on Education for Health Services Administration. Substitutes for “Health Services Administration” that may convey a broader definition of the field include the following: Health Administration, Healthcare Administration, Health Management, Healthcare Management, Health Sector Management, Health Industry Management, Health Administration and Policy. The Blue Ribbon Task Force may wish to consider the extent to which the Accrediting Commission’s label should and does reflect the domain of its work. Any labeling change, of course, would be interdependent with the adoption of an explicit definition of the field.

Conclusions

Formal definition of the field of health services administration has not received significant attention since 1975. Substantial and permanent changes in the field have occurred since that time, in the direction of widening opportunities for graduates of educational programs and increasing interdependencies with public policy organizations, supplier organizations, insurers, and other segments that are not involved directly in health services delivery. The field

of health services administration, along with its stakeholders, should consider a broadened definition of the field that would incorporate and institutionalize those changes in the field.

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APPENDIX C

CONTEMPORARY MODELS FOR ACCREDITATION: LESSONS FOR HEALTH SERVICES ADMINISTRATION EDUCATION ACCREDITATION

Ronald Andersen, Ph.D., Cynthia Carter Haddock, Ph.D., Eugene Schneller, Ph.D. July 8, 2003.

Contemporary Models for Accreditation: Lessons for Health Administration Education Accreditation

Ronald Andersen, Ph.D.
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Eugene Schneller, Ph.D.

July 8, 2003

The Blue Ribbon Task Force on Accreditation of the Accrediting Commission on Education for Health Services Administration and the National Center for Healthcare Leadership commissioned this report.

The authors are listed in alphabetical order and share equally in authorship.

Contemporary Models for Accreditation: Lessons for Health Administration Education Accreditation

EXECUTIVE SUMMARY

Accreditation in health administration serves a broad range of stakeholders. It reviews programs that voluntarily undergo a process to assess their compliance with specified criteria regarding faculty, resources, student body, and other program characteristics. The Blue Ribbon Task Force on Accreditation commissioned this paper. It explores the role that accreditation plays in other fields to assure educational quality, a level of student competence at entry into practice, and advancement of university, student, and field aspirations. The authors have studied the literature on accreditation, engaged leadership from accrediting agencies in a focus group, interviewed experts in the field, and scrutinized accrediting practices in business, medicine, public administration, and public health.

We advance a model of health care management program accreditation that is responsive to disciplinary, university, and field related inputs; program mission and structure; university related processes and educational technologies; and outcomes as they relate to student employment and the field of practice. The model takes into account the fact that entry and advancement in health administration practice are not related to formal licensure or certification. It also considers the great diversity we observe in health administration programs along key dimensions, including the differences in students' experience in the workplace prior to entering graduate programs, the broad range of program missions, and varying expectations of employers.

Accreditation in health administration must function as a process that:

- Establishes and assures minimal levels of program quality.
- Is responsive to the diversity of existing and emergent program missions.
- Successfully meets the needs of the field of practice for employers in program targeted settings.
- Assures that those engaged in the educational enterprise continue to develop the intellectual capital associated with health management education and practice and import into academia the intellectual capital that is produced outside of the academy.
- Is sufficiently flexible to meet the managerial needs for a wide range of health related organizations and aspirants for entry at various career stages.
- Is not burdensome beyond what is necessary to achieve the above goals.

Given the demands of the field of practice for a diversified labor force and wide range of managerial talent, it is important that the accreditation process provides for excellence in degree granting learning programs designed for students who are at early, middle, and later career stages. To this extent, health administration educators must work closely with the field of practice to assure the appropriateness of curriculum and acceptability of the programs' outputs –

their graduates. In the absence of a “hard link” (such as licensure) between academic preparation and practice, accreditation must encourage and recognize the efforts of academics to assess practice and bring the needs of employers into line with the educational effort. The field of practice must signal to the accrediting body that graduates of programs are valued for their choice of an accredited program and success as measured by completion of the accredited degree program.

BACKGROUND AND CHARGE

Over the past several years, a number of leaders from health administration education and practice have voiced concerns about future leadership for the field¹⁴¹⁵¹⁶¹⁷¹⁸. One result of these concerns was the formation of the National Center for Healthcare Leadership (NCHL), whose mission is “to provide a forum for industry-wide collaboration to assure that high-quality, relevant, and accountable health management leadership is available to meet the needs of 21st century health care.” The NCHL’s model for improving health management and leadership capitalizes on the strengths of existing organizations and is based upon a comprehensive, collaborative, and integrated process for career development at early, mid, and advanced career levels.

Consistent with this model, the NCHL has joined together with the Accrediting Commission on Education for Health Services Administration (ACEHSA) to form a Blue Ribbon Task Force on Accreditation. The charge of this Task Force is:

- To conduct an analysis regarding the definition and scope of “health services administration.”
- To conduct an analysis of relevance, application, and essentiality of accreditation for graduate programs in health services administration.
- To conduct and present a comprehensive literature search on accreditation.
- To develop a process for incorporating competency based educational outcome assessment and other best practices into accreditation criteria.
- To publish a “White Paper” on current expectations and requirements for health services administration accreditation which will address and recommend future roles, relationships, and activities.

¹⁴ J.R. Griffith. “Towards Evidence-Based Health Administration Education: The Tasks Ahead.” *Journal of Health Administration Education*, 18, no.2 (2000): 251-262.

¹⁵ G. Mecklenburg. “Career Performance: How are We Doing?” *Journal of Healthcare Management*, 46, no. 1 (2001): 8-13.

¹⁶ G.L. Warden and J.R. Griffith. “Ensuring Management Excellence in the Health Care System.” The Future of Education and Practice in Health Management and Policy: proceedings from the National summit. Supported principally by the Robert Wood Johnson Foundation. *Journal of Health Administration Education*, Special Issue (2001): 19-32.

¹⁷ R.J. Grossman. “The Staffing Crisis.” *Health Forum Journal*, 45, no. 3 (2002): 10-15.

¹⁸ T.H. Thrall. “A Leadership Vacuum.” *Hospitals and Health Networks*, 75, no. 9 (2001): 44-47.

As a part of its work the Blue Ribbon Task Force has commissioned the authors of this paper to explore the role that accreditation plays in assuring educational quality and to identify progressive practices from accrediting processes in other fields that can improve health administration education accreditation and increase the probability that graduates will be able to meet future leadership challenges. James Begun (University of Minnesota) is preparing a paper on the definition and scope of “health administration.” In his paper, he will propose a definition of health administration and discuss the boundaries of the field. He will also consider the pros and cons of a narrow versus broad definition of the field, particularly as it relates to accreditation.

In addition, the Task Force has commissioned Sherril Gelmon (Portland State University) to complete a study that will assess stakeholder satisfaction and expectations regarding ACEHSA accreditation of graduate health management educational programs. Professor Gelmon's study will also investigate certification of undergraduate health management education programs by the Association of University Programs in Health Administration (AUPHA), an area that is outside what we have been commissioned to do.

Finally, ACEHSA, under the leadership of Robert Hernandez, has been carrying out its periodic review of its criteria. Although a final version of the criteria will not be available until after this report is delivered to the Blue Ribbon Task Force, it is noteworthy that a number of the recommendations that come from our scrutiny of other accrediting agencies are likely to be part of the new ACEHSA approach.

METHODS

The Blue Ribbon Task Force on Accreditation, appointed jointly by NCHL and ACEHSA, commissioned this paper in October 2002. During the process of writing the paper, we have reported to and consulted with Marie Sinioris, Vice President and Chief Administrative Officer of NCHL; The Blue Ribbon Task Force, chaired by Peggy Leatt; and the NCHL Advisory Council on Research and Continuous Improvement, chaired by Stephen Shortell.

We have employed multiple methods in developing this paper:

- We have conducted a general literature review on the history and development of accreditation in higher education.

- We attended the national meeting of the Council for Higher Education Accreditation (CHEA) in Phoenix, Arizona, in January 2003. At this meeting, we conducted a focus group and interviewed leaders from various fields, including engineering and technology, nursing, education, and health administration, as well as a representative from the Department of Education. The major intent of the focus group process was to learn about accreditation developments and best practices outside of health administration. (See Appendix A for the focus group questions and Appendix B for the focus group participants.)
- A major activity has been to do “case studies” of the accrediting processes for the schools and programs in which the graduate programs in health administration are mostly located. We have included studies of business, medicine, public administration, and public health. Our intent was to document accreditation processes that are directly related to programs in health administration, to learn about opportunities and constraints these school level accreditations might afford health administration programs, and to discover accreditation practices that might be fruitfully employed in the ACHESA process. We undertook literature reviews and interviewed leaders of the relevant accrediting agencies. (For lists of the interviewees, see Appendix C).

We have studied the forces that have shaped accreditation in the past and outlined a model for accreditation for health administration which we believe might be helpful in the future. We have also outlined a number of lessons from other agencies that may be applicable in health administration education.

THE IDEA OF ACCREDITATION

There is clearly a need for individuals who can provide leadership in the large complex, multi-institutional organizations that have resulted from mergers and other forms of consolidation.. At the same time, there are a growing number and variety of specialty “niche organizations” and a need for management and leadership that can successfully deal with the complexities of group practice, long-term care, specialty acute care (e.g., heart hospitals), and other delivery settings. The diversity and numbers of non-delivery health organizations, supporting the health services delivery system, have also expanded. These organizations are recognizing that health administration education preparation may provide value for managing within a broader sphere, including consulting, insurance and managed care, biotechnology, pharmaceuticals, and the various firms along the health care value chain.

Accreditation is not a process that can completely assure all stakeholders' needs are adequately met. Accreditation alone, for example, cannot assure that the pool of individuals who aspire to be health sector leaders will grow and continue to become more diverse. The ability of the sector to compete with other sectors of the economy in terms of compensation and other aspects of job attractiveness (e.g., fulfilling, challenging jobs; autonomy and creative outlets for practitioners) will have a substantial influence on the applicant pool. Likewise, accreditation cannot assure that universities, in periods of constrained resources, will value health administration education

over other areas of investment. Here, decisions about the value of such education, as it contests with other parts of the academy, will be strongly influenced by university administration and governing bodies, legislators, and other external stakeholders (e.g., employers, foundations, and the general public). These things being recognized, there is much that accreditation can do, particularly in the area of educational quality.

In the United States, accreditation is used to assure quality and public accountability in post-secondary educational institutions and programs. Accreditation has historically been a voluntary, non-governmental process. However, with eligibility for federal funding (including scholarship aid for students) now attached to accreditation, the voluntary nature of accreditation has moved more toward the involuntary and regulatory¹⁹. Should federal funding for health administration be substantially reduced or eliminated, there is some chance that the accreditation will be devalued. However even in years of lean funding, the enthusiasm for this process has not waned. Finally, accreditation remains a non-governmental process, even though recent federal legislation has created tensions between government and higher education accreditation. Perhaps the greatest challenges to programmatic accreditation will come from universities themselves, as they seek to streamline the number of regulatory agencies that affect their environment. As one provost has explained: “I make every programmatic agency that comes onto this campus work to convince me that they bring value.” Accreditation remains a non-governmental process, even though recent federal legislation has created tensions between government and higher education accreditation.

HISTORY OF ACCREDITATION IN THE UNITED STATES

Accreditation is a process of self and peer review that requires institutions or programs to meet certain defined standards, or criteria, for structure, process, and outcome of the educational endeavor. Since the 1980s, accreditation has increasingly sought to promote continuing improvement of quality in colleges, universities, and educational programs.

In the United States, accreditation has the following specific purposes:

- Fostering excellence through the development of criteria and guidelines for assessing effectiveness.
- Encouraging improvement through on-going self-study and planning.
- Ensuring external constituencies that an educational endeavor has clearly defined goals and appropriate objectives, maintaining faculty and facilities to attain them, demonstrating it is accomplishing them and has the prospect for continuing to do so.
- Providing advice and counsel to new and established programs in the accrediting process.

¹⁹ E.S. Lubinescu, J.L. Ratcliff, and M.A. Gaffney. “Two Continuums Collide: Accreditation and Assessment.” In J. L. Ratcliff, E. S. Lubinescu, and M. A. Gaffney, eds. *How Accreditation Influences Assessment*. New Directions in Higher Education, Number 113. San Francisco: Jossey-Bass, 2001.

- Ensuring that programs receive sufficient support and are free from external influence that may impede their effectiveness and their freedom of inquiry²⁰.

There are two “levels” of accreditation. The first level consists of institutional accreditation, such as that done by “regional accreditors,” which examines the quality of the college or university as a whole. Normally, institutional accreditation does not evaluate the quality of specific programs within the institution, although a significant weakness in an individual program can alter the evaluation for the entire college or university²¹. The second level of accreditation consists of specialized, or programmatic, accreditation, which evaluates a specific educational program, department, or school, within an institution of higher learning that is itself typically accredited by one of the regional accrediting commissions. What results from these multiple levels of accreditation is a tiered set of accreditation processes. For example, an accredited health administration program sits within an accredited business school, which itself sits within an accredited university or college; and three different accrediting bodies and processes may be involved.

An accreditation review process occurs on a periodic basis, usually every three to ten years. Typically, this process involves three major activities:

- A self-evaluation by the institution or program, based on the accrediting body's criteria.
- A peer review of the institution or program to gather evidence about its educational quality.
- A decision by the accrediting body to accredit or to not accredit the institution or program.

Accreditation serves a variety of constituencies by providing information about an educational institution or program. It notifies prospective students that an institution or program has met minimum standards of educational quality. It serves to notify academic administrators, deans, and faculty members, of an institution's or program's strengths and areas for improvement. It serves to notify potential employers that an institution's or program's graduates are prepared for a job and/or professional practice. And, it serves to notify taxpayers and the public that taxes and contributions are well spent and that graduates are prepared to use their education in a way that serves the public good.

State licensing boards and certification bodies may require graduation from an accredited professional program as the first step in the registration or certification process. Accreditation may also permit students to be eligible for federal funds in the form of scholarships, loans, and grants, as mentioned earlier.

²⁰ E. S. Lubinescu, J. L. Ratcliff, and M. A. Gaffney. “Two Continuums Collide: Accreditation and Assessment.” In J. L. Ratcliff, E. S. Lubinescu, and M. A. Gaffney, eds. *How Accreditation Influences Assessment*. New Directions in Higher Education, Number 113. San Francisco: Jossey-Bass, 2001.

²¹ Commission on Institutions of Higher Education, New England Association of Schools and Colleges. *Accreditation Handbook: 1983 Edition*. Winchester, MA: New England Association of Schools and Colleges, 1983.

In 1862, the United States Congress enacted the Land Grant Act, providing federal land to states for the establishment of state universities. As a result of this federally fueled growth in higher education, questions arose about the educational quality of these institutions. Without centralized, federal control of higher education, accreditation was a response to these questions of quality from the higher education community. Six regional accreditation associations were founded in the late 1800s and early 1900s²². The first accreditation organizations in the health professions were established around the turn of the 20th century, e.g., osteopathy in 1897, medicine in 1903, and nursing in 1916.²³

Accreditation processes developed more than a century ago for some very good reasons related to quality, credibility of higher education, and protection of the public's interests. To maintain quality, academic institutions' credibility, and protection for the public, these processes have been consistently supported as an integral element of higher education in the United States since that time.

Throughout the history of accreditation in this country, there have been a number of coordinating entities for accrediting bodies and, while accreditation remains a nominally voluntary, non-governmental process, the role of the federal government has varied. Today, the Council for Higher Education Accreditation (CHEA) is the largest higher education membership organization in the United States, with approximately 3000 member colleges and universities and more than sixty participating national, regional, and specialized accrediting bodies. The non-governmental council, formed in 1997, has a voluntary recognition process for accrediting organizations, affirming that standards and processes of member accrediting organizations are consistent with CHEA-established quality, improvement, and accountability expectations²⁴. A seventeen-person board of college and university presidents, institutional representatives, and public members governs the Council.

The Association of Specialized and Professional Accreditors (ASPA) includes approximately fifty member agencies as members and operates to insure that "students in educational programs receive an education consistent with standards for entry into practice or advanced practice in their respective fields or disciplines." This voluntary, not-for-profit association was created in 1993, as a neutral vehicle for discussion of issues relevant to specialized accreditation, separate from the influence of governmental and nongovernmental coordinating bodies that focus primarily on institutional level issues²⁵.

Even though the United States does not have a centralized higher education function, the federal government has increasingly been involved in higher education accreditation over the years.

²² S. B. Gelmon, E. H. O'Neil, J. R. Kimmey, and the Task Force on Accreditation of Health Professions Education. *Strategies for Change and Improvement: The Report of the Task Force on Accreditation of Health Professions Education*. San Francisco: Center for the Health Professions, University of California at San Francisco, 1999.

²³ L. E. Blauch. *Accreditation of Higher Education*. Washington, D.C.: U.S. Government Printing Office, 1959.

²⁴ www.chea.org

²⁵ www.aspa-usa.org

Under the new Higher Education Act in 1992, the Department of Education was given greater oversight authority over accreditation processes. With Departmental recognition standards now in place for accrediting bodies and links between federal recognition and such aspects of higher education as distribution of federal financial aid established, the culture and philosophy of accreditation has shifted from one of peer review and professional judgment to one more of governmental regulation and monitoring²⁶. The Higher Education Act is currently up for re-authorization by the Congress, and some in the accreditation community believe that the federal role may become even more intrusive and standards for recognition more prescriptive in the new, re-authorized version of the Act. However, others are less certain about the outcome of re-authorization. It is clear that the federal push for educational accountability will remain strong. Particular attention to undergraduate education is expected in the re-authorized Higher Education Act.

Accrediting bodies face a number of challenges today. We spoke with several experts in the accreditation field and asked them about what they saw in this regard. (See Appendix C.) Among the challenges reported were:

- Pressures for educational accountability (particularly in light of the impending re-authorization of the Higher Education Act).
- The need to demonstrate cost-effectiveness and “value-added” (in response to criticism from academic administrators).
- Calls for a move from an input-driven approach to accreditation to an educational outcomes, or education effectiveness approach.
- Tension between the rapidly changing “practitioner world” and the more slowly moving world of higher education and accreditation.
- The need for specialized accrediting bodies to deal with increasingly sub-specialized, or “niche,” programs.

ACCREDITATION IN HEALTH ADMINISTRATION EDUCATION

The first graduate programs in health administration were founded in the United States in the 1930s and 1940s. Following a series of organizational meetings in the late 1940s, the Association of University Programs in Hospital (now Health) Administration (AUPHA) was established as a nonprofit corporation in Illinois in 1950 to provide a forum for discussion among directors and faculty of the growing number of hospital (health services) administration programs across the country²⁷.

²⁶ C. A. Tanner. “Accreditation under Siege.” *Journal of Nursing Education*, 35, no. 6 (1996): 243.

²⁷ D. Neuhauser. *Coming of Age: A 50-Year History of the American College of Hospital Administrators and the Profession It Serves, 1933-1983*. Chicago: Pluribus Press, 1983.

In 1968, the Accrediting Commission on Education for Health Services Administration (ACEHSA) was established as a specialized (programmatic) accrediting body for graduate health administration programs. Prior to 1968, AUPHA had conducted reviews of programs and granted approval. The four founding sponsors of ACEHSA were the American Hospital Association (AHA), the American Public Health Association (APHA), the American College of Hospital Administrators (now the American College of Healthcare Executives, ACHE), and AUPHA. Corporate sponsor membership has changed over the years, reflecting changes in the nature of the field and where graduates are employed. Current sponsors include ACHE, the American College of Medical Practice Executives, AHA, AUPHA, the Blue Cross Blue Shield Association, the Canadian College of Health Services Executives, the Federation of American Hospitals, the Healthcare Financial Management Association, and the Healthcare Information and Management Systems Association. Other organizations that have been corporate sponsors in the past, in addition to those already listed, are the American College of Health Care Administrators, the Canadian Hospital Association, the Association of Mental Health Administrators, the American Organization of Nurse Executives, the American Medical Association, the Council on Education for Public Health, the American College of Physician Executives, and the Health Insurance Association of America²⁸.

The current mission statement of ACEHSA is:

Serving the public good through promoting, evaluating, and improving the quality of graduate health services administration education in the United States and Canada. Through our partnership between academe and the field of practice, ACEHSA serves universities and programs in a voluntary peer review process as a means to continuously improve graduate education. In so doing, ACEHSA accreditation becomes the benchmark by which students and employers determine the integrity of health services administration education and standard of measurement for the world community.

Currently (as of November 2002), there are sixty-eight accredited graduate health administration programs in the United States and Canada²⁹. These programs are located in a variety of institutional homes, including schools of business, public health, allied health, and medicine. Most accredited health administration programs are in schools of business and public health. Degrees granted by accredited health administration programs may also bear a variety of titles (e.g., MBA, MPH, MHA, MHSA, MPA), usually reflecting the school and university placement of the program. Because most areas in health administration do not require licensure for entry to practice (nursing home administration being the one notable exception), there is no linkage between graduation from an accredited health administration education program and health administration practice. In professions where licensure is required for practice, licensure requires the “hard link” between graduation from an accredited professional education program and entry to practice.

²⁸ Personal communication from Pamela Jenness, Director of Accreditation Operations, ACEHSA, dated April 14, 2003.

²⁹ www.acehsa.org

The criteria used for ACEHSA accreditation have changed throughout the years since 1968, reflecting changes in the health care system and its environment, as well as changes in management knowledge and practice³⁰. The Commission has moved from a process of strictly quality assurance to one combining quality assurance and quality improvement, linked to program mission, goals, and objectives. Some have even suggested consideration of using a variation of the Baldrige Criteria for program improvement in an accreditation framework.³¹

Six major reviews and revisions of the ACEHSA Criteria have been completed over the Commission's history³². Until 2003, the changes in ACEHSA criteria retained a principally input-driven approach, rather than an educational outcomes focused approach. The changes under consideration begin to move ACEHSA toward a more outcomes oriented model, linked to the individual mission of the program under review.

The Commission has been granted formal recognition by the United States [Department of Education \(DOE\)](#) as the only organization to accredit master's level health administration programs in the United States. The CHEA also recognizes the Commission, and the Commission is a member of ASPA.

The accreditation program of ACEHSA is designed to foster high quality professional education for health services administration. The term "health services administration" is used as the single term that includes health care administration, health services management, hospital or other health care organization-specific administration and management, health planning and evaluation, health policy, and other related activities. All programs seeking accreditation by ACEHSA, regardless of setting, are subject to the [Criteria for Accreditation](#).

In the accrediting process, ACEHSA recognizes that flexibility and innovation are essential to the design and development of curricula and course formats which meet the diverse educational needs of all students (both full-time and part-time) and address the broad scope of career opportunities in the field. Each individual program's mission, goals, and objectives statements serve as the basis upon which the [Criteria](#) are applied. The emphasis placed on various applications of health services administration will therefore depend upon the specific objectives of the program.

LESSONS FROM OTHER FIELDS

On January 28, 2003, we hosted a focus group with a group of leaders from several accrediting agencies. (See Appendix B for a list of focus group participants.) The focus group members

³⁰ G. D. Brown. "The Role of Accreditation in Transforming Health Services Management Education." *Journal of Health Administration Education*, 18: 37-61, 2000.

³¹ S.B. Gelmon, M.E. Sinioris, and K.L. Najafi. "Performance Assessment for Health administration education: Applications of the Baldrige Criteria." *Journal of Health Administration Education*, 13, no.1: 109-128, 1995.

³² Personal communication from Pamela Jenness, Director of Accreditation Operations, ACEHSA, dated April 14, 2003.

were provided a copy of our charge, as well as a brief explanation of the events leading to the Blue Ribbon Task Force. We explained that there are concerns for both entry into practice, as well as for the maturation and development of health administration practitioners in the course of the careers. (See Appendix A for a list of questions that guided the focus group discussion.) Several key points were made during the focus group session, including the following.

- Movement to general criteria. It is clear that outcomes are the principal focus of change in accreditation. Within this context there is a very strong focus on “general criteria” and a “blurring” of disciplinary lines. A set of global issues linked to what it is a graduate should be able to do is of importance. To accomplish this accreditation boards of fields have spent a good deal of time visioning about the workplace and the nature of the field, rather than any one area. Fields that are fairly technical in nature have begun to move away from a “micro” listing of criteria to more global single criteria related to training a competent practitioner. Such fields have given strong billing to criteria and competencies that may lead to success in practice beyond field technique, such as communications skills.
- Entry into practice. There was consensus among focus group members that the role of accreditation is to prepare graduates for entry into practice; and depending upon selection of students, different programs within a field may face different problems as students seek employment. Individuals learn a great deal during the educational years, but they also bring a great deal into the educational experience. It is very difficult to correlate education with the full range of outcomes, especially those that pertain to performance five, ten, or more years into practice.
- Focus on outcomes. The measurement of outcomes is viewed by many accrediting agencies as a very difficult task – some engaging outside consultants to assist in this process. However, several of participants in the focus group pointed to the important role of the university office of institutional assessment, related to student and graduate outcomes, as a source of data.
- Easing the bureaucratic burden. There is a movement to substantially ease the bureaucratic burden of the accreditation process. Surveys are substantially shorter than in the past. At the same time there appears to consensus to move away from a universalistic set of standards and criteria, to criteria that are linked to the program having carefully crafted its own mission, goals and objectives in concert with the world of practice. In this sense, the self-study becomes a “research monograph,” bringing evidence to bear on the assessment of the program and its on-going performance improvement activities. For programs where licensure and certification are part of the field, there is an obvious mix of external and internal standards. It is within this context that agencies see themselves as promoting program improvement, much more than “merely” granting or denying accreditation.

- Changing the role of faculty. The new accrediting environment places more demands on faculty than in the past. Faculty members must be engaged at every step of the process and be able to shape their courses to take into account the lessons gained from the program's having engaged the practice community. They must also have broader understanding of the entire curriculum (as opposed to the individual courses they teach) and how the curriculum builds graduate competencies. Quality improvement activities, including refining and redefining measures and indicators as well as measurement are continuous and require faculty member participation in evaluation and change between accreditation visits.
- Responding to accrediting review bodies. Tensions between accrediting agency strategy and new Department of Education requirements that all deficiencies be corrected in a two-year period appear to exist. This will lead to accrediting agencies being "guarded" in their language regarding program deficiencies and expected progress.
- The contested terrain of accreditation. In some fields, such as nursing, there is competition between agencies of accreditation. It is not clear how this will affect accreditation.

WHAT IS HAPPENING IN FIELDS RELATED TO HEALTH ADMINISTRATION?

As stated earlier, health administration programs may be found in a variety of school and department "homes" within universities. These include business, medicine, public health, and public administration, among others. We have explored accreditation processes and recent developments in accreditation for accrediting bodies in these areas. Our findings are summarized below.

Business

This section was developed as the result of a close reading of materials provided by The Association to Advance Collegiate Schools of Business (AACSB), review of AACSB website materials, as well as interviews with selected informants. Much of the material presented below is abstracted from: *Eligibility Procedures and Standards for Business Accreditation*,³³ The Blue Ribbon Committee on Accreditation Quality³⁴ (BRC), and the *Accreditation Maintenance Handbook* (AMH)³⁵. These are important documents. The BRC proposed a vision of

³³ AACSB. *Eligibility Procedures and Standards for Business Accreditation*, April 2003. AACSB Website, <http://www.aacsb.edu/accreditation/standards.asp>

³⁴ AACSB. Blue Ribbon Committee. A series of papers from the Blue Ribbon Committee can be accessed at: <http://www.aacsb.edu/accreditation/brc/meetingreports.asp#Thought Papers>

³⁵ AACSB. *Accreditation Maintenance Handbook*, December 2002. AACSB Website

management education, including competency areas, which is useful for understanding the environment for accreditation for management.

There is no licensure or certification associated with entry into general management practice. Furthermore, there are no major government linkages between management education, accreditation, or practice that might result in a shaping or reshaping of the management education/accreditation environment. Rather, while frequently facilitated by graduation from a management program, actual job attainment rests strongly on the reputation of the educational institution in concert with the student's presentation of self through prior internship/work experience, leadership experience, and academic achievement. In this environment, the relationship between university education and employment is "soft linked."

Initial AACSB accreditation processes are focused on assuring that the University and School have the necessary resources, commitment, and level of maturity to receive the AACSB accreditation designation. AACSB has been innovative in providing the opportunity for reaccreditation to be significantly more focused on a school's strategic direction and accomplishments.

It is the AACSB belief that accreditation does not create quality learning experiences. Rather, quality is created by the educational standards implemented by individual faculty members in interaction with students. In the AACSB model, "a high quality degree program is created when students interact with a cadre of faculty in a systematic program supported by an institution. Accreditation observes, recognizes, and sometimes motivates educational quality created within the institution."³⁶ The AACSB, like AUPHA, has a candidacy program to bring in new programs that meet thresholds and challenge programs to engage in quality improvement.

Accreditation by AACSB is designed around the proposition that the purpose of graduate education in business is the preparation of students to enter useful professional and social lives. While schools of business and programs within schools may have some sector focus, AACSB accreditation does not focus on any one sector. Furthermore, there is little specific attention in AACSB accreditation materials to the development of executives for middle or late career development.

AACSB accreditation is a signal of quality extended to all business programs across a university. The AACSB requires that all degree programs in a university that have a business focus, and taught by faculty from the business school in a significant proportion, fall under their review. This is different from the ACEHSA approach that has allowed the applicant university to designate those programs that are under review. Programs that are not AACSB accredited are not to be marketed in the same material as AACSB accredited programs.

Areas of Curricular Emphasis

Although AACSB provides a wide range of standards by which programs can guide their design, AACSB recognizes that all standards will not apply to all programs. AACSB provides an

³⁶ AACSB. Eligibility Procedures and Standards for Business Accreditation, April 2003, p. 4.

opportunity for academic programs to link standards to their own strategic direction. Peer review teams must exercise flexibility. Deviations from standards may be encountered that represent innovation or cultural differences that the standards have not anticipated. Evaluations are based on the quality of the learning experience, not rigid interpretations of standards.

AACSB, while not prescriptive, identifies the following areas as important in master's level education:

- Ethical and legal responsibilities in organizations and society.
- Financial theories, analysis, reporting, and markets.
- Creation of value through the integrated production and distribution of goods, services, and information.
- Group and individual dynamics in organizations.
- Statistical data analysis and management science as they support decision-making processes throughout an organization.
- Information technologies as they influence the structure and processes of organizations and economies, and as they influence the roles and techniques of management.
- Domestic and global economic environments of organizations.
- Other management-specific knowledge and abilities as identified by the school.

In training individuals for general management, AACSB indicates that preparation at the master's level not only presupposes the base of general knowledge but knowledge and skill development in an integrative and interdisciplinary fashion. In addition, it is important for students to develop:³⁷

- Capacity to lead in organizational situations.
- Capacity to apply knowledge in new and unfamiliar circumstances through a conceptual understanding of relevant disciplines.
- Capacity to adapt and innovate to solve problems, to cope with unforeseen events, and to manage in unpredictable environments.
- Application of knowledge even in new and unfamiliar circumstances through a conceptual understanding of the specialization.
- Ability to adapt and innovate to solve problems.

³⁷ AACSB. Eligibility Procedures and Standards for Business Accreditation, April 2003. p. 19

- Capacity to critically analyze and question knowledge claims in the specialized discipline.

Internal and External Guidance

AACSB recognizes a wide range of stakeholders in the determination of management education as well as the differences in stakeholder perspective. Identified stakeholders include administrators, faculty members of the business community, and others who can help to shape the mission through the variety of perspectives they contribute to the discussions and processes that establish the statement.³⁸ It is believed that external constituencies provide valuable information about critical skills and knowledge for graduates. Even if schools choose similar domains of learning goals, they are likely to develop the goals in different ways.

Although not an official arm of AACSB, Educational Benchmarking, Inc. (EBI) provides colleges of business with comprehensive, credible, comparative, and confidential assessment tools in support of continuous improvement efforts. The information is valuable as schools assess their annual progress on measured variables and as evidence of progress during the accreditation process.³⁹ The principal products at this point are exit surveys and alumni studies.

Flexibility in Program Design

The AACSB focus allows for a great deal of flexibility in program design:

- **AACSB standards do not focus on the presence of particular courses or treatments. Schools assume great flexibility in fashioning curricula to meet their missions and to fit with their specific circumstances. Some topics may be emphasized for particular learning needs and others may be de-emphasized.**
- Combinations of topics may be grouped to integrate learning. Various topics and learning goals will call for special pedagogical treatment. Schools are expected to determine how these, or other, topics occur in the learning experiences of students, but accreditation does not mandate any particular set of courses, nor is a prescribed pattern or order intended.
- **Curricular contents must assure that program graduates are prepared to assume business and management careers as appropriate to the learning goals of the program.**
- Recognizing the importance of topics such as globalism and information management, the school determines the specific ways globalization and information systems are included in the curriculum, and the particular pedagogies used.

³⁸ AACSB. Eligibility Procedures and Standards for Business Accreditation, April 2003. p. 25

³⁹ <http://www.webebi.com/ManagementEducation/Index.htm>

Within the above context, the review teams employ an approach that is both evaluative and consultative by considering:

- Direction and strategies pursued by the applicant--the unique or dominant areas of emphasis and constituents served.
- Consistency of the applicant's mission with that of the institution and its ability to meet objectives with available resources.
- Commitment to the applicant's mission on the part of the overall institution and their key constituents.
- **Extent to which the achievement of the applicant's mission will lead to delivery of educational programs of overall high quality and value to students.**
- Availability of meaningful measures of performance by which success will be measured.
- Existence of processes and systems through which high quality is achieved and continuous improvement is fostered.
- Continuous improvement is fostered.

The Concept of "Accreditation Maintenance"

Initial AACSB accreditation processes have a strong emphasis on the documentation of the overall quality of the applicant and the extent to which resources are present to assure that the applicant school is meeting its goals. The AACSB accreditation maintenance strategy allows schools of business that are already accredited to engage in a form of evaluation that is principally designed around fidelity of mission, improving quality, peer review and benchmarking, and demonstration of advancement toward goals. The process includes the selection of comparison groups to form a relevant context for judgments, inform strategic planning activities, and assist in the selection of Peer Review Team members. The AMH states: "reviewers from comparable institutions are better prepared to make evaluative judgments about the applicant, to understand the applicant and its aspirations, and to offer suggestions for the applicant's improvement."⁴⁰ Programs undergoing "Maintenance" provide AACSB with a list of schools considered similar in mission as well as other key attributes such as student populations served, size, degree levels, and primary funding source.

Accreditation team members may come from AACSB schools as well as from beyond academia, thus providing an opportunity for practitioner input regarding the applicant's improvement. Materials provided to the team include the applicant program's strategic plan, annual maintenance reports, and a variety of background information. A five page "situational analysis" enables the peer review team to understand the context within which the applicant operates.

⁴⁰ AACSB. Accreditation Maintenance Handbook, December 2002. AACSB Website, p. 28

The team is also supplied the mission statement for all degree programs, a statement of the strategic planning process, and a brief statement of the assessment tools and procedures used to monitor quality.

Observations from Business for Health Administration Education Accreditation

Our review of accreditation in business suggests some observations that may be informative in considering possible changes in health administration education accreditation.

- AACSB's focus on mission provides an important model for ACEHSA to consider as programs, characterized by very different career destinations for graduates; in very diverse university settings emerge. .
- AACSB's emphasis on benchmarking has the potential to shift accreditation far along the continuum from an "audit" model of program criteria toward a model that is characterized on quality improvement. Programs will be required to be explicit about what they do and to collaborate in the metrics that provide evidence for progress.
- AACSB schools frequently subscribe to the services of the EBI, which provides benchmarking information on graduates. The EBI product allows for meaningful comparisons and benchmarking with both aspirant and peer organizations. EBI's independence provides the individual schools with an unbiased assessment. Support for such an activity for ACESA programs would allow for progress in this area.
- AACSB's emphasis on preparing leaders and change agents is consistent with the concerns that have given rise to the Blue Ribbon Committee and broader efforts of the National Center for Health Leadership. It is important to acknowledge, however, that AACSB does not link issues pertaining to accreditation of colleges of business to mid or later career development.
- ACSB directly encourages its member schools to innovate. Recognizing that schools will choose among the variety of accreditation criteria provides a strong message to the schools. While many might argue that the existing range of health administration programs demonstrates that ACEHSA has already recognized the breadth and diversity in program location, design and intention through its decision-making, it may be that AACSB's openness in this area would lead to even greater innovation in the field of health administration education.
- AACSB's emphasis on the "iterative" nature of accreditation, with teams working closely with the schools under scrutiny, would lead to accreditation site visits where there is a real emphasis on areas where improvement or elaboration is necessary.

MEDICINE

Graduate Medical Education

The Accreditation Council for Graduate Medical Education (ACGME) is a private, non-profit council that evaluates and accredits medical residency (graduate medical education) programs in the United States. The mission of the ACGME is to improve the quality of health care in the United States by ensuring and improving the quality of graduate medical education for physicians in training. The ACGME accredits residency programs in specialty and subspecialty areas of medicine, including all programs leading to primary board certification by one of the member boards of the American Board of Medical Specialties (ABMS). Completion of an ACGME-accredited residency program is a prerequisite for certification in a primary board, and completion of an ACGME-accredited subspecialty program is also required before an individual can sit for board certification in the majority of subspecialties.

The ACGME's sponsoring organizations are the American Board of Medical Specialties (ABMS), American Hospital Association (AHA), American Medical Association (AMA), Association of American Medical Colleges (AAMC), and the Council of Medical Specialty Societies. The ACGME accredits almost 7,800 residency programs⁴¹. Its accreditation process affects almost 100,000 residents across the country at any point in time.⁴²

The accreditation of graduate medical education programs is accomplished by the ACGME through its twenty-six Residency Review Committees (RRCs) for the various specialties and the Transitional Year Review Committee (TYRC). Each review committee is composed of six to fifteen volunteer physicians appointed by ACGME's sponsoring organizations and the appropriate medical specialty boards and organizations. These review committees have two primary responsibilities. They (1) periodically revise their specialty's accreditation standards and (2) evaluate residency programs in each specialty and its subspecialties in light of the standards.

To attain and maintain accreditation, residency programs must comply with accreditation standards for their discipline. In addition, their sponsoring institutions must adhere to a set of institutional requirements. These standards and institutional requirements are described in the *Graduate Medical Education Directory*, published annually. Currently, these standards are based on structure, process, and outcome measures, with an increasing emphasis on outcomes described below.

Compliance with ACGME standards is evaluated through periodic review of all programs. Each year the review committees review almost one-half of all accredited programs. Approximately, 2,200 of these reviews involve a formal site visit. The remaining reviews are based on documentation provided by the programs to the ACGME. On average, each accredited residency program is site visited approximately every three to four years. The interval between site visits ranges from one to five years, with a longer period indicating that the ACGME and the relevant

⁴¹ Accreditation Council for Graduate Medical Education. *Graduate Medical Education Directory, 2002-2003*. Chicago: AMA Press, 2002.

⁴² ACGME website: www.acgme.org

RRC is more confident about a program's and institution's ability to deliver quality graduate medical education.

All new residency programs begin as applicants and go through a period of "provisional" accreditation. Programs that have demonstrated compliance with accreditation standards receive full accreditation. If a program is found to have areas of non-compliance (i.e., deficiencies), the ACGME lists these as specific citations in its accreditation letter to the program and expects program action to correct each cited deficiency and to come into compliance. The relevant RRC may monitor a program's progress toward compliance. If a program has significant deficiencies, it may be given a warning or placed on probation. Programs that fail to comply with standards have accreditation withdrawn.

Recently, the ACGME has begun a long-term effort to promote educational excellence through an emphasis on educational outcomes. A major step in this process, the "Outcome Project," has identified six general competencies important to the practice of medicine. This set of competencies evaluates the end product for the progression of physicians from advanced beginners, i.e., medical school graduates, to fully competent physicians, i.e., those who have completed an accredited medical residency⁴³. The six competencies identified and approved by the ACGME in 1999 were:

- Patient care.
- Medical knowledge.
- Practice based learning.
- Interpersonal and communication skills.
- Professionalism.
- Systems based practice.

After the ACGME adopted these general competencies, each specialty had to engage in a definitional task, clarifying what each outcome meant for its specialty. Each specialty has defined what "patient care" and "medical knowledge" means for its discipline. For the remaining four competencies, cross-specialty discussions have begun. These discussions have led to productive institutional approaches and also to efficiencies in development of education processes and evaluation and measurement methods^{44,45}

⁴³ H. L. Dreyfus and S. E. Dreyfus. *Mind Over Machine*. New York: The Free Press, 1986.

⁴⁴ P. Batalden, D. Leach, S. Swing, H. Dreyfus, and S. Dreyfus. "General Competencies and Accreditation in Graduate Medical Education." *Health Affairs*, 21, no. 5: 103-111. (2002).

⁴⁵ (D. Leach. "Building and Assessing Competence: The Potential for Evidence-Based Graduate Medical Education." *Quality Management in Health Care*, 11, no. 1: 39-44. (2002)

In addition to the competencies themselves, ACGME has developed and disseminated a set of references and guidelines for competency assessment. Also, ACGME, in cooperation with ABMS, has assembled a “Toolbox of Assessment Methods”⁴⁶.

Undergraduate Medical Education

In the United States, the Liaison Committee on Medical Education (LCME) determines the accreditation status of educational programs leading to the M.D. degree. The LCME, in cooperation with the Committee on Accreditation of Canadian Medical Schools (CACMS), also accredits M.D. programs in Canada. To be accredited, programs must meet national standards described in the document, *Function and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree*. These standards currently include measures of structure, function, and performance of medical schools' educational programs.

The Council on Higher Education Accreditation and the U.S. Department of Education recognize the LCME. Accreditation by the LCME is required for schools to receive federal grants for medical education and for students to participate in federal loan programs. Students and graduates of LCME-accredited medical schools are eligible to take the United States Medical Licensing Examination (USMLE). Graduates also have eligibility to enter residencies approved by the Accreditation Council for Graduate Medical Education (ACGME). Graduating from an LCME-accredited U.S. school and passing the national licensing examinations are accepted as prerequisites for medical licensure in most states. Provincial licensing boards in Canada also recognize accreditation by LCME.

The seventeen members of the LCME are medical educators and administrators, practicing physicians, medical students, and the public representatives. The AAMC and Council on Medical Education of the AMA each appoint six members. The AAMC and AMA each appoint one student member. The LCME itself appoints two public members, and the CACMS appoints a member.

Currently, the LCME accredits 125 programs leading to the M.D. in the United States; and, together with the CACMS, accredits sixteen M.D. Programs in Canada. The LCME does not accredit schools of osteopathy; the American Osteopathic Association accredits osteopathic medical schools.

The LCME has three types of accreditation. These include full accreditation; initial, provisional accreditation; and accreditation, on probation. The standard term for full accreditation is seven years. Near the end of this period, a fully accredited program completes a medical education database and self-study in preparation for a site-visit. Findings from these three sources are used by LCME in its decision-making regarding continuation of full accreditation. During the seven year period for which accreditation is granted, programs may be required to undergo an interim site visit or to submit interim progress reports. Detailed questionnaires covering each school's medical education programs and finances must be completed each year by all accredited programs.

⁴⁶ www.acgme.org

The LCME awards initial, provisional accreditation to qualified new programs, effective for a designated first-year class of students (the charter class). Surveys, including site visits, are conducted annually, and full accreditation may be given in the year the charter class graduates. The LCME responds to requests for information and assistance from new programs by providing information and consultation, including site visits. To be considered for initial, provisional accreditation, a program must show that it can reasonably be expected to meet accreditation standards when the charter class is admitted. Based on the readiness of the program, the LCME may schedule a survey team visit. A decision about initial, provisional accreditation is based on consideration of pre-survey data and the survey visit report. Once granted provisional accreditation, the M.D. program is re-evaluated annually for continuing provisional accreditation. If deemed ready in the year of charter class graduation, the school may complete a new written report, conduct a self-study, and undergo on-site evaluation for full accreditation. The LCME bases its decision for full seven-year accreditation on findings from these three sources.

An accredited program may be put on probation when it is not in substantial compliance with LCME standards. Probation typically does not extend beyond four years. During that period, a program must address its shortcomings relative to the standards. Site visits are conducted annually during probation. Full accreditation is not granted until the program is again in compliance with standards; and, if that does not occur, accreditation of the program is withdrawn.

According to a recent CHEA monograph⁴⁷, the LCME has largely-competency-based standards. Current standards reflect program structure, function, and performance. In February 2003, several new standards were approved, following review at public hearing and approval by sponsoring organizations. These new standards will take effect on July 1, 2004. Among these new standards is one dealing with graduate competencies. This standard reads, in part, “The medical school faculty must define the objectives of its medical education program. The objectives and their associated outcomes must address the extent to which students have progressed in developing the competencies that the profession and the public expect of a physician.” The annotation accompanying this new standard recognized multiple sets of “competencies” that currently exist, including the general competencies for physicians resulting from the collaborative efforts of ACGME and ABMS, described above. The new standard does not specify a set of competencies to be used by all medical schools. To comply with this standard, a school must demonstrate how its institutional learning objectives facilitate the development of “such general attributes of physicians.” A school may also “establish other objectives appropriate to its particular missions and context.”⁴⁸

Recently, LCME has attempted to become more cost-effective in its operation and to reduce the administrative burden for educational programs. It has reduced both the length of site visits (from four days to three days) and the number of LCME meetings each year (from four to three).

⁴⁷ CHEA Institute for Research and Study of Accreditation and Quality Assurance. *Specialized Accreditation and Assuring Quality in Distance Learning*. CHEA Monograph Series 2002, Number 2, Washington, DC: Council for Higher Education Accreditation, 2002.

⁴⁸ www.lcme.org

The Commission is also seeking to make its processes as “paperless” as possible. In addition, over the last several years, the LCME has reduced the number of standards by approximately 40 percent.

The LCME continues to try to find ways to use accreditation to leverage meaningful change and to be a facilitator of improvement rather than a regulator. Future challenges for LCME include finding ways to use accreditation to link across the medical education continuum (undergraduate medical education, graduate medical education, and, continuing medical education) and to link across health care professional disciplines. In addition, the Commission will be focusing on the culture of medical schools, including leadership of the school, the mission of the school (the “lived mission” as opposed to the enunciated mission), and resource allocation, and its inclusion as an aspect in accreditation processes to a greater extent.

Observations from Medicine for Health Administration Education Accreditation

Our review of accreditation in medical education suggests some observations that may be informative in considering possible changes in health administration education accreditation:

- The ACGME has made a concerted move to use of general education outcomes/competencies, shared across specialties and programs, in its accreditation processes. The LCME has made its accreditation process competency-based. This is similar to what we have seen in other fields in our research for this paper. While few health-related fields currently use a competency-based approach, many are moving in this direction.⁴⁹
- The ACGME effort will be implemented over several years and has included cross-specialty cooperation and development of standards, processes, and assessment tools. Health administration will need to consider the investment in time, effort, and financial resources needed to successfully implement this approach.⁵⁰
- Both ACGME and LCME accreditation processes continue to include structure and process measures, even in light of their focus on outcomes. Health administration education accreditation should consider the appropriate balance among these levels and types of measures in its accreditation process.
- The LCME has made an effort to streamline its processes, reducing costs and administrative burdens on accredited schools of medicine. We believe that similar efforts would be worthwhile for ACEHSA and its constituents.
- Medicine has attempted and continues to attempt to engage the full field (undergraduate medical education, graduate medical education, and continuing medical education) in thinking about accreditation and how common themes and competencies can run across these different career stages, while maintaining each

⁴⁹ Institute of Medicine. *Health Professions Education: A Bridge to Quality*, 2003

⁵⁰ S.B. Gelmon. “Intentional Improvement: The Deliberate Linkage of Assessment and Accreditation.” In *Assessing Impact: Evidence and Action*. Washington, D.C.: American Association for Higher Education, 1997

level of accreditation in its appropriate role. This may be useful for the health administration field.

Public Administration

The National Association of Schools of Public Affairs and Administration (NASPAA)⁵¹ is an institutional membership organization that exists to promote excellence in public service organization. Membership includes university programs in public affairs, public administration, and non-profit management in the United States. This organization also serves as the accrediting body for masters programs in public affairs. The Commission on Peer Review and Accreditation (COPRA) conducts a rigorous process of voluntary peer review that evaluates whether a program has met NASPAA's *Standards for Professional Master's Degree Programs in Public Affairs, Policy and Administration*. The Association is recognized by CHEA and is a member of ASPA. it is not recognized by the Department of Education.

Like ACEHSA and other accreditation processes, each program that chooses to go up for accreditation conducts a yearlong self-study process and prepares a related document that is submitted to COPRA. The self-study document is reviewed by COPRA, and the process is continued with a campus site visit by a COPRA-appointed team. After the site visit, a final review is completed by COPRA, which makes a decision as to whether the program is in conformance with the *Standards*. Accreditation by NASPAA has existed for more than a quarter century, and more than 135 graduate programs in public affairs are currently accredited by NASPAA. The Master of Public Administration (MPA) and Master of Public Policy (MPP) degree programs are accredited by NASPAA. Similar to health administration, there is no licensure for individuals working in public service (public affairs, public administration, non-profit management) positions in the United States. Therefore, there is no direct link between graduation from a NASPAA-accredited graduate program and entry to practice in this field.

According to a recent CHEA-sponsored study, NASPAA has largely competency-based standards⁵². The NASPAA accreditation process is mission-based but with specified common core curriculum requirements. The common curriculum has helped provide a common understanding of what an MPA or MPP program provides. The NASPAA *Standards* ask programs to consider mission-based competencies for their graduates, but NASPAA has not adopted a specific set of consensus competencies for the field.

Like other accrediting bodies, NASPAA is dealing with “larger forces” such as government, universities, and the public in terms of challenges it is facing. These entities are seeking greater accountability, a clearer focus on education outcomes, and evidence of independence of the accreditation process (from the membership association).

⁵¹ www.naspaa.org

⁵² CHEA Institute for Research and Study of Accreditation and Quality Assurance. *Specialized Accreditation and Assuring Quality in Distance Learning*. CHEA Monograph Series 2002, Number 2, Washington, DC: Council for Higher Education Accreditation, 2002.

One specific challenge facing NASPAA is the proliferation of specializations within public administration and public policy programs. The largest growth in this area has been seen in development of and enrollment in specializations in nonprofit management and health administration. Currently, NASPAA does not specify what a specialization within an MPA or MPP program should look like. At this point, specializations are reviewed for “truth in advertising,” but not for educational quality. The Association is now developing a quality review mechanism for specializations in the programs they accredit. They are consulting with ACEHSA as they develop this mechanism for health administration specializations; NASPAA views ACEHSA as the degree accreditor for health administration programs.

Observation from Public Administration for Health Administration Education Accreditation

Our review of accreditation in public affairs and public administration provides two observations that may be useful for ACEHSA to consider.

- Accreditation in public administration utilizes a mission-based competency approach. That is, there is not an agreed upon set of competencies for the entire field, but rather each program develops a set of graduate competencies, in light of its own mission. This differs from the ACGME approach described above. Should health administration education use one set of competencies for the entire field, or should it use a mission-based competency approach, that is built on the variety of program missions?
- The accreditation process in public administration does not currently have any sort of guidelines or standards for sub-specialties or concentrations within accredited programs. However, the number of such sub-specialties and concentrations is growing and consideration is being given to development of guidelines by the accrediting body. Currently, there are a number of rather specialized, “niche” programs that are accredited by ACEHSA. Should guidelines be developed to review these, within the broader ACEHSA standards?

Public Health⁵³

Of the sixty-eight ACEHSA accredited graduate programs in health administration, eighteen are located in schools of public health accredited by the Council on Education for Public Health (CEPH). The CEPH is an independent agency recognized by the U.S. Department of Education to accredit schools of public health (thirty-two), as well as community health education (fifteen) and community health/preventive medicine programs (thirty-five) located in other college and university settings. The accreditation practices of CEPH are especially relevant to our consideration of health administration accreditation because CEPH provides more general institutional accreditation for a major proportion of the ACEHSA accredited programs. Also, CEPH may provide the only specialized accreditation for other health administration programs

⁵³ Much of the information provided in this section is taken from the CEPH web page: <http://www.ceph.org/about.htm> and <http://www.ceph.org/proc.htm> and from interviews with officers of CEPH, ASPH and deans of schools of public health – see Appendix C.

not accredited by ACEHSA but located in schools of public health or other public health programs accredited by CEPH.

The objectives of CEPH are: 1) to promote quality in public health education through a continuing process of self-evaluation by the schools and programs that seek accreditation; 2) to assure the public that institutions offering graduate instruction in public health have been evaluated and judged to meet standards essential for the conduct of such educational programs; 3) to encourage – through periodic review, consultation, research, publications, and other means – improvements in the quality of education for public health.

Graduate education in public health began in the early 1900s. Formal accreditation began in the mid-1940s when ten schools were recognized by the American Public Health Association (APHA) – the nation's largest individual public health membership organization. APHA carried out accreditation of graduate professional education until 1973. In 1974, APHA and the Association of Schools of Public Health (ASPH), the national organization representing deans, faculty and students of accredited schools of public health, established CEPH.

The CEPH is a private nonprofit corporation directed by an independent board, with APHA and ASPH as its two corporate members. The ten-member board is solely responsible for adopting criteria by which schools and programs are evaluated, for establishing policies and procedures, for making accrediting decisions, and for managing the business of CEPH. Three members are appointed by APHA and must be involved in the practice or administration of public health service. Three members are appointed by ASPH and must be faculty, students, or administrators in schools of public health. Two members, representing the general public, are jointly appointed by APHA and ASPH. Finally, two members are elected by CEPH to represent professional and educational organizations in community health education and community health/preventive medicine. Fees and contributions from the profession and the academic community support CEPH.

Public health school accreditation is a voluntary process initiated by the university. The school or program must undertake a self-evaluation, submit a self-study document, and host a team of qualified peer reviewers who validate the self-study during an on-site visit to campus. The document is reviewed prior to the visit and areas for clarification, elucidation or onsite focus are identified. The team interviews university officials, administrators, faculty, students, alumni, and community leaders; inspects facilities and resources; and examines supporting documentation. The site visit team prepares a report of findings, observations, and recommendations that is forwarded to the CEPH board and the chief executive officer of the university. The board makes a final decision that might be pre-accreditation, continued accreditation, accreditation, denial of accreditation, probationary accreditation, or revocation of accreditation. Denial, probation and revocation decisions may be appealed. All final decisions are made public.

Once accredited, a school or program is reviewed at regular intervals, at least every seven years; and interim reports may be required. If an accredited school or program undergoes major organizational changes, CEPH may require review prior to the date previously stipulated. The accredited status of each school or program is published annually in APHA's *American Journal*

of Public Health, is included in national publications of accredited institutions of postsecondary education, is transmitted to the US Department of Education, and is available upon request from CEPH.

The CEPH intends its accreditation principles to reflect its commitment to quality in education and quality in accreditation. These principles include:

- Self-evaluation – CEPH expects that the most significant benefits to the school or program of accreditation to result from the process of self-evaluation. The ideal self-study identifies strengths and weaknesses and provides a constructive forum for building consensus and establishing institutional commitment.
- External peer review – CEPH subscribes to external expert judgment about the educational programs as the fundamental nongovernmental approach to quality assurance. Its roster of potential site visitors includes outstanding academicians as well as well as nationally recognized public health practitioners who are expected to assess the relevance of educational programs to the world of practice.
- Mission is central – while all public health schools are assumed to share a common purpose to prepare competent professionals – each school or program is expected to develop its own distinctive mission. CEPH's evaluation is based on this stated mission along with related goals and objectives.
- Focus on outcomes – CEPH seeks to focus on the competencies and professional knowledge and skills students acquire through their course of study. The hope and expectation is that acquisition of these competencies, knowledge and skills is linked to proficiency in practice. A survey of fifty specialized accreditors by the Council for Higher Education Accreditation in 2002 classified CEPH as one of thirty-five accreditors having “competency based standards” compared to fifteen that had “largely competency based” and nine that had “largely content based.”⁵⁴
- Objectivity and fairness – CEPH strives to hear all views but to exclude from decision-making those who have a vested interest in the outcome of a decision. It attempts to provide clearly stated criteria and procedures in advance of the review. School or program officials may respond in writing and appear in person when the accreditation decision is made.

Our interviews with officers of CEPH and ASPH and public health school deans⁵⁵ reveal that CEPH accreditation principles and procedures have been subject to change and ongoing review by academics, practitioners, foundations, the Accrediting Agency Evaluation Unit with the U.S. Department of Education, and CEPH itself. There was general support for CEPH as an accrediting agency independent of ASPH, APHA, and the federal government. More schools and programs are seeking accreditation with accredited programs increasing at a faster rate than

⁵⁴ CHEA Institute for Research and Study of Accreditation and Quality Assurance. *Specialized Accreditation and Assuring Quality in Distance Learning*. CHEA Monograph Series 2002, Number 2, Washington, DC: Council for Higher Education Accreditation, 2002.

⁵⁵ See Appendix C.

schools but concerns are also growing regarding the increasing costs and burdens of carrying out the accreditation process.

There was general agreement that accreditation focuses on turning out competent entry level professionals and has less relevance to the production of leaders and high level executives and it is especially difficult to establish the link between accreditation and achievement in mid career and later. There was also some consensus that a prime purpose and achievement of accreditation was to “level the playing field” and assure minimum standards for public health graduates.

While added value from CEPH accreditation should be further enrichment and continual learning for all schools and programs, there was less consensus regarding the extent to which this goal is being achieved. While all interviewees acknowledged the movement of CEPH toward competency based outcome criteria, some comments stressed the need to continue to assess structure and process to better understand what is associated with good outcomes and other comments called into question how well the outcomes based criteria are being effectively implemented.

Finally, concerns were expressed about the role of CEPH as the setter of standards or the enforcer of standards. Some felt that the accrediting agency should be the enforcer and that deans, faculty, students and leaders from the field should be setting the standards. However, possibly due to some void in leadership in Public Health, standard setting has fallen increasingly to CEPH.

A number of events and processes in recent years have affected and continue to influence CEPH accreditation practices:

- The recommendations of the 1988 IOM report, *The Future of Public Health*, prompted national discussion about how graduate schools of public health contribute to a trained workforce.⁵⁶ The report highlighted the need for improved work force development to meet the demands of emerging public health problems. Fineberg and colleagues identify the 1988 IOM report's resolve “that professional education be grounded in ‘real world’ public health as the most influential recommendation in the report.”⁵⁷ One response was that CEPH revised accreditation criteria should include a required practicum experience.
- A follow up IOM report in 1991 recommended that schools of public health recruit senior level and mid career professionals and increase the number of graduates who can assume system level leadership positions.⁵⁸
- In 1995, the Pew Health Professions Commission concluded, “Traditional accreditation serves as an impediment, real or imagined to changing education and it has outlived its current social usefulness. It must be reinvented to serve the more pressing social need of making educational institutions truly responsive, or it must be simply discarded.”⁵⁹

⁵⁶ Institute of Medicine. *The Future of Public Health*. Washington, DC: National Academy Press, 1988.

⁵⁷ H.V. Fineberg, G.M. Green, J.H. Ware & B.L. Anderson. “Changing Public Health Training Needs: Professional Education and the Paradigm of Public Health.” *Annual Review of Public Health*, 15: 237-257, 1994.

⁵⁸ Institute of Medicine. *Education for the Health Professions*. Washington, DC: National Academy Press, 1991.

⁵⁹ Pew Health Professions Commission. *Critical challenges: Revitalizing the Health Professions for the Twenty-First Century*. San Francisco: UCSF Center for the Health Professions, p. 20, 1995.

- The Task Force on Accreditation of Health Professions Education, after extensive consultation and discussion with a wide range of stakeholders, concluded that accreditation must become a value added activity focused on assessment and improvement of educational programs. This improvement will require a simplified process focusing on improvement, creation of closer links with clients and customers and use of generic benchmarks or standards.⁶⁰
- In 2000, an ASPH committee charged with “enlightening member schools about accreditation,” concluded that improvements might be made to make CEPH better understood and valued.⁶¹ These included careful selection of council members and site visitors, promotion of an attitude of collegiality, review of the content and appropriateness of the criteria and especially of the core curriculum and review and clarification of the basis for the number of years awarded to a school when accredited.
- The recent report by the IOM, *Who Will Keep the Public Healthy?*, is likely to impact on future accreditation practices.⁶² The report recommends that public health professional education include not only the traditional five core components of public health (i.e., epidemiology, biostatistics, environmental health, health services administration, and social and behavioral science), but also encompass eight critical new areas: informatics, genomics, communication, cultural competence, community based participatory research, policy and law, global health, and ethics. The report concludes that each of the new areas should be included in graduate level public health education with competencies identified and opportunities for specialization offered.

The CEPH is currently reviewing and considering revisions of the criteria by which it evaluates graduate schools and programs of public health for accreditation. In response to an invitation from CEPH, the deans and faculties of the schools in ASPH have reviewed the criteria and suggested changes.⁶³

- While “ASPH believes there is significant value in our CEPH accreditation, enhancements are necessary to make the criteria standards less ambiguous, the process less onerous and the ultimate outcome focused on quality enhancement.”
- “Criteria, particularly those addressing schools’ instructional programs, should move from a process that currently emphasizes the number of public health courses -- inputs -- to one that emphasizes competency of graduates -- outputs.”
- “The current system of accreditation includes some criteria that amount to moral judgments on matters that are not directly relevant to the education of students.”

⁶⁰ Taskforce on Accreditation of Health Professions Education. *Strategies for Change and Improvement*. San Francisco: UCSF center for Health Professions, 1998.

⁶¹ M. Ibrahim. “ASPH Accreditation Project.” *Public Health Report*, 115:584, 2000.

⁶² Institute of Medicine. *Who Will Keep the Public Healthy? Educating Public Health Professionals for the 21st Century*. Washington, DC: National Academy Press, 2002.

⁶³ Personal communication from Susan Scrimshaw, PhD, Chair of the Executive Committee ASPH and Harrison C. Spencer, MD, MPH President and CEO of ASPH to Patricia P. Evans, Executive Director of CEPH, dated August 29, 2002.

Examples given included community service, involvement of faculty and students in decision-making and a racially diverse faculty. “While SPH may have shared social values, and while we believe that it is incumbent on SPH to advance these values, these values stand outside the academic criteria evaluating the quality of the education received, which we believe should be the most important criterion for judgment.”

- “Criteria for accreditation should reflect a more inclusive definition of public health professionals... Criteria should provide the flexibility to appropriately train the broad array of public health professionals in our schools.”

OBSERVATIONS FROM PUBLIC HEALTH FOR HEALTH ADMINISTRATION EDUCATION ACCREDITATION

This review of CEPH accreditation suggests to us some summary observations of possible relevance to future consideration of ACHESA accreditation:

- CEPH has the site visit team contact the school before the visit. ACHESA might wish to consider a similar process.
- CEPH accreditation is increasingly emphasizing leadership, a particular concern of NHCL in health administration
- CEPH is moving toward competency-based criteria for accreditation, as is ACHESA. There continues to be ambivalence as to how far CEPH has moved and what the criteria should be. While CEPH defines its accreditation process as competency based and the survey by the Council on Higher Education for Accreditation classifies CEPH as having “competency based standards,” ASPH believes that standards should be changed even more to emphasize competencies of graduates.
- There continues to be debate regarding the role of CEPH. Should the role be limited to enforcing standards, or should it include the setting of standards (What should be the role of ACHESA?).
- While there are apparent strains between CEPH and ASPH, there seems to be general agreement about the value of having the organization that accredits the schools separate from the one that accredits them (How separate should ACHESA be from AUPHA?).
- While there is general support for movement toward competency-based criteria, there is also support for a continued role for structure and process measures in the accreditation process (What should be the relevant role of each type of measure in the ACHESA accreditation process?)
- There is strong support for making the accreditation process less onerous in CEPH as in ACHESA.

TOWARD A MODEL OF HEALTH CARE MANAGEMENT PROGRAM ACCREDITATION

Figure 1 provides a model for thinking about the forces that we believe have determined health administration accreditation in the past and are likely to influence it in the future. This delineation of forces is based on our personal experiences, literature reviews, focus group work, and interviews with leaders in the field. The model also employs the traditional structure, process, and outcomes framework Donabedian used for assessing quality of care⁶⁴ and applies the framework to health administration education.⁶⁵

The model notes four potential forces driving the criteria used for health administration accreditation. The relative import of these forces varies at any point in time and changes over time. The forces include:

- *Disciplinary emphasis.* This force leads to criteria stressing the importance of basic disciplines, such as economics, management science, information science, political science, or sociology. It seemed to be more dominant in an earlier time when health administration education was seeking legitimacy in the academic realm. As emphasis shifts to mission and practice related criteria, less emphasis may be placed on disciplinary criteria. This seems to be happening in other fields with academic rigor and comprehensive coverage of important disciplines less explicit in the criteria. We feel that health administration has not reached the stage where appropriate disciplinary emphasis can be assumed in the programs and criteria need to continue to include disciplinary guidelines.
- *Mission emphasis.* ACEHSA, as well as the principal accrediting agency for general management education, has declared they are “mission driven.” This means that each individual program’s mission, goals, and objectives statements serve as the basis upon which the criteria are applied. And, while the current ACHESA accreditation may not be structured to accommodate the diversity of missions put forth by its members (e.g., the current management-oriented criteria make it very difficult for policy tracks in health policy and management programs to be accredited), acknowledgment of this diversity leads us to recognize that accreditation in management will not mirror accreditation in fields that have directly linked education to practice entry, performance, licensure, and certification (e.g., medicine). The ACEHSA’s migration to a more mission-focused accreditation process should lead to increased diversity of programs reviewed. It further suggests that accreditation, by bringing together mission with other forces on accreditation, requires flexibility and agility on the part of the accrediting agency. This focus also requires the agency to recognize the extent to which a mission statement may be compatible (or incompatible) with the purpose of the agency.

⁶⁴ Avedis Donabedian. *Exploration in Quality Assessment and Monitoring: The Definition of Quality and Approaches to its Assessment. Volume I.* Ann Arbor, MI: Health Administration Press, 1980

⁶⁵ See for example, PL Davidson, RM Andersen, DW Hilberman, and TT Nakazono. “A Framework for Evaluating the Impact of Health Services Management Education.” *The Journal of Health Administration Education* 18:1, Winter 2000, 63-104.

- *Location.* Clearly, accreditation criteria can be influenced by the type of school or program (business, medicine, public administration, public health) in which a program is located and the general accreditation requirements for that type of school. Further, type of degree program (e.g., MHA, MBA, MPH, or MPA) is associated with type of school/program and may raise additional challenges for the development of accreditation criteria appropriate for programs in different settings. We feel there is a place for programs in all of the above locations and accreditation criteria should be flexible enough to recognize the strengths of each location to health administration education and practice.

- *Connection with the world of practice.* A final force in our model that drives change in accreditation is the link between health administration education and the field of practice. All of our case studies of accreditation in the health fields point to increased links of education and practice and movement of the accreditation criteria to emphasize this link.

The model in Figure 1 suggests that there are essentially four types of accreditation criteria:

- There are criteria about inputs, primarily about the characteristics of students entering programs and the bases upon which they are admitted. However, characteristics of schools and universities in which programs are located and program links to the surrounding community and health care industry are important inputs in the education process which are also included in accreditation criteria.

- Structural characteristics are the traditional criteria for accreditation including characteristics of faculty, curriculum, facilities, finances, and ties to practice.

- Process characteristics define the way education and learning take place in the program. We note increasing emphasis on process relative to structure with attention focused on experiential learning.

- Outcomes are certainly attracting the most attention in the shift toward competency-based criteria for assessing educational outcome. These outcomes can be of the more short-term variety (Does the graduate possess the competencies, skills, knowledge, and abilities, deemed necessary for career success and does the graduate obtain a suitable entry level job?); or they may be more long term (Does the graduate achieve career advancement and become a leader in the field?). While the longer term outcomes are of great interest to the field, there is considerable agreement in the accreditation field that accreditation almost exclusively deals with preparation and outcomes relevant for entry to practice.

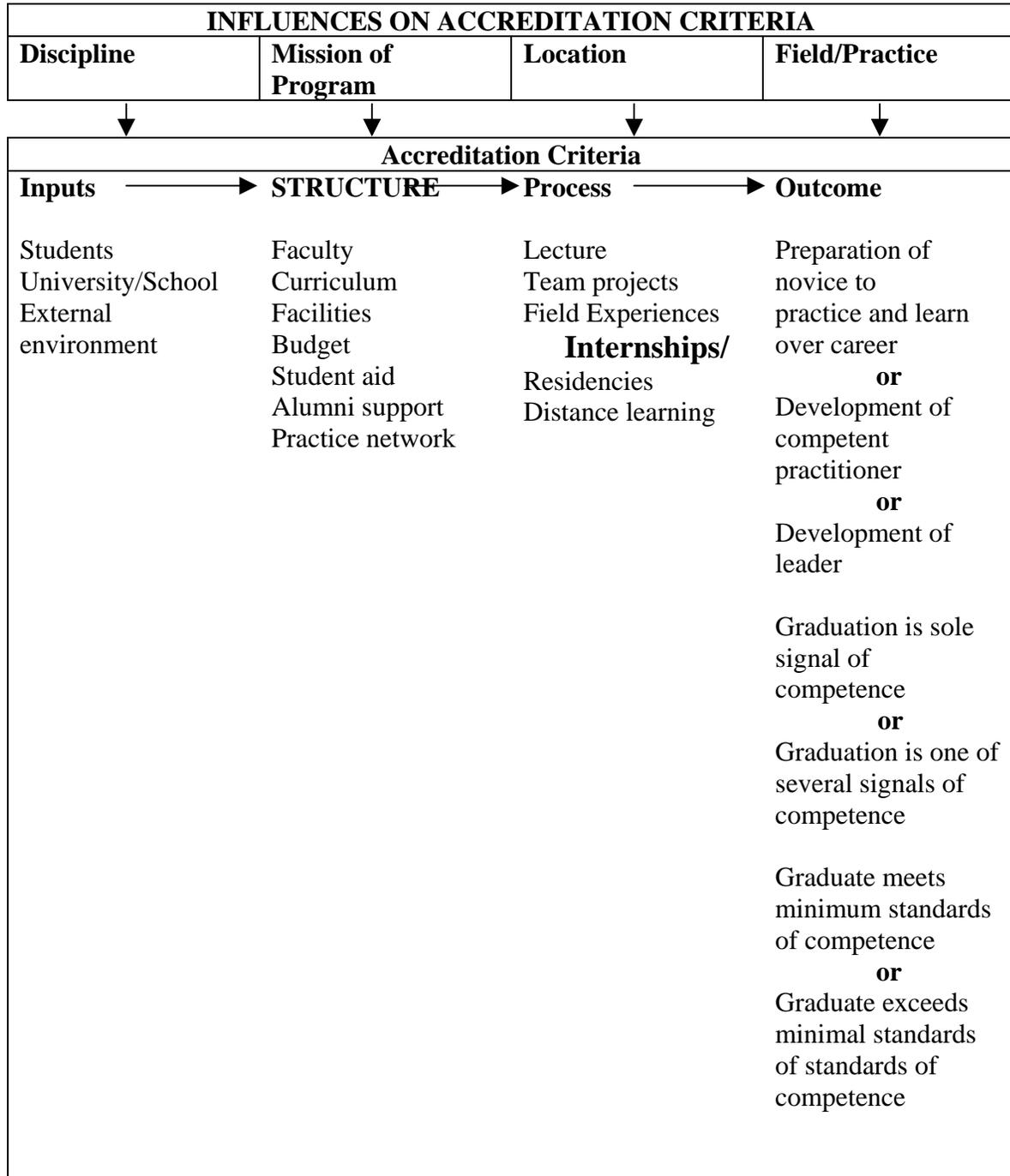
In Figure 1, we have incorporated the previously mentioned dimensions of accrediting agencies to highlight some alternative outcomes sought by different programs or debated in the accreditation literature. One set of alternatives has to do with whether the mission of the

program is to prepare novices to learn on the job or graduate already competent practitioners or even proficient or expert in the field.⁶⁶ Another set involves whether graduation should be the primary signal to prospective employers of the competency of the prospective employee or just one of several signals used by employers. The latter is the case in health administration today and comparisons with other occupations suggest that licensure and certification may be required to attain the former. A final set of alternatives concerns whether accreditation should assure that all graduates achieve minimal standards or should seek or demand achievement beyond those minimal standards.

⁶⁶ H. L. Dreyfus and S. E. Dreyfus. *Mind Over Machine*. New York: The Free Press, 1986.

FIGURE 1

A Model of Health Care Management Program Accreditation



Reviewing our comprehensive model and the linkages of inputs, structure, process, and outcomes leads us to the following observations:

- In the input stage the field must be active by sharing expectations for improving the match between what programs offer and what students/graduates desire.
- While emphasizing competencies and outcomes is very appealing, they are still a product of structure and process.
- When outcomes are less than desired, it is through the measurement of structure and process and the linkage to outcomes that provide directions for improvement. Further, the linkages once made between outcomes and structure and process – establish the validity of some structure and process measures that might be more simply and inexpensively collected in subsequent accreditations.
- When considering competencies as outcomes, a prevailing assumption appears to be that competencies have been validly linked to longer term outcomes such as employability, job success and career advancement. Our assessment of the literature is that the assumed links have often not been established. Further, when links have been attempted, the basis is usually “expert opinion.” While a difficult methodological challenge, we believe this is certainly an area for further research in the accreditation process.
- In a field where there is an absence of licensure or certification, the value of what is to be gained by the student (input stage) and the recognition of graduate competencies (outcome stage) requires careful consideration.
- Success of the model will depend on a “contract” for engagement between academia and practice regarding the role of program accreditation and employment in this Century’s management. A closer relationship between academia and the field is especially important at the input and entry into practice stages. The field must articulate what it requires for task performance, leadership and succession. Academia must make the necessary adjustments.

CONCLUSIONS

To summarize the general conclusions of our paper, we first present several assumptions that guide our recommendations and then outline five recommendations for the Blue Ribbon Task Force to consider.

ASSUMPTIONS

1. *Accreditation of graduate programs in health administration, as in other fields, must focus on graduates at their entry to practice, not on later career progression and achievement.* As noted earlier, it is difficult, if not impossible, to correlate education with

the full range of outcomes, especially those that pertain to performance five, ten, or more years into practice.

2. *Any changes in ACEHSA criteria or processes must satisfy Department of Education and Council on Higher Education Accreditation requirements for recognition.* The quasi-regulatory nature of these recognition processes must be acknowledged as an underlying consideration of any change in programmatic accreditation by ACEHSA.
3. *The increasing pressure for educational accountability to the various stakeholders of accreditation (students, academic administrators, employers, taxpayers, the public) must also be seen as an important underlying consideration in any changes.* The trust in accreditation as an effective vehicle for quality assurance and improvement held by these stakeholders must be honored and maintained.

RECOMMENDATIONS

1. *Engage the full field to define the scope of health administration education and the implications of program diversity for the field and programs.* Achieving clarity will provide a framework for judging aspirants to ACEHSA accreditation and the mix and nature of the kinds of competencies and outcomes desired for graduates and the field. The outcomes of this process might lead ACEHSA to develop more than one accreditation track and increase its scope of influence.
2. *Move to educational outcomes based accreditation.* As noted earlier, ACEHSA continues to use non-competency based standards for accreditation. Our field has not made enough progress in this regard and lags behind other fields in this regard. The currently proposed changes in the ACEHSA Criteria would begin to move us in this direction, however.

In the past, it has been assumed that:

Knowledge = Competency.

However, more recent thinking has concluded that:

Competency = Knowledge+Skills+Behaviors+Attitudes.

The recent Institute of Medicine report *Health Professions Education: A Bridge to Quality* clearly calls for the clinical disciplines to move toward competency-based criteria.

There appear to be two models for competency-based accreditation, one that is mission-based (as used by AACSB and NASPAA) and one that uses general competencies applied to all programs (as used by ACGME). While the proposed changes to ACEHSA criteria, currently under consideration, move toward a mission-based approach, we do not recommend one of these models over the other. Rather, we recommend that the health

administration education community engage the field of practice broadly in deciding which model is most appropriate for ACEHSA to employ. This is a decision that neither the field of practice or the academic community can make unilaterally.

If a model of general competencies is chosen, however, it will be necessary to develop a set of competencies that can be agreed upon and used, recognizing the varied nature of our programs and the diversity of markets for graduates.

Two related issues that we note are in the area of assessment and faculty role. With competency-based criteria, new assessment methods for students and graduates will have to be developed (as seen in the ACGME *Toolbox*). Also, there will be a need to develop new faculty skills, attitudes, and levels of involvement. Faculty will no longer be able to see the curriculum from within the “silos” of courses they teach, but will need a broader view of where the material covered in their courses fits into the total curriculum and how it is related to graduate competencies.

3. *Move to greater emphasis on quality improvement.* Other accrediting bodies are attempting to place a greater emphasis on quality improvement of educational programs rather than strictly, or even primarily, quality assurance. For example, the AACSB has differentiated its focus in initial accreditation and subsequent accreditation decisions, and CEPH features greater communication between programs and site visit teams, beginning prior to the actual visit. While there has been an increasing emphasis on quality improvement over the last several years, ACEHSA needs to explore additional mechanisms for an even greater focus on quality improvement. In addition, to considering innovations already used by other accrediting bodies, one possible avenue would be to investigate the possibility of using Baldrige Award-like criteria in the accreditation process. More well defined guidelines for site visit and/or more specific instructions for site visitors might also be considered.
4. *Reduce the administrative burden.* Can site visits be shortened? Can greater use be made of technology? Can ACEHSA coordinate its activities more closely and achieve greater integration with the activities of related accrediting bodies, e.g., AACSB, CEPH? Answers to these, and similar questions, must be addressed by ACEHSA.
5. *Engage the field of practice to more fully participate in the accreditation review process and to value the employment of graduates of accredited programs.* This report has noted the “soft-link” between education and entry into practice and the multiple sources for health management talent at the entry level. If ACEHSA is to be successful in the long run, professional societies and employer groups must have a larger stake in ACEHSA, to communicate the quality of graduates and the extent to which the competencies that characterize an ACEHSA graduate can bring needed value to employer organizations. Newer organizations, such as NCHL, may choose to become corporate sponsors of ACEHSA. Outcome measures related to graduation, such as the placement of ACEHSA program graduates, starting salaries, and level of entry position, must be realistic and accepted by both the academic programs and the responding field of practice.

**APPENDIX A
FOCUS GROUP QUESTIONS**

What are the principal issues facing your organizations?

What do you consider to be the best practices in accreditation?

What is facilitating change in accreditation?

What is hindering change in accreditation?

How is accreditation in your field likely to change in the next five years?

What are the drivers for change?

How do you balance the pressures from various constituents?

Who is the principal client?

What are the relationships between the products of accredited programs and the mature practice community?

What is the relationship in your field between university-based education and continuing education?

**APPENDIX B
FOCUS GROUP PARTICIPANTS**

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APPENDIX C
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APPENDIX D

STAKEHOLDER SATISFACTION WITH THE ACCREDITATION PROCESS: A REPORT TO THE BLUE RIBBON TASK FORCE

Sherril B. Gelmon, Dr. P.H., with Khalid Wahab and Kathi Ketcheson, Ph.D. July 2003.

Stakeholder Satisfaction with the Accreditation Process

A Report to the Blue Ribbon Task Force

Sherril B. Gelmon, Dr.P.H.
with Khalid Wahab and Kathi Ketcheson, Ph.D.
Final Report -- July, 2003

In January 2003, the National Center for Healthcare Leadership (NCHL) initiated a research study as part of the work of the activities of the joint NCHL-ACEHSA (Accrediting Commission on Education for Health Services Administration) Blue Ribbon Task Force (BRTF). Dr. Sherril B. Gelmon, Professor of Public Health at Portland State University, was commissioned to design and lead this study. She was assisted by Mr. Khalid Wahab, graduate research assistant, and Dr. Kathi Ketcheson, web survey design/technology consultant. An Advisory Group, consisting of members of the BRTF and NCHL staff, was charged with providing advice and review on the various stages of this research study; the members were Peggy Leatt, Robert Hernandez, Wayne Lerner, Jack Trufant, Cathy Robbins and Marie Senioris. This group has been very valuable in providing oversight and advice through this study.

This report documents the study purpose, focus, methods, findings, and conclusions; these conclusions are those of the authors and have not been reviewed or endorsed by any of the sponsoring or participating organizations. It is anticipated that the BRTF, ACEHSA and NCHL will all draw further conclusions from these findings. This report is intended for use by these groups, all of whom have a detailed knowledge of health administration education – thus no historical context or definitions with respect to this field and related accreditation issues is included. External publications following this report will include relevant context-setting and descriptions of key environmental and stakeholder interests and issues.

A draft of this report was provided to the BRTF in June, and was also forwarded to the NCHL Research Council. Detailed feedback was provided by the BRTF, as well as the two reviewers designated by the Research Council; additional feedback was received formally and informally from others, as well as at the June 2003 AUPHA Annual Meeting where these results were presented. This feedback has been carefully considered and all elements addressed as feasible given the context and scope of this study.

Study Purpose

The purpose of the study, as defined by the members of the Blue Ribbon Task Force, was:

To assess and monitor changes in stakeholder satisfaction and expectations regarding accreditation of graduate and certification of undergraduate health management and policy educational programs.

The primary focus within this was a near-term survey to "assess", with the implied intent to conduct longitudinal follow-up (on a timeframe to be determined) in order to "monitor changes." The emphasis was defined as graduate health management educational programs and the stakeholders of these programs. However, it was also specified that attention was to be paid to

the role of AUPHA-member undergraduate programs as these are also relevant to career paths and to potential future strategies for enhancement of health management and policy educational preparation.

Study Focus

In conducting this study, NCHL and the BRTF wanted to seek the input of multiple stakeholder groups in order to answer questions that were not currently being addressed by other NCHL or ACEHSA initiatives or research studies. Thus the intent of this study was to be non-duplicative of the other efforts of the Blue Ribbon Task Force (such as the accreditation white paper), other NCHL-commissioned research studies, or the activities of the current ACEHSA Criteria Review.

Three broad over-arching questions were identified at the outset of the study. These would apply to all stakeholders, and were:

- What is the value-added/benefit of accreditation/certification?
- Is the "product" (i.e. the graduate) prepared and competent for the work environment?
- How could systems of accreditation/certification of health management and policy educational programs be improved to better serve the needs of stakeholders?

Study Population

In order to address these questions from a range of perspectives, a number of key stakeholder groups were identified by the members of the BRTF. Different strategies were used for each in identifying the potential survey population. These are listed below, as well as the population identified for each:

- Program directors of ACEHSA-accredited programs (graduate): all program directors were invited to participate; contact information was provided by ACEHSA (N=67).
- Program directors of AUPHA-certified programs (undergraduate): all program directors were invited to participate; contact information was provided by AUPHA (N=37).
- Program directors of ACEHSA-candidacy programs (graduate): all program directors were invited to participate; contact information was provided by ACEHSA (N=11).
- Faculty from non-accredited/member programs who are individual members of AUPHA: these individuals could offer a perspective of programs outside of AUPHA/ACEHSA while having some knowledge of health administration education through their affiliation; a list of these individuals was provided by AUPHA (N=72 plus 6 program directors of AUPHA associate graduate member programs that are not ACEHSA candidates).
- Program directors of programs not seeking ACEHSA accreditation: given the overlap of ACEHSA with other specialized accrediting organizations, programs were identified that offer a specialization/concentration in health management (or related titles) and are accredited through public health (Council on Education for Public Health -- CEPH), business (Association for Advancement of Collegiate Schools of Business -- AACSB), and public administration (National Association of Schools of Public Affairs and Administration -- NASPAA) were identified. In the case of AACSB, the Executive Director provided a list based on a sort of internal databases; in the cases of CEPH and NASPAA program and program director contact information was available publicly on their respective websites. The study team further triaged these lists to identify programs that are roughly comparable to the ACEHSA-accredited programs in terms of the scope of health administration content, as well as to exclude programs already included in the ACEHSA-accredited list as many of

these programs have multiple accreditations (business N=23; public health N=13; public administration N=27).

- Students from a range of ACEHSA-accredited programs: each program director was invited to submit a list of up to 10 names and emails of current students in their graduate program; they were asked to select a representative group (N=32 programs with 10 names each).
- Recent alumni from a range of ACEHSA-accredited programs: each program director was invited to submit a list of up to 10 names and emails of recent (within the past 10 years) alumni of their graduate program; they were asked to select a representative group (N=31 programs with 10 names each).
- Key informants from major stakeholder organizations (professional associations, trade associations, membership groups): each of the ACEHSA corporate sponsors (other than AUPHA as it was already well-represented by the faculty and program directors) was asked to provide a list of 10-15 leaders within their organization; those responding tended to provide a list of Board members or other leadership group. Six of the corporate sponsors responded. All of the current ACEHSA Commissioners were also included in this group. NCHL provided a master list of its leadership groups as well (total N for this group was approximately 100).
- Employers (both CEO's and human resource directors) from a range of settings within the health industry (systems, managed care, insurance, pharmaceutical, long-term care, mental health, public health, government, consulting, etc.): NCHL provided the list used for the core competencies project; this had considerable diversity of representation across health industry sectors. The list was augmented with some additional respondents identified by members of the BRTF. Over 500 names were provided; duplicates from other lists were removed and multiple names from a single organization were sorted to avoid over-representation from any one organization. The affiliations of these individuals suggested that all were either in a position to be direct employers or to influence employment decisions through their business, organizational roles or management procedures. It should be noted that NCHL expressed a concern about the release of the email addresses on their lists; confidentiality was maintained through administrative processes and separation of lists of names from those with emails (total N for this group was approximately 300).

For ease of survey administration, ultimately all of these respondents were categorized into four groups:

- Students
- Alumni
- Faculty/program directors (accredited, non-accredited, and undergraduate programs – the first five categories listed above)
- Employers/other stakeholders (those who employ or who exert influence over employers through various policy and practice arenas – the last two categories listed above)

In all cases, the survey team could clearly match each potential respondent to one of these four groups.

Study Methodology

Given the number of stakeholder groups, and an identified desire to seek broad input into this study, it was determined that a survey methodology would be most appropriate.

Survey Design

Survey development began with two key activities: 1) A brainstorming session with key informants (BRTF members and others) was conducted in order to develop a list of core concepts to be addressed with each stakeholder group. 2) A review was conducted of relevant literature and contact with other key informants to obtain other surveys on similar topics. A number of specialized and regional accreditors were contacted, as well as individuals who have recently conducted dissertations or organization-based studies, and a few relevant survey instruments were obtained. Documentation from the 1993 ACEHSA surveys of stakeholders was also reviewed, as well as summary information from the 1988-1990 ACEHSA criteria revision and related information collection.

A series of surveys, customized for each stakeholder group, was designed between late January and late February 2003. Common questions were derived from the major questions and core concepts were developed for all potential respondents, as well as specific questions addressing each stakeholder group's interests in health management education. Survey questions were developed and reviewed in consultation with members of the Blue Ribbon Task Force; a conversation was also held with the faculty consultants developing the White Paper. Tailored Design Method principles (Dillman) were used to maximize response rates. The Task Force gave final approval of the surveys at the end of February 2003. The specific content of the surveys is discussed below under "Survey Administration."

The survey methodology and instrumentation was submitted to the Human Subjects Research Review Committee at Portland State University in order to receive IRB approval, and this was granted in March 2003.

Survey Administration

A decision was made early in this project to administer this survey via the Web because of efficiency of distribution, minimal resource expenditure, and streamlined data capture. All of these activities would have consumed considerably more time and resources through a paper survey. After evaluating a number of survey tools we selected WebSurveyor 4.0, as it provided the necessary functional and security features that were needed to conduct this survey. A single entry point for all users with built-in conditional logic was used to direct users to the appropriate sections/questions. Once the survey was designed, it was uploaded onto a secure online server provided by WebSurveyor. All the relevant HTML files and survey data were stored at that location until the completion of the survey at which point the data was downloaded to a local computer for analysis.

A single distribution list for the entire survey population was created in Excel and imported into WebSurveyor. At that point, an introductory message was created and sent electronically to all of the potential respondents on the list (mid-March 2003). WebSurveyor allowed us to keep track of all individuals who had responded to the survey; this enabled us to send reminders only to those individuals who had not yet responded. A two-week time frame was allocated between the initial message and the first reminder; a second reminder was sent two weeks later. At the conclusion of this time period (six weeks total) the survey was "closed" to prevent further responses (late April 2003).

A number of security features in WebSurveyor were used to prevent any inadvertent misuse of the survey that could have posed threats to the validity of the survey responses. Each individual on the mailing list was assigned a unique identification number that allowed us to create a custom URL for each recipient. Both the custom URL and allowing only one response per unique identification number prevented respondents from forwarding the link to others. This therefore precluded submission of multiple responses by a single user, as well as forwarding of the survey to a potential respondent who was not part of the survey population. A "cookie" was also set in the users' computers to prevent them from loading the survey on their own computer after it was submitted. Anonymity of response was ensured by using a unique identifier, rather than an individual's name or email address.

Given the use of the electronic survey distribution and response mechanism, all surveys began with a common question that allowed respondents to self-identify themselves as one of the following:

- Student in a graduate program in health administration
- Recent (within past ten years) alumnus/a of a graduate program in health administration
- Employer who may hire graduates of health administration or other management education programs
- Faculty member and/or program director in a health administration or other comparable management education program with emphasis in health

There were a few direct email queries from potential respondents who felt that they could respond in more than one category. They were guided to select the respondent group that best represented their interests. In almost all cases, these were members of the "employers" group who were also alumni of a health administration program (usually of greater than 10 years) and/or served as adjunct faculty in a health administration program. The survey team had no control over which group respondents ultimately selected, but trusted that respondents responded accurately.

The response to this question took the respondent directly to the relevant survey instrument for that population (a seamless process for the respondent). For faculty members, the next question selected out those respondents affiliated with undergraduate programs, and lead them to a series of questions where the wording was refined to reflect undergraduate education and program certification, rather than graduate accreditation. Questions were nearly identical to those filled out by graduate faculty, but were contextualized for the undergraduate programs.

Data Capture

Processes for data capture directly into suitable databases for subsequent analysis were built into the survey design. The WebSurveyor software allowed for data to be captured directly (both quantitative and qualitative) and then translated into appropriate languages for analysis; see "Data Analysis" below. The only person with access to the entire raw data file was the graduate assistant hired at Portland State University; respondent names and identification numbers were maintained in a separate file from the file with the actual responses. Thus it was not feasible to link responses to any individual. No members of the Blue Ribbon Task Force or other components of the NCHL leadership had access to the raw data.

Data Analysis

At the conclusion of the survey time frame, the data was downloaded as four "comma separated files" (one for each category of the stakeholders) and subsequently imported and converted into Excel format. After some initial data cleaning, the files were then imported into SPSS for analysis. Frequency distributions for all variables were conducted, and cross-tabulations among specific variables were run to determine potential relationships. Some manual manipulation of the data was also necessary due to the architecture of the WebSurveyor data files; this was kept to a minimum to ensure the accuracy of the presented data. Tests of significance were not conducted, as it was felt by some reviewers that this would move the report away from practical interpretation to more academic reporting potentially reducing its relevance and use by some readers. All relevant results are reported here in order to provide complete information, given that the BRTF requested information on certain questions and response categories. The only exception relates to two questions specifically requested by AUPHA regarding alumni activities; these results will be reported directly to AUPHA.

Limitations and Assumptions

As with any survey, there are some limitations and assumptions that must be considered when interpreting the findings. These include the following:

- The short time frame for completion of this project may have compromised the ability to get more responses from a larger population. Initially NCHL wanted this project completed within 3 months, which the survey team felt was impossible for reasonable results. The six month period (including reporting) provided more time for follow-up; ideally there would have been further follow-up to potential respondents to further increase the response rates. However, an initial contact and two follow-ups at two to three week intervals is considered good practice in surveys such as this one. The survey team also did not wish to be intrusive in pursuing non-respondents.
- Resource limitations prevented other kinds of follow-up through direct contact, and/or use of other modalities to seek responses. The study team was limited in the time they could devote to the study given the resources available to support them, and the project reviewers (both BRTF and NCHL Research Council members) were also limited in their ability to respond to drafts of instruments and reports.
- No advance notice was provided to potential respondents. The survey literature documents that a "cold call" with no advance notice will result in lower response rates than when individuals are contacted initially and have an opportunity to consider survey participation before being faced with an actual response deadline. However, the resource limitations identified above precluded the time allocation necessary for this advance contact. This may have affected response rates, in particular with groups such as the employers who did not have a direct affiliation and/or motivation to respond.
- Some potential respondents were identified by groups that may suggest bias in the selection: program directors selected students/alumni to respond; ACEHSA corporate sponsors selected a leadership group from their respective organization to respond; NCHL provided names of key individuals involved in NCHL activities. In each case, the survey team trusted that these lists were provided to represent multiple interests of the relevant group, and hoped that the individuals responding on behalf of these groups did not provide a biased list. Policies of universities, as well as of the professional and trade organizations, prevented the survey team from having direct access to master lists of relevant populations from which to select a

sample. Even if such access had been possible, resource constraints would have compromised the study team's ability to select an unbiased representative sample, leading us to believe that key contact individuals could better select a sample for us.

- Respondents were assumed to have some knowledge of accreditation in health administration education or related programs. In some cases a lack of such knowledge was overcome by familiarity with the field and therefore the ability to respond to most of the questions. Individuals can always choose to not respond to a specific question or select a "do not know" or "not applicable" response. However, some individuals may have chosen to not respond due to a lack of knowledge. This is a concern primarily among the "employer" population group where there may be bias in sector representation by respondents. This cannot be determined, however, given the separation of respondent identity from their response.
- Exclusive administration of the survey via the Web with some populations will introduce bias by excluding potential respondents who do not have email or computer access. This was not a concern of the study team or the sponsoring organizations as all potential respondents were identified with email addresses, and there did not appear to be any significant gaps in sector representation. The primary group where this might have been an issue was the "employer" group given that some community-based providers may not have email; since this population was drawn heavily from the list developed by NHCL for its Web-based competency survey in 2002, the study team assumed a level of confidence with the comprehensiveness of representation of the list.

Study Findings

The findings are presented in five major sections below:

- Profile of respondents
- Benefits of accreditation
- Preparation of graduates
- Improvements in systems of accreditation
- Conclusions and recommendations

The final surveys are appended to this report, in a format modified from the Web-based delivery. Readers may refer directly to the surveys for the exact wording and format of questions, taking into account that the actual appearance and flow of the survey was designed for Web access.

Profile of Respondents

The overall response rates, including surveys sent and actual surveys reaching recipients, are provided in Table 1, below. Surveys bounced when the email address provided was a bad address; time did not permit going back to the source of the address to seek a correct address. In general, each group was well represented both in terms of the numbers of surveys sent and the response rates. It is not surprising that the employer group has the lowest response rate, but nonetheless a response of 28% on a "cold" call is generally considered satisfactory. There is a slight over-representation of students in the overall distribution of responses, but this has been controlled for in the analysis by investigating responses by individual category of respondent. Despite the limitations described above, the response rates for each group can be considered as adequate to good, and the results can be generalized to a larger population within the context of the limitations.

Table 1: Overall Response Rates

Category	Surveys Sent	Bounced Surveys	Successful Survey Delivery	Surveys Submitted	Response Within Category	Percent of Total Responses
Alumni	330	19	311	106	34%	20%
Students	337	11	326	181	56%	34%
Faculty	263	7	256	143	56%	27%
Employers	393	23	370	104	28%	19%
Total	1323	60	1263	534	42%	100%

Within the faculty group, there were only 10 responses from undergraduate program representatives (out of a potential respondent population of 37). This small number precludes reporting unique data on their responses, as it cannot be considered representative of the population of undergraduate programs nor is it of sufficient size for detailed analysis. Where feasible (i.e. the questions are identical and permit aggregating the data), this group's responses have been included in the overall faculty responses. No specific data on undergraduate programs is therefore reported here.

Sixty percent (N=88) of faculty respondents were currently employed in public universities; the remainder (N=53) are employed in private universities. Half (N=54) of the employer respondents were employed in hospitals/health systems. Another 30% (N=32) of employers were currently employed in either associations, consulting or supplier companies.

The descriptive information collected about the respondents related to their careers in health management; no other socio-economic-demographic data was determined to be relevant to the scope of this study. While historically students would not have been asked questions about careers, trends identified by AUPHA and other groups have demonstrated that the current student population in many programs has an increasing number of graduate students who have worked in health care prior to entering a graduate program, and may continue to work while enrolled. Therefore, students are included in this survey's career information (60 students indicated they were currently working in a health care management position). Table 2 shows the years of experience of respondents. As one would expect, students have the least experience in the field, followed by alumni, and then faculty and employers.

Table 2: Years of Experience in Health Management

Years of Experience	Alumni		Students		Faculty		Employers		Total	
	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent
Less than 2 years	27	25%	28	47%	1	1%	1	1%	57	14%
Between 2 - 5 years	23	22%	17	28%	9	6%	3	3%	52	13%
Between 6 - 10 years	40	38%	9	15%	31	22%	6	6%	86	21%
Between 11 - 15 years	7	7%	2	1%	25	18%	16	15%	50	12%
More than 15 years	9	8%	4	7%	74	53%	78	75%	165	40%
Total	106	100%	60	100%	140	100%	104	100%	410	100%

All of the faculty respondents indicated they hold at least one graduate degree; nearly half of the faculty include a masters degree in health management/administration as one of their advanced degrees. Nearly all (93%, N=97) of the employer group indicated that they hold a graduate degree; 67% (N=70) hold a masters degree in health management/administration. Table 3 presents summary data on the year respondents received a graduate degree in health management; students are not included as they have not yet graduated.

Table 3: Year Graduate Health Management Degree Received

Year Degree Received	Alumni		Faculty		Employers		Total	
	N	Percent	N	Percent	N	Percent	N	Percent
Before 1960			2	3%			2	1%
1960-1969			11	16%	7	10%	18	7%
1970-1979			24	35%	29	41%	53	22%
1980-1989	1	1%	19	28%	18	26%	38	16%
1990-1994	5	5%	9	13%	12	17%	26	11%
1995-1999	41	39%	3	4%	3	4%	47	19%
2000-2003	59	56%			1	1%	60	25%
Total	106	100%	68	100%	70	100%	244	100%

Employers were asked if they were familiar with the activities of any of the educational accrediting organizations that might accredit graduate programs in health management. Seventy percent (N=75) indicated some familiarity; three quarters (N=75) were familiar with ACEHSA, with only approximately 10% familiar with each of AACSB (N=14) and CEPH (N=11) and only 3% (N=3) familiar with NASPAA.

Finally, faculty and employers were asked which accrediting agency was responsible for accrediting their graduate program at the time they graduated (alumni were all from ACEHSA-accredited programs, so were not asked this question). The responses, presented in Table 4, show a majority of each population group graduated from ACEHSA-accredited programs, with 16% of faculty also receiving their masters degree from programs accredited by the business school accreditor. Some faculty respondents indicated that their program was accredited at the time of graduation by ACEHSA and another accreditor, thus a single response could be counted twice in this table.

Table 4: Accreditor of Graduate Program at Time of Graduation

ACCREDITOR	Faculty		Employers		Total	
	N	Percent	N	Percent	N	Percent
ACEHSA	42	70%	47	76%	89	73%

AACSB	9	15%	2	3%	11	9%
CEPH	2	3%	3	5%	5	4%
NASPAA	2	3%	0	0%	2	1%
Other	5	8%	10	16%	15	12%
Total	60	100%	62	100%	122	100%

Benefits of Accreditation

The first research question was: What is the value-added/benefit of accreditation/certification? A series of questions regarding functions, benefits and effectiveness of accreditation was developed. The BRTF agreed that there was little benefit in asking these questions of students and alumni other than in the context of their personal satisfaction with the accreditation process and its implications for their own careers (see discussion of satisfaction, below). Specific questions regarding functions were asked only of faculty; other questions related to benefits were also asked of employers.

The 135 faculty respondents in the tables that follow are those faculty identifying themselves as affiliated with programs currently accredited by ACEHSA or in candidacy status with ACEHSA (total N=74), or in programs currently accredited by AACSB (N=17), CEPH (N=27), or NASPAA (N=17). It should be noted that some of the faculty who are individual members of AUPHA also are affiliated with programs accredited by one of these agencies; this accounts for the potential discrepancy between the survey population numbers and the response numbers.

The responses in the tables that follow should be clearly understood as faculty perceptions of the accrediting agencies, not the actual position or stated intent of the agency itself. The results are not intended as judgments of the quality or performance of any of the accrediting agencies, nor are they intended as the basis for comparing the performance of ACEHSA to any of these other accrediting agencies. Rather the focus is to provide some reflection from stakeholders who believe they are familiar with the work of the accrediting agencies, and may use this information and/or make statements/judgments about the educational preparation of graduates based on their personal knowledge. The results are not intended as a basis from which to draw comparisons between ACEHSA-accredited and non-ACEHSA accredited programs, nor was there any intent to attempt to understand why some programs do not seek ACEHSA accreditation. These perspectives are all outside the scope of the present survey.

There are a number of functions that accrediting agencies may fulfill, as described in the literature and in policy statements and other official documents of the accrediting agencies and associations. Faculty were asked to indicate their agreement with a series of statements regarding the functions of any health management education program accreditation. These are further broken down in Table 5, below, by the nature of program accreditation of the health administration or other management education program with which the faculty respondents were affiliated. The specific responses are listed in rank order of total responses. This table demonstrates that there is overall agreement on the primary functions of accreditation, with the emphasis on raising standards, continuous improvement, minimum competency, and distinguishing top quality programs. It should also be noted that the last three statements listed in Table 5, which were ranked lowest by all respondents, reflect a somewhat negative yet nonetheless evident perspective on accreditation -- one that is contrary to those receiving the highest numbers of responses.

Table 5: Functions of Accrediting Agencies -- Agreement Responses

FUNCTIONS:	ACEHSA (N=74)		AACSB (N=17)		CEPH (N=27)		NASPAA (N=17)		TOTAL (N=135)	
	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent
Raise the standards of performance for programs	72	97%	17	100%	26	96%	16	94%	131	92%
Put more emphasis on continuous improvement	67	91%	17	100%	27	100%	13	76%	124	87%
Put more emphasis on assuring that graduates meet at least a minimum level of competency in core areas	57	77%	16	94%	18	67%	16	94%	107	75%
Help prospective students to distinguish the top quality educational programs from others	55	74%	14	82%	19	70%	14	82%	102	71%
Make the process more cost-effective	51	69%	12	71%	17	63%	10	59%	90	63%
Minimize the paperwork involved	47	64%	10	59%	17	63%	9	53%	83	58%
Allow greater flexibility in applying criteria to specific programs	42	57%	13	76%	16	59%	10	59%	81	57%
De-emphasize the "inspection" format of accreditation	46	62%	11	65%	14	52%	9	53%	80	56%
Be paperless	31	42%	8	47%	11	41%	5	29%	55	38%
Allow less flexibility in applying criteria	26	35%	4	24%	10	37%	5	29%	45	31%
Define lower thresholds for the standards	14	19%	2	12%	4	15%	2	12%	22	15%
Lower the standards of performance	3	4%	0	0%	2	7%	0	0%	5	3%

Faculty were asked to indicate their agreement with a series of statements that comprise the Association of Specialized and Professional Accreditors (ASPA) "Code of Good Practice." These statements, in Table 6, are again presented according to the nature of program accreditation of the health administration or other management education program with which the faculty respondents were affiliated. There is some variation in rank order among the program groups recognized by the four different accrediting agencies; more extensive data collection (beyond this survey's scope) would be necessary to truly understand this variation. Of interest here, in particular, are the rankings for ACEHSA and the implications of these rankings for its work. Special notice could be given to the comparisons with AACSB (despite relatively small response numbers) given the frequency with which ACEHSA-accredited programs and their graduates are compared to AACSB programs/graduates by faculty and other stakeholders. Certain responses were given higher levels of agreement on some statements for AACSB programs, potentially meriting some further comparative investigation.

Table 6: Faculty Agreement with ASPA Code of Good Practice Components

	ACEHSA (N=74)		AACSB (N=17)		CEPH (N=27)		NASPAA (N=17)		TOTAL (N=135)	
	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent
ACCREDITATION:										
Provides a trustworthy external review of educational programs	66	89%	15	88%	25	93%	14	82%	120	84%
Promotes integrity and professionalism among educators	59	80%	12	71%	21	78%	11	65%	103	72%
Focuses reviews on knowledge and competence	51	69%	14	82%	20	74%	12	71%	97	68%
Respects and protects institutional autonomy	53	72%	14	82%	16	59%	10	59%	93	65%
Maintains a broad perspective as the basis for wise decision-making	51	69%	13	76%	17	63%	9	53%	90	63%
Ensures expertise is applied in all of its work	49	66%	12	71%	18	67%	11	65%	90	63%
Maximizes effectiveness in the educational program	39	53%	9	53%	11	41%	10	59%	69	48%
Total	74		17		27		17		143	

Faculty and employers were asked to indicate their level of agreement with a list of generally accepted benefits of accreditation at both the institutional and programmatic levels. Table 7 presents the results of all answers of either "strongly agree" or "agree".

Table 7: Benefits of Accreditation—Faculty/Employer Agree Responses

	Employers (N=103)		Faculty (N=143)		Total (N=246)	
	N	Percent	N	Percent	N	Percent
BENEFITS OF ACCREDITATION						
Advances/enhances the profession	92	89%	126	88%	218	89%
Supports individual credentialing/ recognition	74	72%	98	69%	172	70%
Affords opportunities for educational funding	62	60%	98	69%	160	65%
Supports access to the profession	72	70%	85	59%	157	64%
Facilitates professional mobility	69	67%	81	57%	150	61%
Provides consumer protection	43	42%	80	56%	123	50%

As can be seen in Table 7, in general there is a high level of agreement among both employers and faculty with respect to accreditation advancing/enhancing the profession, and relatively high agreement with the benefit of supporting individual recognition and/or credentialing. Employers give a much higher ranking to supporting access to the profession than do faculty (70% vs. 59%), and to facilitating professional mobility (employers 67% vs. faculty 57%). Faculty give a higher ranking to affording opportunities for educational funding than do employers (69% vs. 60%). Faculty indicate a higher level of agreement with providing consumer protection (56% vs. 42%),

although neither of these responses is as high as might be expected given that one of the stated functions and purposes of accreditation is protection of the public.

The faculty responses can be further analyzed by sub-categorization by the accrediting agencies as shown in Table 8 below. Some interesting variations in responses and overall levels of agreement appear across the four different accrediting agencies, but it is not possible to draw specific conclusions based upon the small overall responses for the three agencies other than ACEHSA, and without further information as a basis for interpretation and explanation (which is not available as intended through this survey). This information is presented for the interest and information of the reader, but substantial conclusions about perceptions of the other three accrediting agencies cannot be gathered.

Table 8: Benefits of Accreditation by Accrediting Agency–Agree Responses of Faculty

	ACEHSA (N=74)		AACSB (N=17)		CEPH (N=27)		NASPAA (N=17)		TOTAL (N=135)	
	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent
BENEFITS OF ACCREDITATION:										
Advances/enhances the profession	67	91%	15	88%	24	89%	16	94%	122	90%
Affords opportunities for educational funding	51	69%	13	77%	17	63%	11	65%	92	68%
Supports individual credentialing/recognition	49	66%	14	82%	14	52%	13	77%	90	67%
Supports access to the profession	47	64%	13	77%	12	44%	11	65%	83	50%
Provides consumer protection	45	61%	11	65%	16	59%	11	65%	83	50%
Facilitates professional mobility	42	57%	9	53%	14	52%	10	59%	75	14%

Many stakeholders of accreditation claim that there are specific benefits of educational accreditation at the programmatic level. Faculty were asked to respond to each of these benefits on a five point scale of agreement. These responses (agree/strongly agree) are presented by nature of program accreditation in Table 9. The benefits receiving consistently highest levels of agreement include status, recognition, student recruitment, and quality/performance improvement. Two areas of interest that reflect changes in the field are the benefits of access to federal funding (historically very important for ACEHSA programs) and professional advancement of graduates (a benefit of ACEHSA accreditation advocated over the years by some of the ACEHSA corporate sponsors). Some members of the BRTF were interested in the perception of a benefit related to advancing the national research agenda for the discipline; this statement consistently received the lowest levels of agreement and suggests that this is not an appropriate role for accreditation.

Table 9: Faculty Agreement with Benefits of Accreditation by Accrediting Agency

BENEFITS OF ACCREDITATION	ACEHSA (N=74)		AACSB (N=17)		CEPH (N=27)		NASPAA (N=17)		TOTAL (N=135)	
	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent
Status within the field of health administration education	70	95%	16	94%	22	81%	15	88%	123	86%
Recognition from the field	67	91%	14	82%	24	89%	16	94%	121	85%
Student recruitment	65	88%	14	82%	24	89%	16	94%	119	83%
Program marketing	64	86%	12	71%	24	89%	16	94%	116	81%
Confirm program quality to stakeholders	65	88%	15	88%	21	78%	13	76%	114	80%
Opportunity to respond to established standards	61	82%	15	88%	22	81%	13	76%	111	78%
Identify and develop processes for continuous performance improvement	58	78%	15	88%	21	78%	15	88%	109	76%
Self-evaluation	59	80%	12	71%	23	85%	12	71%	106	74%
Mechanism for performance measurement	58	78%	13	76%	22	81%	12	71%	105	73%
Recognition by the university	56	76%	11	65%	20	74%	17	100%	104	73%
Focus attention of faculty and staff on goals and objectives	56	76%	12	71%	21	78%	12	71%	101	71%
Collegial exchange	57	77%	14	82%	19	70%	11	65%	101	71%
Develop a focus on mission and customer expectation	49	66%	10	59%	18	67%	12	71%	89	62%
Access to federal funding	51	69%	10	59%	11	41%	11	65%	83	58%
Engage administration in planning	43	58%	11	65%	16	59%	10	59%	80	56%
Professional advancement of graduates	39	53%	9	53%	15	56%	12	71%	75	52%
Advance the national research agenda in the discipline	25	34%	7	41%	9	33%	5	29%	46	32%

Faculty were also asked to assess the effectiveness of the accreditation process in accomplishing a number of potential outcomes. The responses, shown in Table 10, illustrate an emphasis on outcomes related to program planning, assessment and improvement. Much less emphasis is given to issues related to resource allocation, stimulation of research, and promotion of service and outreach. In some areas of accreditation, a major emphasis is on learning -- improving the quality of student learning and attending to assessment of that learning. These both appear relatively low in the overall list of effectiveness in achieving outcomes; given the increasing emphasis from the U.S. Department of Education and others on assessment, this might be one area meriting further attention by the participating educators.

Table 10: Faculty Agreement with Effectiveness of Programmatic Accreditation

	ACEHSA (N=74)		AACSB (N=17)		CEPH (N=27)		NASPAA (N=17)		TOTAL (N=135)	
	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent
EFFECTIVE IN:										
Stimulating program review	70	95%	15	88%	27	100%	15	88%	127	89%
Clarifying program mission and goals	64	86%	17	100%	23	85%	15	88%	119	83%
Fostering ongoing planning	61	82%	14	82%	22	81%	14	82%	111	78%
Improving the educational program	58	78%	13	76%	22	81%	14	82%	107	75%
Improving education overall	60	81%	13	76%	18	67%	15	88%	106	74%
Evaluating program effectiveness	60	81%	13	76%	20	74%	13	76%	106	74%
Considering issues of diversity	55	74%	10	59%	19	70%	11	65%	95	66%
Improving services to students	52	70%	10	59%	17	63%	13	76%	92	64%
Improving teaching	44	59%	12	71%	17	63%	11	65%	84	59%
Improving quality of faculty and staff	48	65%	13	76%	12	44%	9	53%	82	57%
Fostering community and stakeholder involvement in the program	46	62%	9	53%	12	44%	12	71%	79	55%
Improving administrative leadership	42	57%	9	53%	17	63%	11	65%	79	55%
Clarifying governance roles	40	54%	10	59%	15	56%	12	71%	77	54%
Improving learning	43	58%	12	71%	13	48%	8	47%	76	53%
Improving assessment of student learning	41	55%	12	71%	12	44%	10	59%	75	52%
Promoting service and outreach	36	49%	8	47%	8	30%	6	35%	58	41%
Stimulating research	29	39%	10	59%	6	22%	4	24%	49	34%
Improving resource allocation procedures	22	30%	7	41%	8	30%	9	53%	46	32%

Perceptions of the value and benefits of accreditation are also reflected in stakeholder satisfaction. Students and alumni were asked a series of identical questions regarding their knowledge of the accreditation of their health administration program and its potential impact on their learning and their careers. Approximately three quarters of both students and alumni knew their program was accredited at the time they applied for admission. Both groups indicated that programmatic accreditation was an important factor in their decision to apply to that program, as shown in Table 11.

Table 11: Importance of Program Accreditation in Decision to Apply

IMPORTANCE	Alumni		Students		Total	
	N	Percent	N	Percent	N	Percent
Very important	59	77%	110	83%	169	80%
Somewhat important	17	22%	17	13%	34	16%
Not important	1	1%	6	5%	7	3%
Total	77	100%	133	100%	210	100%

In order to further investigate the importance of accreditation, students and alumni were asked the likelihood that they would have transferred to another accredited program if their program had lost its accreditation while they were a student. Although this is a hypothetical situation and it is impossible to judge what would really happen in such a situation, approximately 60% (N=172) of alumni and student respondents indicated "very likely" or "somewhat likely", reinforcing that accreditation was an important factor in their choice of program. Of those who said they would have transferred, approximately half (N=92) of all alumni and students responding said they would have transferred anywhere to ensure graduation from an accredited program. Forty-four percent (N=47) of students said they would only have transferred if the program was located at the same university, while 40% (N=25) of alumni said they would have transferred only if the program were in the same city.

Over 90% (N=167) of students felt that accreditation had an impact (ranked "significant" or "some") on the quality of the education they received. Eight-five percent (N=90) of alumni indicated the same responses. Two-thirds (N=66) of alumni felt that their program's accreditation helped them when searching for internships or field experiences; the remaining one third (N=39) said it did not make a difference. Of those students who have searched for internships or field experiences, 56% (N=72) indicated that the program's accreditation was helpful, while the remainder indicated it was not helpful or did not make a difference. Alumni were also asked about the contribution of their program's accreditation status in the success of their job search upon completion of their academic program. Fifty-six percent (N=60) indicated that it was either somewhat or very helpful.

All respondents were asked how their career has been influenced (or, in the case of students, will be) by being a graduate of an accredited program. Responses were sorted to ensure only those who had indicated that they had graduated from an accredited health administration program were included. Responses are shown in Table 12. As shown in Table 12, approximately 70% of the respondents indicated that their educational preparation was recognized by employers; while over three-quarters of students said "yes" to this influence, which may be suspected to have skewed the overall responses, within each group the "yes" response was given by over half of the respondents. Students also anticipate that they will be able to take advantage of the alumni network, yet the responses from alumni, faculty and employers do not indicate nearly as high a level of influence for this category. There is some support for accreditation having influence in obtaining positions and in career advancement, but it is clear that students have much higher expectations for the potential influence of program accreditation than the actual experience of alumni in particular as reported here.

Table 12: Influence of Program Accreditation on Career

Influence	Alumni (N=106)		Students (N=181)		Faculty (N=47)		Employers (N=62)		Total (N=396)	
	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent
My educational preparation was recognized by employers	63	59%	142	79%	25	53%	43	69%	273	69%
Able to take advantage of the alumni network	20	19%	102	56%	13	27%	22	36%	157	40%
It helped me get positions	28	26%	73	40%	20	43%	22	36%	143	36%
It helped me in career advancement	24	23%	74	41%	16	34%	26	42%	140	36%

Preparation of Graduates

The second research question asked: Is the "product" (i.e. the graduate) prepared and competent for the work environment? Some of the questions asked with respect to this research question focused on employer and faculty responses regarding employment preferences. Another important component of answering this research question addressed the NCHL draft competencies for health administrators, and perceptions of level of competency.

The culture of health management and policy education and practice has long suggested that health industry employers have specific preferences when they hire new employees. Employers were asked what their preferences are; faculty were asked their perceptions of employers in their local area. Eighty-three percent (N=86) of employers indicated that they have a preference for the kind of educational program the potential employee has completed or the degree held; 72% (N=97) of faculty indicated they believed employers in their area have preferences in hiring graduates. Fifty-six percent (N=58) of employers indicated they have a preference for hiring graduates of an accredited program. Table 13 shows the responses to this question for hiring to fill an entry-level management position. When hiring for executive-level positions, employers indicated that their preference is likely to be experience (53%), followed by a combination of experience and program of study (31%).

Table 13: Preference for Degree for Entry-Level Management Positions

DEGREE PREFERENCE	Employer Responses		Faculty Responses	
	N	Percent	N	Percent
Health administration	76	74.0	73	51.0
Business	44	42.3	62	43.8
Public health	15	14.4	21	14.7
Clinical health professions	18	17.3	7	4.9.0

Public administration	6	5.8	7	4.9
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This preference information is further detailed in Table 14, indicating the preference for graduates of specific universities or programs. Again, employers indicated their own preference while faculty offered their perceptions of the preferences of local employers. Thirty-nine percent (N=40) of employers indicated a preference; 58% (N=80) of faculty indicated that employers appear to have a preference for a specific university/program. Employers are concerned about the degree and the institution from which the potential employee received that degree; faculty perceive that employers hire based on traditions of hiring practice and alumni affiliation. There may be some specific local traditions that are not revealed through a national respondent group of employers. However, this difference between articulation of preference and perceptions of practice potentially merits further attention and discussion between employers and faculty.

Table 14: Basis of Preference for Degree for Entry-Level Management

BASIS OF PREFERENCE	Employers (N=40)		Faculty (N=80)	
	N	Percent	N	Percent
Concerned about degree and institution	30	28.8	45	31.5
Alumni of that university	21	20.2	57	39.9
Pay attention to rankings	20	19.2	29	20.3
Tradition of hiring from certain universities	7	6.7	64	44.8
Loyalty to local university	7	6.7	40	28.8

Finally, employers were asked to indicate any preference for certain positions and for certain kinds of organizations by nature of degree obtained. Over 80% (N=86) of employers indicated some clear preferences for certain degrees for various kinds of expertise. In terms of expertise, employers indicated the following degree preferences:

- Health administration degree for positions requiring expertise in: general administration (36%), planning (34%), policy development (32%), performance improvement (27%)
- Business degree for positions requiring expertise in: financial management (86%), information management (35%), human resources (29%), general administration (26%) planning (24%)
- Clinical health professions degree for positions requiring expertise in: clinical management (61%)

No clear preferences were indicated for specific kinds of expertise for potential employees with degrees in public health or public administration; this likely reflects the population sample and might have produced a different result if more employers working in the government positions at local, state and/or federal levels had been a larger part of the employer population sampled. Similarly, no clear preferences by degree were indicated for individuals with expertise in evaluation and research, and again likely reflects some bias in the study population.

In terms of settings, employers expressed preferences by degree as follows:

- Health administration degree for positions in settings of: hospitals/health systems (54%), ambulatory clinics (48%)

- Business degree for positions in settings of: insurance (55%), consulting (55%)

No clear preferences were indicated by setting for graduates with degrees in public health, public administration or clinical health professions, nor for any of the other settings offered (government, long-term care, mental health, foundations, associations, community-based health organizations, research organizations). Again, this likely is reflective of some bias in the distribution of employer respondents across settings.

This data is a general snapshot and would need further understanding of the nature of the employing organization (not available here) to draw any substantive conclusions. What is useful, however, is to consider the preferences that are expressed (as compared to focusing on those that are not expressed), and to make use of this information in preparing graduates of health administration programs to be attractive in the marketplace for hiring for various sectors and various kinds of expertise.

A primary area of interest for NCHL in this survey of stakeholder satisfaction was to gain information on perceptions of achievement of the six competencies for health management developed by NCHL. The version of the NCHL competencies used was the current draft that was publicly available from the NCHL website in January 2003. The wording of the overall competencies was used; space did not permit detailed description of the content of each competency or the sub-points that have been developed by the NCHL competency group. Respondents were asked to respond to this wording alone, and were not asked to comment on the relevance of the competencies or on any other missing areas of competency (this is outside the scope of this present survey, and is work underway through another NCHL project).

In the case of students, they were asked "How prepared are you for each of these competencies" and responded on a scale of "highly prepared, somewhat prepared, not well prepared, unable to judge." Alumni were asked "When you completed your health management education program, how prepared were you for each of these competencies?" Employers were asked "In general, how prepared are graduates of accredited programs in health management for each of these competencies?" Alumni and employers responded using the same scale as that provided for students. Employers were also asked if they observed any differences in the level of competency among various graduates. Twenty-eight percent (N=29) indicated that graduates of accredited programs are generally more competent; however half of the employers (N=54) indicated they were unable to judge and one-fifth (N=21) indicated there was no difference.

Faculty were asked to assess the preparation of graduates of accredited health management programs in general, and then to assess the graduates of their own program (using the same scale described above); they consistently ranked their own graduates as being more highly prepared in each area than graduates in general. The data presented below are the responses faculty gave for their own graduates that are assumed to have a higher level of accuracy than generalized assumptions about all graduates.

Table 15 presents the responses for each group and overall for those responding "highly prepared." Students and alumni rank themselves more highly prepared than the assessments faculty or employers make of the students/alumni. There is also considerable variation in the extent of "highly prepared" responses for each of the six core competencies. This suggests the opportunity for further investigation to ensure that academic programs of study are, in fact,

preparing the graduate for these competencies. It also suggests the need for development of some sort of self-assessment tool that students and faculty can use while students are enrolled in a program, and that could then be adapted for use in a performance assessment mechanism in employment settings.

Table 15: NCHL Draft Core Competencies -- Highly Prepared Responses

COMPETENCY	Alumni (N=106)		Students (N=181)		Faculty (N=143)		Employers (N=104)		Total (N=534)	
	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent
Learning and performance improvement	64	60%	122	67%	59	41%	19	18%	264	49%
Professionalism	86	81%	143	79%	65	46%	32	31%	326	61%
Personal and community health systems	51	48%	82	45%	67	47%	15	14%	215	40%
Leadership	68	64%	115	64%	52	36%	10	10%	245	46%
Collaboration and communication	83	78%	141	78%	73	51%	20	19%	317	59%
Management practice	47	44%	78	43%	81	57%	16	15%	222	42% %

These responses can also be considered in terms of the overall rankings. Faculty ranked graduates highest on the competency of management practice, and lowest on leadership. Employers ranked graduates highest on professionalism, and lowest on leadership. Alumni and students ranked themselves highest on professionalism, and lowest on management practice. This suggests a need for attention to the competency of management practice in particular given the completely opposite responses of faculty as compared to alumni/students, but also attention to the other competencies and potential gaps between what faculty perceive as relevant learning and skill development experiences and what students/alumni are actually called upon to do and know in the workplace.

Improvements in Systems of Accreditation

The third research question was: How could systems of accreditation/certification of health management and policy educational programs be improved to better serve the needs of stakeholders?

To answer this question in part, faculty were asked to indicate their agreement with a series of statements illustrating the role of accreditation as a mechanism to shape higher education trends and practices. As stated earlier, these results should not be interpreted as reflections of official policy of any of the accrediting organizations, but should be considered as faculty perceptions of the work of these organizations. It should also be remembered that the different accrediting organizations face somewhat different challenges and respond to different market issues as a result of their missions and purposes, and these may affect the ways in which they operate or are perceived to conduct their work.

Table 16 presents the responses indicating "agree" or "strongly agree", by each of the accrediting agencies as well as total. There is consensus on the role of accreditation as a mechanism to assure quality and accountability, promote program improvement, and identify important issues. In the case of ACEHSA and CEPH, there is a stronger level of agreement in terms of the contribution that programmatic accreditation makes (as compared to institutional); the responses

are lower for both AACSB and NASPAA. AACSB programs indicate a much higher level of agreement with respect to "certifies that programs are meeting their educational objectives" and "encourages the use of outcomes assessment to improve learning and teaching processes." These are areas where ACEHSA may wish to give some additional thought in order to raise these perceptions among ACEHSA-accredited programs (again, reflecting U.S. Department of Education standards, as well as higher education practice in general).

Table 16: Shaping Higher Education -- Faculty Agreement Responses

	ACEHSA (N=74)		AACSB (N=17)		CEPH (N=27)		NASPAA (N=17)		Total (N=135)	
	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent
ACCREDITATION:										
Assures that a program is meeting minimum standards of educational quality	61	82%	15	88%	21	78%	15	88%	112	83%
Identifies important issues programs need to address	58	78%	15	88%	19	70%	14	82%	106	79%
Stimulates program improvement	58	78%	13	76%	20	74%	14	82%	105	78%
Helps program meet accountability requirements	56	76%	14	82%	20	74%	13	76%	103	76%
Contributes to the programs in ways that institutional accreditation cannot	55	74%	9	53%	19	70%	10	59%	93	69%
Inspires public confidence in programs	49	66%	13	76%	18	67%	12	71%	92	68%
Certifies that programs are meeting their educational objectives	50	68%	14	82%	16	59%	11	65%	91	67%
Encourages the use of outcomes assessment to improve learning and teaching processes	45	61%	14	82%	14	52%	13	76%	86	64%
Develops a broad consensus on standards of good practice in higher education	42	57%	10	59%	17	63%	11	65%	80	59%
Encourages stability in the operation of certified programs	47	64%	7	41%	15	56%	8	47%	77	57%
Helps programs meet constituents' needs (public, students, employers, etc.)	39	53%	12	71%	13	48%	8	47%	72	53%
Promotes academic excellence	37	50%	10	59%	14	52%	9	53%	70	52%
Promotes articulation and coordination among accredited programs	26	35%	10	59%	9	33%	9	53%	54	40%
Encourages innovation among accredited programs	16	22%	5	29%	5	19%	4	24%	30	22%

A number of trends in higher education were identified in the course of survey development. Faculty and employers were asked to rate the level of influence they think each of these trends in higher education will have on the future directions of accreditation of health administration education programs (major/potential/unlikely future influence). Table 17 presents the "major influence" responses for faculty, employers and overall, with number of responses and an overall ranking. Employers rank the influence on accreditation of the expanding use of the

Internet/computer technology and increasing demands for accountability highest, whereas faculty rank the influence of dwindling financial resources highest, followed by the same two as indicated by employers. Faculty see accreditation as being influenced more by increasing competition for students, whereas employers ranked the influence of attention to the quality of teaching and learning on accreditation higher. Changing methods of paying for higher education and the increase in numbers of accredited programs in a geographic region were both ranked as having the least influence on accreditation.

Table 17: Higher Education Trends -- Major Influence Responses

Trends in Higher Education	Faculty Responses	Faculty Ranking	Employer Responses	Employer Ranking	Total Responses	Total Ranking
Expanding use of the Internet and computers for instruction	71	2	60	1	131	1
Increasing demands for accountability to various publics	70	3	58	2	128	2
Dwindling financial resources for higher education	75	1	51	4	126	3
Changing demands for	66	4	50	5	116	4
Expanding use	61	5	51	3	112	5
Increasing collaborations between higher education and the health industry	55	7	41	7	96	6
Increasing	57	6	37	10	94	7
Increasing attention to quality of teaching and learning	45	10	43	6	88	8
Expanding requirements for standard performance indicators	46	9	36	11	82	9
Changing workplace and	42	11	37	9	79	10

needs for retraining						
Changing student demographics (adult, part-time, minority, etc.)	53	8	26	12	79	11
Changes in health services delivery and reimbursement	37	12	40	8	77	12
Changing methods of paying for higher education	26	13	25	13	51	13
Increasing number of accredited programs in geographic region	22	14	16	14	38	14

When this data is further analyzed by accrediting agency, some interesting variations appear among the different accreditors (see Table 18). ACEHSA-accredited programs are perceived to emphasize the influence of dwindling financial resources and increasing demands for accountability; AACSB and CEPH accredited programs both are perceived to emphasize the influence of changing demands for preparation for health services administrators. While the NASPAA-accredited programs also are perceived to rank the influence of dwindling financial resources as having the highest influence on accreditation, some of the other areas of influence rated as "major" by NASPAA-accredited programs are quite different than those for the other three accreditors. These perceptions of influence may merit further exploration in the context of the disciplinary contexts and institutional organization of programs offering degrees through business schools, public health, and public administration.

Table 18: Higher Education Trends -- Major Influence by Accreditor

	ACEHSA (N=74)		AACSB (N=17)		CEPH (N=27)		NASPAA (N=17)		TOTAL (N=135)	
	N	Rank	N	Rank	N	Rank	N	Rank	N	Rank
TRENDS IN HIGHER EDUCATION										
Dwindling financial resources for higher education	39	1	7	3	14	2	9	1	69	1
Changing demands for preparation for health services administrators	38	3	9	1	15	1	2	14	64	2

Expanding use of the Internet and computers for instruction	36	4	7	3	13	3	7	2	63	3
Increasing demands for accountability to various publics	39	1	6	6	13	3	3	10	61	4
Expanding use of distance learning	31	5	5	8	12	5	6	4	54	5
Increasing collaborations between higher education and the health industry	31	5	8	2	10	8	3	10	52	6
Increasing competition for students	31	5	4	12	10	8	5	6	50	7
Increasing attention to quality of teaching and learning	25	8	6	6	11	7	3	10	45	8
Changing student demographics (adult, part-time, minority, etc.)	21	10	5	8	12	5	6	4	44	9
Changing workplace and needs for retraining	23	9	7	3	10	8	3	10	43	10
Expanding requirements for standard performance indicators	20	11	5	8	10	8	7	2	42	11
Changes in health services delivery and reimbursement	20	11	5	8	3	13	4	7	32	12
Changing methods of paying for higher education	15	13	3	13	2	14	4	7	24	13
Increasing number of accredited programs in geographic region	11	14	3	13	4	12	4	7	22	14

Conclusions and Recommendations

The results of this survey demonstrate that accreditation of health administration programs is valued by all constituencies – faculty and program directors, students, alumni, employers, and other key stakeholder groups. There is a widespread perception of benefits to the field, with support across all constituencies. Accreditation is perceived to advance and enhance the profession of health administration, and is a mechanism that confirms program quality to multiple stakeholders. For the individual student or graduate of an accredited program, it gives recognition from the field at large, and supports individual access to the profession. It also is perceived to aid in student recruitment and in career progression over time. However, as has been demonstrated in other surveys by ACEHSA and other accreditors over the past few decades, the interpretation of the value of accreditation varies among different “publics” suggesting a need for more information and public education.

The survey results offer an endorsement of the benefits of programmatic accreditation. In particular, these benefits include stimulating routine and ongoing program review and improvement, clarifying program mission and goals, and fostering ongoing planning. There is also agreement with the core principles of the Association of Specialized and Professional Accreditors “Code of Good Practice” with particular reinforcement of the principles that accreditation offers a trustworthy external peer review, promotes integrity and professionalism,

and respects institutional autonomy. This latter point is particularly important for ACEHSA-accredited programs given the multiple academic and administrative units across university campuses where health administration programs may be located, and the multiple kinds of academic institutions that offer health administration programs.

The responses to the NCHL draft competencies suggest the need for continuing discussion to clarify both the areas of competency and the appropriate educational venues for gaining knowledge and skills for different areas of expertise and for different kinds of settings in the health care industry. The highest overall rankings on the competencies were for the areas of professionalism and collaboration/communication, and the lowest overall rankings were for the competency areas of personal and community health systems and for management practice.

This leads to a series of recommendations for future activities, which are framed in particular as actions that can be pursued by the key audiences of this report – ACEHSA, AUPHA, and NCHL.

It should be noted that these are the recommendations of the lead author alone, based upon analysis of the results of the survey, combined with two decades of experience in health management and policy education, accreditation, independent research on accreditation and performance improvement in higher education and health services delivery, and involvement in higher education policy. These recommendations have not been reviewed or ratified by any of the sponsoring organizations. However, it is hoped that they are relevant to the interests of these groups and might be considered and pursued.

RECOMMENDATIONS FOR ACEHSA

ACEHSA as the single agency recognized by the U.S. Department of Education to accredit graduate programs in health administration has a defined role, history and position from which it can respond to changes in the health care industry and in higher education, and work with key stakeholders to shape the educational preparation of health administrators for a wide range of settings and positions across the health care industry. ACEHSA has a long and successful history of doing this (as evidenced by continuing participation by programs in the accreditation process and by its continuous recognition by the U.S. Department of Education with no adverse decisions in USDE reviews), but as with any accrediting agency it is subject to considerable scrutiny from its stakeholders. Accrediting agencies can always do more to respond to these needs and concerns, and the results of this and similar studies of ACEHSA serve to reinforce the importance of its continued role and value. A response by ACEHSA to ensure its near-term activities adapt to changes in the health and education markets will require certain new investments to do this effectively:

- Dedicated leadership is required, who can act in a full-time capacity on behalf of educators, practitioners, and other consumers of health management and policy education but also with time and knowledge to participate actively in higher education and accreditation policy work in order to be aware of new opportunities and to position health administration education to respond quickly to new challenges. Over the past three decades every executive leader of ACEHSA has recognized the need for a greater time commitment in order to provide this leadership, but has always been constrained by resource availability.

- Commitment of new and enhanced resources is also necessary to conduct the regular work of the accreditation process through support of a sufficient number of staff who understand the nature and process of health management and policy education and can provide consultation to programs. As well, sufficient administrative staff are needed who can support the extensive logistics and be quickly responsive to questions and concerns from faculty in accredited programs, programs contemplating accreditation, potential students, employers and others seeking public information about accreditation status and meaning. ACEHSA staff are known (presently and historically) to be as responsive as they can be, but as with the executive leadership there is a tradition of ACEHSA being under-resourced in staff support.
- Continued and new commitment of resources is needed to adequately support the work of site visit teams, the Board of Commissioners, and the Board of Corporate Sponsors. This is where the bulk of investment of ACEHSA's resources has gone traditionally, and new investment could help the Boards, in particular, by support for time and activities to plan for new directions and initiatives.
- Active and enhanced collaboration with key stakeholder groups (both those currently represented on the Board of Corporate Sponsors and other relevant groups with complementary interests) will help to shape the future accreditation program, while maintaining the independence and integrity of ACEHSA in its policy development and application – a vital component of its recognition by USDE and other oversight bodies. ACEHSA historically brought these groups together for periodic conversations, and could position itself for future leadership by being a facilitator of such conversations.
- Initiation of new conversations with other accreditors who have overlapping interests (in particular, business, public health, and public administration, and to a lesser extent medicine, nursing and other health professions with interests in management) could help to determine ways to create synergies of efforts to further enhance curricula and educational preparation of students for management roles in all of these disciplines. This does not suggest a need to redefine official roles and scope of accreditation recognition, but rather to identify new opportunities for collaboration and cooperation, resulting in creative strategies at the campus level for individual programs as well as nationally among and between the accreditors (and their sister educational membership associations).

RECOMMENDATIONS FOR AUPHA

AUPHA has a long-standing tradition as an international membership organization of evolving to respond to current issues and trends, and of being expansive in its embrace of all constituencies providing education in health management and policy. It has the potential to be a major convener and facilitator for new developments -- as a membership association is able to do, and in a way that is not prescribed within the mandate of an accrediting organization, which can be a limiting factor for ACEHSA. Over the years AUPHA has been known and valued among its members for its leadership role in development of curricular materials that respond to new trends and support its members (and others who access these materials) to develop and implement new curricular content and teaching strategies. Given the results of this survey and related activities, this suggests the following:

- The perceived competency gaps should be further addressed through both future curriculum development activities and additional research to better understand the nature of the current curricula and the actual “outcomes” of graduate health administration education – i.e., the competencies demonstrated by new graduates. Given NCHL's investment in competency

development, this is clearly work that ideally should be conducted in partnership between AUPHA and NCHL – AUPHA representing the academics in particular, and NCHL offering a strong base of support from the field of practice.

- Attention to competency development also suggests the opportunity to use competency assessments in-process throughout educational programs and continuing on during career progression. Collaboration among AUPHA, NCHL and key national professional membership organizations (several of which serve as ACEHSA Corporate Sponsors and have demonstrated their commitment to health administration education) could result in development of an adaptable competency assessment that could be applied across the wide variety of educational programs and contexts within health administration, with applications for students upon program entry, throughout their program of study, as an exit assessment, and then for ongoing career development. Given the current increase in emphasis on “outcomes” and competencies across all disciplines in higher education (and in particular in new directions of the standards of the six regional/institutional accreditors), health administration educators would be well-advised to move forward quickly in this area, and could be in a leadership role in higher education as few other disciplines have developed models with this sort of breadth of application.
- To do this work on competency assessment will require new resources for targeted curriculum development to respond to the competencies – resources that AUPHA will need to support its own work, but that also may have most impact if developed through a collaborative effort with NCHL, ACEHSA and other interested stakeholders willing to participate. Recognizing the investment that NCHL has made in competency development, it appears logical that a partnership with NCHL to adapt its work and further develop the applications of the competency framework would be an effective strategy.
- An opportunity exists to build an integrated model with linkages among strategies for assessment of student learning, programmatic assessment and improvement, and faculty development to create and then assess such activities. AUPHA provided leadership on outcomes assessment and continuous improvement in the 1990's, and could now take new developments both within health administration and within other fields to further advance this work. In particular, there is a need and an opportunity to develop materials that will be useful and relevant for program directors and faculty members as they are called upon to develop detailed assessment strategies that reflect program organization and philosophy in order to respond to regional/institutional accreditation standards, let alone institutional commitments to assessment and the requirements of various other accrediting and certifying organizations.

RECOMMENDATIONS FOR NCHL

NCHL as a relatively new organization has the energy and creativity characteristic of new ventures, and brings together a wide range of employers and other health industry sector representatives, as well as selected academic representation. It has shown that it has the ability to obtain funding and to initiate projects, and could be well-positioned to provide leadership in the future development of health management and policy education through close collaboration with ACEHSA, AUPHA and other key stakeholders. In order to further the work of NCHL in

achieving its mission, and to support the work of organizations such as ACEHSA and AUPHA, the following are suggested:

- NCHL's "membership" base provides it with an excellent foundation from which to continue to promote and enhance dialogue among educators and practitioners. It offers the neutrality of a non-academic organization that may make it more acceptable to some practitioners, while it also has the academic connections to provide an entry point for such collaborative conversations. As NCHL continues to evolve and develop, it hopefully can ensure participation in such conversations from all sectors of practice in the health care industry and from all sectors of higher education to ensure that NCHL programs and products can be broadly relevant and useful.
- NCHL has already made a significant commitment to competency development (as referred to above), and therefore ideally will be a key player in future work on developing applications of the competencies for routine use by the health administration educational programs. A particularly valuable contribution for next steps in this work will be identifying how these competencies play out in different curricula in terms of program focus (for example, in a business program vs. a public health program), level of learner (undergraduate students vs. graduate students vs. working professionals returning to obtain a master degree), institutional mission and focus of the university (research institutions vs more teaching-intensive institutions), and health industry sector focus (such as health systems vs. mental health vs. long-term care).
- Assuming long-term resource stability, NCHL might even consider becoming a corporate sponsor of ACEHSA thus having a direct role in shaping the work of accreditation of health management and policy education (subject, of course, to the necessary application and approval processes by the Board of Corporate Sponsors).

Recommendation to All Stakeholders

The final recommendation is directed to all participants in accreditation and health management and policy education, and repeats recommendations made in several venues over the past 20 years – to rethink the accreditation framework and philosophy in terms of one that fosters a spirit of performance improvement. There is wide support for such a strategy, including the following:

- Performance improvement was the rationale underlying the 1990 substantive revision of the ACEHSA Criteria for Accreditation, at that time largely driven by the "Agenda for Change" of the Joint Commission on the Accreditation of Health Care Organizations.
- There is an increasing emphasis in higher education on assessment and evidence of learning outcomes, and such an approach lends itself to an accreditation strategy that emphasizes evidence of outcomes and improvements, and goes beyond a strategy of inspection and minimalist response to standards.
- The recent IOM reports on the future of health services delivery in the United States have implications for the preparation of health services managers across the industry; conversations about the "quality chasm" now need to move to development of specific strategies to prepare health management and policy students to address these issues.
- There is continuing relevance of the various Pew Health Professions Commission reports on the future educational preparation of health professionals, and in particular the recommendations of the Task Force on Accreditation of Health Professions Education which suggested core criteria for accreditation and new strategies for shifting accreditation to an improvement philosophy.

- Finally, the continuing stability and enhancement of the Baldrige National Quality Program performance improvement framework suggests new opportunities for health management and policy education to learn from this framework and begin to apply core components of it in the accreditation process. There are currently new demonstrations by some accreditors of how to apply it (in particular the Academic Quality Improvement Project of the Higher Learning Commission, North Central Commission of Colleges and Schools).

Each of these initiatives offers relevant content from which to enhance the work of ACEHSA; rather than repeat those recommendations here it is recommended that a new initiative be created to develop and implement such a framework with the emphasis on action and applicability to enhance health management and policy education and the practice of health administration.

Conclusion

This survey has demonstrated widespread support for accreditation as it applies to health management and policy education. A number of issues for future study are identified, and suggest the opportunity and need for a collaborative approach among key stakeholders. There are multiple interest groups who have a stake in the educational preparation of individuals for careers in health management and policy, and these survey results provide a perspective on their interests and impressions. While the focus of this survey was not intended to be a performance review of ACEHSA, the results do reinforce the perception of the value of ACEHSA to the field and provide a basis for continued enhancement of the activities and scope of ACEHSA. Through collaboration among concerned organizations such as ACEHSA, AUPHA, NCHL, and the corporate sponsors of ACEHSA, clear opportunities exist to continue to improve the closely intertwined functions of educational program delivery, program assessment and improvement, and individual professional development in order to ensure stakeholder satisfaction with graduates of health management and policy educational programs.

APPENDIX E

ACEHSA INTERIM PROGRESS REPORT TO THE DEPARTMENT OF EDUCATION AND ACCREDITATION PHILOSOPHY EMBODIED IN PROPOSED CRITERIA FOR ACCREDITATION CHANGES

Accrediting Commission on Education for Health Services Administration. *Interim Progress Report to the Department of Education* (June 2003).

ACEHSA

ACCREDITING COMMISSION ON EDUCATION FOR HEALTH SERVICES ADMINISTRATION Founded 1968

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INTERIM PROGRESS REPORT TO THE DEPARTMENT OF EDUCATION

In June of 2002, the National Advisory Committee on Institutional Quality and Integrity recommended that The Accrediting Commission on Education for Health Services Administration (ACEHSA) be granted continued recognition for a period of five years. This recommendation was approved by the Secretary in October.

The Advisory Committee further recommended that the Commission submit an interim report demonstrating full compliance with the Criteria for Recognition.

The Committee noted two areas that were to be addressed in the Interim Report, they were as follows:

1. The agency needs to adopt a written policy that enables the agency to initiate adverse action as circumstances warrant. [§602.20]
2. The agency needs to revise its policies to incorporate all of the requirements of section 602.21. The agency also needs to document and report on the results of a full review of its criteria (individually and as a whole) for their adequacy as measures of quality prior to proposing changes and seeking input regarding those changes. [§602.21]

The following is the Interim Report of The Accrediting Commission on Education for Health Services Administration.

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1. The agency needs to adopt a written policy that enables the agency to initiate adverse action as circumstances warrant. [§602.20]
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At the November 2002 meeting of the Commission the following policy was adopted:

Article 18. Policy Statement: Adverse Action and Withdrawal from Accreditation

Section 1. Initiation of Adverse Action

When the Commission determines that a program fails to comply with the standards of quality outlined in the Criteria and that identified deficiencies have not been satisfactorily addressed in the allowed time frame, initial accreditation may be denied, or the existing accreditation status may be withdrawn. The denial of initial accreditation, or the withdrawal of accreditation is considered an adverse action. Adverse actions can be initiated based on review of complaints, progress reports, site visit reports, and/or annual reports. Failure to submit required reports may also initiate adverse action. Adverse actions follow the due process rules given in “Denial of Accredited Status by the Commission” and “Withdrawal of Accredited Status by the Commission.” Adverse action will be initiated when the Commission determines that the program has either failed to come into compliance with all the Commission Accreditation Criteria within two years of a formal site visit without good cause, the program has undergone major changes in its faculty and/or leadership, curriculum, organizational setting, or administrative support that impact the program’s continued ability to meet the standards of good quality for graduate programs in health services administration, or the program has failed to meet the reporting requirements of the Commission.

As of this writing, the Commission has not had cause to enforce this policy. However, this policy change has been communicated to all parties concerned.

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2. The agency needs to revise its policies to incorporate all of the requirements of section 602.21. The agency also needs to document and report on the results of a full review of its criteria (individually and as a whole) for their adequacy as measures of quality prior to proposing changes and seeking input regarding those changes. [§602.21]
-

At the April 2003 meeting of the Commission the following policies and procedures were adopted:

Article 22a. Policy Statement: Review of the Criteria For Accreditation

Section 1. Underlying Values

A program in health services administration is designed to prepare leaders who are sensitive to the dynamics of the healthcare environment and the healthcare industry. The Criteria for Accreditation serve as the standards for measuring the quality of a program in health services administration. The Criteria must reflect the current state of the healthcare environment and anticipate the trends of the

future in order to guide programs toward the preparation of the healthcare leaders of tomorrow. This presupposition compels the Commission to assess the Criteria as they relate to measuring the quality of the program and to meeting the demands of the profession.

As part of its ongoing commitment to the relevancy and rigor of health services administration education, the Commission shall periodically review the Criteria for Accreditation. There shall be two levels of review: (1) interim review and (2) full revision.

Section 2. Criteria Review Committee

The Commission shall have a Criteria Review Committee that will meet on an annual basis. The Chair of the Commission will appoint the committee. The responsibility of the Committee will be to monitor any feedback received by the Commission on its Accreditation Criteria and serve as the review committee for the Criteria. The Committee will report to the Commission on an annual basis.

Section 3. Interim Criteria Review

The Commission shall conduct an interim review of the Criteria every two years. The purpose of this review is to evaluate:

- 1. The adequacy of the Criteria to signal academic quality;*
- 2. The ongoing relevance of the Criteria to the changing needs of the field;*
- 3. The extent to which the Criteria reflect the changing nature of the field of higher education and different methods of education delivery; and*
- 4. The need for changes to the Criteria.*

This level of review incorporates input from the Corporate Sponsors, the Board of Commissioners, and a focus group of programs that have participated in accreditation reviews in the previous 24 months. The review shall include a comprehensive examination of the Criteria for Accreditation both individually and as a whole. The Criteria shall be assessed in terms of their form and function as they relate to the preparation of leaders in health services administration. Moreover, the Criteria will be evaluated for their validity and reliability in assessing the quality of a program in health services administration.

Section 4. Full Criteria Revision

If, as a result of an interim review, the Commission determines the need to make changes to the Criteria, the Commission will immediately initiate a full Criteria revision.

Ideally, this revision process will take twelve (12) months to complete. A call for comments will be broadcast over the Internet and any routine publication of the Commission. Input will be sought from the Association of University Programs in Health Administration (AUPHA), other the Commission Corporate Sponsors, students, and other relevant stakeholders.

A specific communiqué will be directed toward the Commission accredited programs. An iterative approach will be used to formalize the final revised version of Criteria. The final version of the Criteria must be approved by a two-thirds vote of the Board of Commissioners.

Section 5. Implementation of Revisions

Those revisions to the Criteria for Accreditation that are an outcome of a full review shall become effective one year after the official publication by the Commission. Ideally, the publication of the Criteria and supporting material shall correlate with the traditional academic year in order to assist those programs preparing for a site visit. Any other revised policy or procedures shall become effective as determined by the Board of Commissioners.

Approved November, 1996

Text Edition 2/25/98

Revised 9/28/01

Approved as Revised, April 26, 2003

Article 22b. Procedure for Criteria Review and Revision

Responsibility for review and revision of ACEHSA Criteria rests with the Criteria Review Committee of the Commission. Authority to approve changes to the Criteria rests with the Commission. The Criteria Review Committee is also responsible for ensuring that changes to the Criteria are appropriately reflected in the Self-Study Guide. The Criteria Review Committee will meet annually at the Commission's fall meeting to review and evaluate any feedback from the Commission on the existing Criteria. In the event that there is significant concern about the Criteria, the Committee may immediately initiate an interim criteria review. If there is not an area of significant concern regarding the Criteria, the Committee will conduct an interim criteria review every two years.

Section 1. Interim Criteria Review

The interim criteria review will involve the following process;

- 1. The Criteria Review Committee will extend a Call for Input from the following ACEHSA Stakeholders:*
 - Accredited Programs*
 - Candidate and Pre-Accredited Programs*
 - ACEHSA Corporate Sponsors*
 - Other practitioner stakeholders not affiliated with current ACEHSA Corporate Sponsors*
 - Other stakeholders as identified by the Committee.*

The Call for Input will ask the following questions:

- *Is the Criteria adequate to signal academic quality;*
- *What is the ongoing relevance of the Criteria to the changing needs of the field;*
- *What is the extent to which the Criteria reflect the changing nature of the field of higher education and different methods of education delivery; and*
- *Is there a need for changes to the Criteria.*

ACEHSA will also take the opportunity of AUPHA's Annual Meeting or Leaders Conference to hold a forum on this issue.

Following evaluation of the input received, the Criteria Review Committee will determine the need to proceed to a full criteria revision.

Section 2. Full Criteria Revision

In the event that the Criteria Review Committee identifies the need for significant changes to the Criteria, it will initiate a Full Criteria Revision. In order to accomplish such, the Committee will be expanded to include non-Commissioners from the academic and practitioner communities.

The following process will be followed in a Full Criteria Revision:

- 1. A call for comments will be broadcast over the Internet and any routine publication of the Commission.*
- 2. Input will be sought from the Association of University Programs in Health Administration (AUPHA), other the Commission Corporate Sponsors, students, and other relevant stakeholders. A specific communiqué will be directed toward the Commission accredited programs.*
- 3. The Committee will meet at least monthly as it implements an iterative approach to develop the draft version of the revised Criteria.*
- 4. The draft of the revised Criteria will be presented to the Commissioners at their Spring Meeting for endorsement.*
- 5. Once endorsed by the Commission, the draft revised Criteria will be forwarded to the field for further input. That input will be gathered through written communication and discussion at the AUPHA Annual Meeting.*
- 6. Further refinement based on feedback will be conducted and a final proposed revision of the Criteria will be presented to the Commission in the late summer for vote via teleconference at an early September meeting.*
- 7. The final version of the Criteria must be approved by a two-thirds vote of the Board of Commissioners.*
- 8. Final Revised Criteria will then be shared with the field, accompanied by the advisory that the revised Criteria and attendant Self-Study Guide will go into effect for site visits taking place 12 months after distribution and beyond.*

Approved as Revised, April 26, 2003

Although these policies and procedures were not formally acted upon until the April 2003 meeting, in order to fulfill the expectation of the DOE that a criteria review be documented in this report, ACEHSA has pursued this process for criteria review during the academic year 2002-2003.

In the Fall of 2002, ACEHSA launched its criteria review process. The first step in this process was to determine the extent to which the current ACEHSA Criteria:

- a) signal academic quality;
- b) are relevant to the changing needs of the field;
- c) reflect the changing nature of the field of higher education and different methods of education delivery; and
- d) were in need of revision.

The letter requesting input from academic programs and the field are attached at Enclosures 1 and 2.

Feedback was received over the next two months, and follow-up solicitations of input were sent via email in an effort to maximize response to the request for input.

The synopsis of input received through the review process is attached at Enclosure 3.

As the synopsis at Enclosure 3 demonstrates, there was an indication that a revision to the Criteria was warranted. However, prior to initiating major revisions to the Criteria, ACEHSA held a final discussion with academic program leadership and other stakeholders at the AUPHA Leadership Conference in March of 2003. The input received at that conference is encapsulated at Enclosure 4.

Following this meeting, the ACEHSA Criteria Review Committee met to set about revising the Criteria based on the feedback received. The draft revised Criteria were reviewed by the Commission at its May meeting and forwarded to the field for review and comment. The draft revised Criteria are attached at Enclosure 5.

Feedback on the draft revised Criteria is still being received as of this writing. ACEHSA will be holding an open forum on the Criteria at the AUPHA Annual Meeting on June 25, 2003. It is expected that changes to the enclosed document will be recommended at that meeting. The Commission will take those suggestions under advisement, finalize the Criteria over the summer, and distribute them to the field in the early fall of 2003 for implementation in the fall of 2004.

The Criteria Review/Revision process initiated this year was accelerated in order that ACEHSA might meet the requirement to document a full review of the Criteria in this Interim Report. In keeping with the revised policy, ACEHSA will review the Criteria again in 2004 to determine whether revision is necessary.

Enclosure 1

October 17, 2002

Sample Academic Program Director

Dear :

The Accreditation Commission on Education for Health Services Administration is conducting a full review of the Accreditation Criteria for the conduct of graduate education for health services administration. Each of the *Criteria for Accreditation* will be examined in terms of their relevance for the preparation of leaders in health services administration. The *Criteria* are also being evaluated for their validity and reliability in assessing the quality of a program in health services administration. This review is an important activity we undertake to fulfill Department of Education requirements for accreditation.

We are initiating our review now and seek your involvement in this process. We ask that your program review the current *Criteria* and provide us with your suggestions concerning the *Criteria* and improvements that you recommend. Please do not restrict your scrutiny to the Criteria pertaining to course content. Universities are undergoing substantial changes in mission, financing, appointment structure and other areas that may impact accreditation. For example, an issue facing many programs is the blending of practitioner-academic role within our programs. Our Criteria should reflect these changes. Suggestions you might make concerning additional standards or processes that might be used in the accreditation process are also welcomed. Input you receive from recent alumni about their level of preparation for health administration will be appreciated. We have enclosed a copy of the current *Criteria for Accreditation* to expedite your review. You may wish to visit our web site at www.acehsa.org for additional information

We ask that you submit your suggestions to us by **January 10, 2003**. Following receipt of responses from your program and others, we will determine the need for a revision to the *Criteria for Accreditation* during the Winter/Spring of 2003. If merited, revisions will be developed and distributed to the field in June of 2003 for your additional feedback and comments to be received by September 2003. Final approval of the revised Criteria is anticipated at a Fall 2003 meeting of the Commission.

We look forward to receiving your suggestions on the initial revisions to the *Criteria* as well your feedback on the draft revisions that you will receive in June 2003. Please contact me if I can answer any questions concerning this process. I can be reached by phone at 205/934-1665, email at hernande@uab.edu, or mailing address: P.O. Box 530905, Birmingham, AL 35253.

Sincerely,



S. Robert Hernandez, Dr.P.H.
Professor, University of Alabama at Birmingham
Chair, Criteria Review Committee

Enclosure: *Criteria for Accreditation*

ENCLOSURE 2

October 17, 2002

Sample Corporate Sponsor Letter

Dear :

The Accrediting Commission on Education for Health Services Administration (ACEHSA) is undertaking a review of the ACEHSA Criteria for Accreditation, the educational standards for ensuring quality in the graduate programs in our field. The Department of Education requires this review for our continued accreditation and it is important for us to know your beliefs about the relevance of our Criteria for preparation of future leaders in health services administration.

Among other things, we are examining each specific criterion in terms of its relevance to the preparation of graduates you may hire one day. The intent is to tailor the educational Criteria to the needs of the health administration workplace of the 21st century. We seek your involvement as both a leader in the field and as a customer of the graduate programs. Specifically, we are interested in knowing what skills you believe graduates of academic programs should possess to be successful in your organization.

I have attached an abbreviated list of the current Criteria we use in the accreditation process. We would very much appreciate your comments on the extent to which you believe they equip our graduate health services administration programs in effectively preparing qualified professionals to meet your needs. Feel free to focus your comments on some or all of the Criteria. You may refer to our website www.acehsa.org for additional information about ACEHSA.

We need your response no later than January 10 in order to draft revised Criteria for Accreditation in Spring, 2003. Revisions will be circulated to you and others next June for additional feedback, leading to adoption of the final revised Criteria at the fall 2003 meeting of the Commission. If you have any questions, please contact me by phone at 205/934-1665, email at hernande@uab.edu or mailing address: P.O. Box 530905, Birmingham, Alabama 35253.

Sincerely,



S. Robert Hernandez, Dr.P.H.
Professor, University of Alabama at Birmingham
Chair, Criteria Review Committee

Enclosure: *Criteria for Accreditation*

ENCLOSURE 3**SUMMARY OF RESPONSES
TO REQUEST FOR FEEDBACK****CRITERIA FOR ACCREDITATION
ACCREDITATION COMMISSION ON EDUCATION
FOR HEALTH SERVICES ADMINISTRATION****FEBRUARY 2003**

The Accreditation Commission on Education for Health Services Administration (ACEHSA) began a full review of the *Criteria for Accreditation* used to accredit graduate education in health services administration programs during the fall of 2002. Comments on relevance and suggestions for improvements in the *Criteria* were solicited from the academic and practitioner communities.

A total of 42 responses were received with 32 academic programs and 10 practitioners or professional associations providing input. Some comments received were general in nature, applied to all the standards, or related to processes used in accreditation. Other comments were related to specific Criteria. An overview of the general comments and comments about processes used in accreditation will be provided first. This material will be followed by the Criteria specific feedback received.

The Criteria Review Committee of the Commission will consider these recommendations as it begins the process of drafting improvements in the current standards and the processes used in accreditation. Proposed revisions will be made available for additional comments during late spring of 2003. Adoption of changes will occur at a fall meeting of ACEHSA.

General Responses

It was suggested that the name of the commission be changed to Accrediting Commission on Education for Health Services Management. Management was viewed to be a more appropriate term for the current emphasis of our programs.

Another respondent felt that the layout of the Criteria seems to load too many things into Criterion I. They suggested placing Students and Graduates as a separate criterion, placing Research/Scholarship and Service in the Faculty criterion, and placing Institutional Support as a separate criterion. This would leave Criterion I as: Program Mission, Goals, and Objectives.

A recommendation was made that standards remain broad and flexible because of the evolving nature of health administration practice. Programs must have the flexibility to modify course content, as curriculum needs change. A related call for flexibility came from several respondents who suggested that differences among programs in terms of

mission and strategy should result in differences in curriculum. Some programs not preparing graduates for careers in public health felt curriculum requirements were too restrictive and suggested that allowance be made for unique program missions. Requiring explicit applications to health service organizations was viewed as constricting. Another respondent had an opposing view and suggested that the continuing move toward dual degrees presents a challenge to insuring that relevant health care applications are in the curriculum. A proponent of more flexibility posited that the curriculum requirements of ACEHSA might be broadened if the composition of the ACEHSA Board included representatives of the pharmaceutical, biotech, medical device, consulting, and financial sectors.

One respondent reported that their program was subject to accreditation criteria of CEPH as well as ACEHSA. They suggested that attempts should be made to coordinate better criteria between these two organizations since they appear to have conflicting standards.

Another suggestion was that an effort is needed to market the value of accredited programs to health services employers. It was recommended that this initiative be based on a study of current attitudes of employers.

Suggestions about Process and the Self Study Guide

Some ACEHSA criteria were viewed as beneficial for promoting meaningful discussion among faculty about topics that might otherwise be delayed or neglected, such as mission, goals, objectives, curriculum philosophy, and related issues. Other items were viewed as of little value to the accreditation decision and data were tedious to collect and tabulate. Questions in this category include employment settings of graduates after three years, consulting activity of faculty, faculty committee memberships, and related issues. Constructive suggestions for removing redundancies and streamlining data collection were provided. Suggestions for improving Figure 1A also were received from other respondents. These focused on altering and renaming a number of columns.

Some comments focused on the methods used for accreditation. It was felt that guidelines should be developed for how the standards are evaluated and scored. A related question concerned the amount of content required under each of the curriculum items. For example, how many contact hours must be devoted to legal and ethical analysis?

A related comment was that few of the criteria translate into operational terms. It is not apparent that the Commission articulates what constitutes clear evidence that a criterion is not met, partially met, or met. Operationalization of criteria and stronger training and direction for site visitors was viewed as needed to remove unwanted variability from site visit team assessments.

It was suggested that the site visit should not focus on each item of the criteria, but on areas of serious concern to the visitors. In addition, the visit should not be conducted

unless the team is fairly certain that the program is ready and that the visit will be successful. Time also should be devoted to identification of best practice and commending best practice in specific areas.

Criteria Specific Comments

Criterion I. Program Mission, Goals, Objectives and Performance

I.A. Mission, Goals and Objectives

Several comments were received in this area. One suggested that a better definition of quality improvement was needed. Several respondents stated that mission and goals should not be continuously adjusted, but periodically modified as needed. One respondent questioned why teaching institutions were held to research and grant generation requirements if research was not part of their mission. A suggestion was received that mission statements ought to reflect a comprehensive approach that includes the Physician Practice Management field. It also was believed that Criteria I is too broad.

I.B. Students and Graduates

Numerous comments were received about this area with several respondents requesting flexibility in measures of student quality, especially for programs serving practitioners or mature students for whom traditional measures of quality such as GPA and GRE scores seem irrelevant. One respondent spoke of the difficulty in infusing diversity into the bricks and mortar of the campus. Another respondent wanted gender and sexual orientation added to diversity, another noted the difficulty of tracking alumni who do not want to respond to program queries, and another asked for clarification of what constitutes a formal student complaint. It was also suggested that student concerns, rather than complaints, be monitored. A recommendation was received that CEOs employing a graduate should evaluate the graduate's competence one year after graduate. This feedback would allow the Program to assess the preparation the university gave the graduate as required under criterion I.B.5. Another respondent suggested that student career plans reflect the field of Physician Practice Management.

I.C. Research and Scholarship

Numerous comments were received in this area with calls for a balance between research and service, questions concerning expectations for practitioner/scholars, objections to requirements for scholarship from ALL faculty, and concerns that some of these items appeared redundant. It was noted that the question of scholarship should not be defined purely in terms of research. Another commented that we appeared to encourage practitioners to become involved in research and thought the effort laudable. Another thought that academicians should define ways to help practitioners make more effective use of research

results in day-to-day decision-making. There was also concern for identifying what kind of research is appropriate. Another respondent thought that programs should be aware of MGMA, the ACMPE College, and its related research arm resources and programs. Recommended worded included: “creation, synthesis and dissemination of knowledge.” It was also recommended that we give attention to industry -practice-based research and come to grips with the need for funded research.

I.D. Service

One comment questioned the value of only counting uncompensated service by faculty in this category. Another thought that faculty should include individuals experienced in Physician Practice Management. There was concern with redundant dates and a suggestion for combining some of the charts I.D. 1 and 2.

I.E. Institutional Support

Five comments were received about these standards with one asking for clarification about what constitutes sufficient support when a University has more than one accredited program. Another noted the difficulty program directors have having authority over the curriculum when students take courses outside the home department. A third respondent suggested a wording change to correct poor wording. A fourth wanted web-based information included in material the Commission insures provides accurate information to the public. Another recommended wording included: “The Program will ensure the quality of its teaching, research, and service through ongoing relationships with and active involvement and support of a variety of health services organizations and agencies as appropriate to its mission.”

Criterion II. Teaching and Curriculum

II.A. Curriculum Design

Two respondents suggested that programs should reference the competencies for which they are preparing program graduates in this section of the standards and relate it to the overall curriculum. Another suggested that syllabi should identify the competencies for which students are being prepared and that the measures we look at should be much more “competency” based. A fourth suggested that programs invite experienced preceptors or health care executives to review the curriculum annually to assure relevance and practical applicability to the work setting.

II.B. Curriculum Content

General Curriculum Content Comments

It was noted that the curriculum requirements have expanded substantially over the years as the complexity of health administration has increased. While acknowledging the requirement for an expanded curriculum, it was posited that students might benefit from “selectives.” Rather than mandating that content is covered in courses required of all student, some of the ACEHSA mandated curriculum might be offered in elective courses. While most of the content should be in required courses, this flexibility allows students to focus or specialize on areas they believe are most beneficial for their development.

General comments about the curriculum content areas noted a need to include high-level core competencies such as professionalism, communication, emotional intelligence, and strategic thinking. These would be in addition to disciplinary area knowledge.

Several respondents felt that the curriculum might be tied to the competency domains of the profession. It was recommended that competencies be established in behavioral terms so that observations could be made by not only looking at processes but outcomes as well.

Another respondent viewed the curriculum content criteria as lacking a consistent perspective, vacillating between a student skill perspective and a curriculum content perspective. Criteria seemed to combine multiple domains, making them a very uncertain guide to analysis and action. Moreover, the ten curriculum content areas are not mutually exclusive, creating the possibility of a program receive multiple “hits” for a single area that needs improvement. Another comment received was that the ten curriculum content areas should have comment sections that list suggested material to be covered.

Specific Curriculum Content Recommendations

A suggested wording change was made for II.B.2. It was recommended that the word “alternative” be changed to “various” in relation to the financing mechanisms under which health organizations are managed.

It was pointed out that II.B.3 contains the only mention of communication skills and, specifically, these skills are very focused on “managing human resources and professionals...” It was noted that communication skills (written, oral and presentation) are critical to all areas of management, both internal and external to the organization. There also only seemed to be vague reference to planning in the curriculum.

Specific changes in content areas were recommended. It was suggested that *II.B.5. Statistical, quantitative, and economic analysis in decision making* as

well as ***II.B.4. Managing information resources and collecting, analyzing and using business and health information in decision making*** be modified. Revised criteria would be ***Economic and financial analysis to support decision-making*** and ***Managing information including the collection, the statistical and non-statistical analysis, and the summarizing of data for decision-making***. Statistical and economic analysis were seen as very different with economic analysis focusing on concepts such as marginal benefits and costs and related concerns while statistical tools (while useful for some kinds of economic analysis) also focus on estimating numerous associations such as between an intervention and an outcome. Qualitative analysis also seems important for management decision-making and was not listed.

It was recommended that ***II.B.7. Organizational and governmental health policy formulation, implementation and effect*** be revised to ***Governmental health policy formulation, implementation and effect***. Organizational policy, or strategy, is a component of criterion II.B.1. and placing organizational in this criterion is redundant and seems to muddy the content area of government health policy.

One respondent noted that managers must understand health policy implications for managing organizations and that policy makers should understand how policy affect organizational operations. Another suggested that understanding the population health was irrelevant for other than public health graduates and should not be mandated.

It was recommended that ***II.B.9. The development, organization, financing, performance and change of health systems in diverse communities drawing broadly on the social and behavioral sciences*** is dropped. The terms are viewed as broad and far-reaching, making it hard to know what would fit or not fit into this criterion. Much of this criterion was viewed as being covered elsewhere with more specificity. If the criterion is retained, it was suggested that it should be modified significantly.

It was pointed out that II.B.10 contains two issues that should be separated. It also was recommended that risk management and Balanced Scorecard be addressed here.

Comments were received about specific curriculum components that should be added or expanded. It was suggested that medical terminology is essential for managers and should be required. A respondent recommended that entrepreneurship, change management, and innovation be added to the required curriculum. Another respondent noted the need for emergency preparedness and bioterrorism planning, especially as it relates to JCAHO and OSHA regulations. Additional content was suggested with new and/or possibly more explicit criteria needed relative to (1) change management; (2) management of diverse cultures; (3) ability to communicate-both written and oral; (4) knowledge of governance;

(5) community preparedness for disaster and emergency management; (6) specialized healthcare knowledge; and (7) interpersonal skills. Specific examples for each area were provided. The need to expose students to the legal and ethical impact of the new science of genomics was articulated; as well as the need for students to understand and be able to develop linkages, collaborative ventures, and/or strategic partnerships.

Several respondents suggested that practical skills to address issues related to outpatient care in the medical practice setting are not apparent in the requirements and that the curriculum content might be improved by adding categories from the ACMPE Body of Knowledge. Specific areas that should be considered include: Governance and Organizational Dynamics; Risk Management; Business and Clinical Operations and Human Resources Management. The responsibilities of the professional administrator were also viewed as relevant.

Several individuals noted that the focus of course content should be broadened from single delivery sites to be more inclusive of broad health care delivery options. The value of exposing students to ambulatory care and group practice operations was stressed.

II.C. Applied and Integrative Learning

Some respondents questioned whether or not integrative experiences actually meant experiential learning opportunities. Another suggested that the Commission should state that a capstone course is a required part of a defined curriculum.

Criterion III. Faculty

III.A. Qualifications and Availability

Two comments were received suggesting that the Commission encourage participation of adjunct and part-time faculty in program meetings, committees, and planning activities. Another noted that the standards focus on research and scholarship activities of faculty, but are relatively silent on industry experience and career achievement of practitioners. Embracing the academic-practitioner model suggests greater emphasis on this area. Another respondent suggested that gender and sexual orientation be added to the description of faculty diversity. Finally, a program pointed out that correcting diversity imbalance could take years while DOE requirement for rectification of a problem within two years can be an impossible task for programs without faculty openings.

III.B. Responsibilities

One respondent questioned why the Commission seeks evidence that the faculty participate in defining needs and have membership on appropriate search committees.

III.C. Recruitment, Development and Evaluation.

One respondent noted that this might not be possible for small programs located in large schools.

ENCLOSURE 4
ISSUES RAISED AT CRITERIA REVIEW SESSION AT AUPHA LEADERS
CONFERENCE

- 1) It should be noted in our tally of responses that in many cases one program's response represented the input of multiple faculty members.
- 2) It would be useful to provide programs with sample syllabi based on core competencies (See St. Louis). Faculty need to ask themselves as they develop syllabi: "What am I doing to actively develop these competencies / SKA's?"
- 3) Cost of making these changes are high.
- 4) A national benchmarking effort would help (Schneller). Evaluation mission / program quality in relation to peer institutions.
- 5) US Army Baylor program...mapping project...for Annual Meeting?
- 6) Share sample matrices on website.
- 7) How do we measure whether competencies are achieved...need external assessment tool.
- 8) Need to share best practices at AUPHA Annual Meeting.
- 9) What should the Commission report to the public about accredited program status?
- 10) Given the increased emphasis on evidence-based practice, ACHESA should keep research. What is the purpose of having the research requirement? Bring new thinking into program on a regular basis. If other ways to demonstrate currency, that should be considered. Look at nature of research...broaden the definition of research.
- 11) ACHE needs to recognize scholarly contributions to the field as part of FACHE process.
- 12) What outcomes should we share with the public?
- 13) Don't be too influenced by what AACSB does.
- 14) Do we look at inputs or outcomes?
- 15) In many ways we're already measuring outcomes.

- 16) Cultural setting of program influences curriculum...how do we find core curriculum?
- 17) Remember, richness comes from diversity.
- 18) Is the common core too small to be called a field?
- 19) Need to define concepts...research, competency, outcomes.

ENCLOSURE 5**Accreditation Philosophy Embodied in Proposed
*Criteria for Accreditation Changes***

The Accrediting Commission on Education for Health Services Administration (ACEHSA) recognizes that the field of health services administration embodies a broad and diverse number of career paths and roles that may be carried out in a variety of healthcare delivery or business settings such as hospital-based systems, medical group practices and healthcare consulting firms. Each program should have the latitude to determine its particular orientation. The criteria should not dictate that a program has either a general or specialized focus in terms of the setting for which it is preparing its students.

ACEHSA also recognizes that the growing demand from students and the practitioner community for greater choice and exposure to management dynamics and challenges beyond the traditional hospital setting has validity and is an issue directly related to the provision of quality relevant education. While the criteria should not impose which direction a program should take, they should assure that the program clearly articulates its focus to students and the public at large and that the program is internally structured to carry out this focus out.

Specifically, programs that publicize a more general health service orientation should clearly articulate this and be able to demonstrate that their curricula does in fact provide a balanced perspective across multiple healthcare settings. On the other hand, those that place major emphasis on a particular setting (whether it be hospitals, group practices, pharmaceutical companies or other) should clearly articulate this focus to the public and align its curriculum accordingly.

The revised *Criteria for Accreditation* will require that each program:

1. Articulate the specific focus and orientation of the program through its mission statement, goals or objectives, as well as materials promoting the program to the public, and
2. Indicate how this focus is supported through course content and other learning resources and activities, such as student selection, faculty selection and activities, and related activities.

While a core curriculum content will be required of all ACEHSA accredited programs, programs will have the flexibility to focus their course offerings based on their unique mission. While each of the curriculum content areas will need to be offered by an accredited program, a program may vary the breadth and depth of its coverage of a content area based on its mission.