
The McNerney Forum

Jeptha W. Dalston
Lawrence D. Prybil
Howard Berman
John S. Lloyd

Transforming the Accreditation of Health Care Management Education

Recognizing the considerable changes occurring over recent years in health care, the Accrediting Commission on Education for Health Services Administration (ACEHSA) sought to remake itself to become a more vital participant in the field. This article reports the rationale, objectives, and process pursued by ACEHSA as it underwent this transformation and adopted a new name: Commission on Accreditation of Healthcare Management Education (CAHME). This paper features the planning document adopted to lead CAHME through the future. It also highlights actions taken to date and subsequent steps planned.

“Change is the law of life. And those who look only to the past or present are certain to miss the future.”

— John Fitzgerald Kennedy

The enormous changes in health care over the 1990s and into this century jarred all components of the field. Accreditation of health administration education did not escape these sea change impacts. Rather, accreditation found itself weakened and largely disconnected from its lifelines, adrift in past practices, and in dire need of updating, revitalizing, and strengthening.

Through recognition of these factors, the corporate sponsors, Board of Commissioners, and other leaders of the Accrediting Commission on Education for Health Services Administration (ACEHSA)—the single accrediting authority for graduate education in health administration since 1968—concluded that the commission must act boldly and swiftly. Boldness and swiftness are not strong suits of educational settings; only

survival of the commission buoyed a sense of mandate and urgency. Thus came about a commitment with fervor to transform the commission.

This article reports the rationale, objectives, and process pursued by ACEHSA to transform itself. Background information emphasizes the context for the transformation and explains the adoption of a new central planning and implementing document, “Building the Profession Through Quality and Value for Health Administration Education and Practice: A Strategic Blueprint for the Future.” The article includes a summary of actions taken to date, the next steps contemplated, and a statement on the outlook for the future. The synopsis is followed by the document as adopted.

Background

The corporate sponsors, commissioners, management and other stakeholders of ACEHSA set out to develop a bold but practical strategy for trans-

Jeptha W. Dalston, Ph.D., F.A.C.H.E., is president and CEO of HealthExec, Inc., former president and CEO of the Association of University Programs in Health Administration (AUPHA), and former president and CEO of the Accrediting Commission on Education for Health Services Administration. Lawrence D. Prybil, Ph.D., F.A.C.H.E., is a professor in the College of Public Health, University of Iowa. Howard Berman, M.H.A., is vice chairman of the Lifetime Healthcare Companies. John S. Lloyd, M.B.A., M.P.H., is president and CEO of the Commission on Accreditation of Healthcare Management Education (CAHME). Address correspondence to Dr. Dalston at 3333 Eastside Drive, Suite 220, Houston, TX 77098. Email: wim@flash.net

forming the accreditation of health administration education. The commission organized a task group in the summer of 2003 to design and recommend a strategy for accomplishing this massive task. The report of the task group was approved in November 2003, during a joint session of ACEHSA's corporate sponsors and the organization's Board of Commissioners.

This report constituted a preliminary proposal for fundamentally strengthening the governance, finance, standards, processes, and relationships of the commission. The proposal was approved for broad-scale consideration by those in the health care education field. Core objectives of the proposed plan were: 1) to relate academicians and practitioners more closely and continuously; 2) to streamline the accreditation processes; 3) to relate accreditation standards more closely and more quickly to dynamics of the field; and 4) to strengthen the capabilities of and performance by the commission.

The "Strategic Blueprint," as the document came to be called, was discussed, dissected, debated, vetted, and refined extensively from January to June 2004. The refined Strategic Blueprint paper was approved for implementation by all the ACEHSA corporate sponsors. The last corporate sponsor to approve the plan was the Association of University Programs in Health Administration (AUPHA), which did so through action by its Board of Directors with concurrence of its membership during the AUPHA annual meeting in early June 2004. Later that month, formal action was taken by the ACEHSA corporate sponsors and the Board of Commissioners to adopt the Strategic Blueprint. Implementation then proceeded, following the framework and guidelines laid out in the new document.

A New Name

The plan for transforming the commission focused upon strengthening the profession through enhancing quality and value of health administration education and practice. Though developed by ACEHSA, the plan called for renaming the commission the "Commission on Accreditation of Healthcare Management Education" or CAHME. The rationale for this name change is explained in detail in the document, which is featured at the end of this paper.

Translating the CAHME Vision into Action

Similar to the plans drawn by an architect, the construction manager makes modifications to meet the requirements of the site and the owner. Shortly after the completion of the Strategic Blueprint, the building of CAHME began. An interim board of directors made up of ACEHSA commissioners and members of the old board of sponsors came together in mid-2004. This group decided on four specific priorities that it wished to accomplish as quickly as feasible:

- Continue smooth operations of the accreditation process utilizing existing ACEHSA standards;
- Recruit a solid core of founding corporate sponsors;
- Complete the essential steps of the corporate restructuring outlined in the Strategic Blueprint, which included codifying the name change, writing new bylaws, meeting legal requirements of the original corporate charter in the state of Illinois, and complying with the official recognition policies of the U.S. Department of Education and the Council on Higher Education Accreditation;
- Conduct and successfully complete a search for a new president and chief executive officer.

Since adequate resources for ACEHSA were a continuing challenge, considerable effort was directed at identifying "founding corporate sponsors" who would be willing to commit \$20,000 for three successive years to create a stable operating base. The membership committee was able to recruit an initial group of 11. As of May 16, 2005, at which time the first annual meeting took place, a total of 19 corporate members—out of a target of 30—had been secured. Professional association members include: the American College of Healthcare Executives, American College of Medical Practice Executives, American Hospital Association, American Health Information Management Association, American Society of Health-System Pharmacy, Association of University Programs in Health Administration, Blue Cross Blue Shield Association, Federation of American Hospitals, Healthcare Financial Management Association, Medical Group Practice Association, and Health Information and Management Systems Society. Market organization members include: Ascension Health, Catholic

Health Partners, National Center for Healthcare Leadership, Hospital Corporation of America, Scripps Health, St. Luke's Episcopal Health System, Sutter Health, and Texas Health Resources.

At the first annual meeting, the corporate members met and ratified the name change, new purpose and bylaws, and elected a permanent Board of Directors. In addition to these two important steps, during the first year of implementation of the Strategic Blueprint the commission accomplished the following:

- Reaffirmed Accreditation Council policies, procedures and processes;
- Established the Standards Council's charge and appointed its membership;
- Continued ongoing program pre-accreditation and accreditation activities with indistinguishable interruptions;
- Recruited a new president and chief executive officer;
- Adopted a strategic implementation plan called "Metrics for Success," which built upon the earlier Strategic Blueprint reported in this article.

Based on direction from "Metrics for Success," the initial recommendations for the Accreditation Council were to:

- Review existing accreditation criteria and recommend changes to be implemented by January 2006;
- Develop a plan to improve effectiveness and efficiency of the site visit process by spring 2006;
- Develop a comprehensive database by May 2006;
- Review and improve the site survey evaluation instrument by May 2006.

The recommendations for the Standards Council included these initial objectives:

- Establish a Standards Council (Dr. Tom Royer, CEO of Christus Health, was chosen as the first chair among 10 members, with equal representation from academe and the market/profession sectors);
- Complete, review, and publish revised accreditation criteria by June 2006 to be implemented for the academic year starting in August 2009;
- Continuously review standards to ensure complete review every four years.

In June 2005, the Standards Council met in Dallas to begin the process of not only defining what it means to be a "premier accrediting agency," but also defining how the standards review process would proceed. In July, the Accreditation Council began a series of working sessions designed to improve current accreditation processes, work flows, and service to programs.

While a great deal has been accomplished, much remains to be done. The CAHME Board of Directors is working diligently to meet the expectations of the health care field. The Strategic Blueprint report laid out the guidelines for change, and construction is well underway. To ensure that we are designing a system that works, CAHME is providing opportunities for input from graduate programs, corporate members, and the health care field broadly. A series of "town meetings" are scheduled for 2006 to give professionals an opportunity to comment on the work of the councils.

When a change occurs as significant as the one that turned ACEHSA into CAHME, it is important to assure that change is actually improvement. The Board of Directors is endeavoring to see that CAHME accreditation is meaningful, not only to the graduate programs but also to the students and families who rely on the accreditation "mark" in making crucial career decisions.

The value of accreditation to programs is improvement in processes and quality. CAHME is aware that potential employers of graduates of CAHME-accredited programs expect these people to be fully prepared for demanding career positions. Much more needs to be done to prove to all parties that CAHME has become a "premier accrediting agency," and that CAHME accreditation is valuable.

The Strategic Blueprint

What follows is the document as approved by the ACEHSA governing body in June 2004.

INTRODUCTION

Both opportunities and imperatives challenge leaders in education and practice within the healthcare¹ field. Opportunities arise from major new pressures for quality, awareness that major improvements are needed in health management education, and mounting motivation for change. The imperatives focus upon much-publicized

healthcare systemwide deficiencies, coupled with a demand for enhanced management performance. The needs are compelling and the moment is now.

As a national resource for assuring and enhancing quality in healthcare management education, the Accrediting Commission must assume a leadership role in quality through its accreditation standards with accompanying influence and authority. To do so, however, the Commission itself must become more efficient, financially sound, and broadly reconfigured.

As an initial step in that direction, ACEHSA formulated a Joint Task Group (JTG) through discussion accompanied by a sense of urgency during the spring meeting in April 2003 of the ACEHSA Corporate Sponsors and Board of Commissioners.²

The premise that accreditation can and should play a leading role in meeting today's challenges is supported by the recently completed report of the Blue Ribbon Task Force on Accreditation (BRTF).³ This report presents both a framework and specific recommendations for accreditation that provide a background and build a foundation upon which changes can be implemented. The elements of this paper which relate directly to BRTF recommendations are cross-referenced.⁴ The Strategic Blueprint paper also incorporates major components of the BRTF report as well as the perspectives of the Commissioners, Corporate Sponsors and AUPHA members.

THE IMPERATIVE FOR TRANSFORMING ACEHSA

The external forces affecting the healthcare field in the latter part of the 20th century have created the need for important changes to occur in healthcare management education and practice. These changes have required a shift in emphasis and a need for expanded skill sets among practitioners. Healthcare organizations have also experienced severe financial constraints and have reduced their investments in management development activities. Opportunities for residencies, fellowships, and related management development activities have suffered. Dialogue between academics and practitioners has also declined in a period when better communication is essential. The cumulative effect of these changes has been a blurring of career pathways and a loss

of the sense of purpose that has been a feature of healthcare management practice. There is no common agreement on standards for what constitutes a "traditional" career or for appropriate career development activities.

Additionally, values anchored in concern for improving the health of individuals and populations have often been compromised in the debate about whether organizations should emphasize the "bottom line" or the mission. The need for transforming ACEHSA derives from a desire to strengthen the healthcare management education process by reinforcing the original values of the field: leadership with a humanitarian bent; dedication to community service; emphasis on mentoring; and commitment to high quality care. These values must underpin healthcare management practice whatever the setting, service or organizational type.

Concern about the skill sets required of healthcare management executives also must be addressed. The Accrediting Commission must join others in aggressively strengthening the field of practice in order to enhance the contribution of healthcare management to the public it serves. One benefit of transforming ACEHSA is identification of healthcare management core competencies for use by healthcare management education programs. The Commission can use these core competencies to facilitate significant changes in curriculum development and curriculum design and to engender renewed emphasis on educational outcomes.

The National Summit Conference, "National Summit on the Future of Education and Practice in Health Management and Policy," in Orlando, Florida, initiated constructive dialogue between academics and practitioners. It provided an opportunity for both groups to come together and rebuild a sense of community around common issues and concerns. This revitalized sense of community promises a new era of energy, commitment, and creative approaches. The proposed transformation of ACEHSA described in this document is an important beginning toward fulfilling the promise of improving healthcare management education.

TRANSFORMATION OF ACEHSA INTO CAHME

For both substantive and symbolic reasons, it was

recommended that the name of ACEHSA be changed. Substantively, the name change recognizes that some accredited programs now pursue missions that focus on other than health services delivery. While the transformed ACEHSA respects traditional missions oriented to health services delivery, it also recognizes the value of missions in addition to health services delivery. Symbolically, movement to a new name is an important expression of the seriousness of intent and far-reaching nature of the transformed initiative.

Accordingly, this paper sets forth a new name for ACEHSA. The new name is designated as the Commission on Accreditation of Healthcare Management Education (CAHME). The term "healthcare" is recommended rather than health services to reflect that our concern is not just the delivery of health and medical services to patients but also the broader concern for the health of communities and populations. In addition, the term management is used to reflect the broad involvement in setting strategic direction for organizations and ensuring that planning activities are realized through strategic management activities.

OBJECTIVES OF THE TRANSFORMATION

The objectives to be achieved by this initiative are as follows (see BRTF Recommendation R1 and R20):

- Set into place a new vision for ACEHSA that will serve as a vehicle for reinventing it and identifying new goals that better address the compelling needs of the healthcare system.*
- Enhance connection with essential components of the healthcare field, especially practitioners, payers, and suppliers.*
- Strengthen the ACEHSA governance function.*
- Improve the efficiency and effectiveness of the accreditation process, establishing ACEHSA as a recognized leader in accreditation methodology and practice.*
- Enhance the timeliness, currency, and positive impact of the accreditation criteria.*
- Reposition ACEHSA so as to be financially strong.*

THE VISION FOR CAHME

(See BRTF Recommendation R1)

The following represents the future envisioned

for healthcare management education accreditation and the transformed CAHME. Timelines for accomplishing components of the vision will be determined by the CAHME Board of Directors.

CAHME will be recognized and respected as a premier accreditation agency in the field of higher education. It will be seen as an innovator in accreditation processes, techniques and best practices. The educational programs it accredits, the universities in which they are located, and the practitioner community will view the CAHME accreditation process as highly efficient, effective, meaningful, and valuable. CAHME will serve as an authoritative source for qualitative benchmarks for healthcare management education.

There will be tangible evidence to show that CAHME contributes substantially to improving the quality of healthcare management and leadership in North America, with measurable benchmarks against which progress can be assessed and performance improved.

The priorities of CAHME and the educational programs it accredits will demonstrate strong commitment to improving the health of individuals, families, communities, and populations through improving the organization, management, and delivery of healthcare services and products.

CAHME will be known as an innovator and actively promote quality innovations in learning, such as distance and experimental learning and other pedagogical developments.

Through a combination of accreditation fees, grants, philanthropic gifts, and sponsorship support, CAHME will have solid financial foundations and sound financial operations.

The preceding vision statement suggests that the cornerstone for the future of healthcare management will emphasize integrity, strength, and competence. These characteristics coupled with the legacy of healthcare management rich in values and commitment serve as basic underpinnings for the CAHME vision.

This vision also suggests that CAHME accreditation standards, processes and values will serve as standard bearers for academic education. Accreditation of health administration academic programs will stand shoulder to shoulder with and will become a leader among other higher education accreditation agencies. CAHME will also

be seen as a role model for other components of healthcare management in terms of the values we cherish and our process of efficiency.

This future will allow healthcare management accreditation to contribute substantially to quality patient services and to fulfill expectations of the practicing community across the growing healthcare field. CAHME will be viewed as a peer by major healthcare organizations, professional societies and trade associations as this future is realized.

REVIEW AND VETTING

In moving toward definitive recommendations of a far-reaching, much needed transformation of ACEHSA, the JTG recognized that extensive review and vetting of the paper would improve its quality and pave the way to broad-scale support. Accordingly, the document was conveyed in draft form to constituents of the Corporate Sponsors in December 2003. There followed review during early 2004 of the paper by each Corporate Sponsor in its own method and timing.

Particular effort was made by AUPHA leadership to inform, solicit reaction and recommend modifications during January and February 2004. Also, the ACEHSA Board of Commissioners deliberated and offered suggestions for refinements during this time. Other Corporate Sponsors also expressed their views.

This activity resulted in development of a revised draft that was the object of a focused discussion during the Academic-Practitioner Conference on March 3, 2004, in Chicago at the American College of Healthcare Executives (ACHE) Congress on Healthcare Management. Constituents of multiple Corporate Sponsors were present but particularly those of AUPHA. Spirited and constructive discussion resulted in ideas/suggestions for further refinements. Based on this cumulative feedback, the ACEHSA Board of Commissioners made additional improvements and voted unanimous approval of the document in late June 2004. The current document is a result of this extended development process.

STRUCTURE OF CAHME

A. Corporate Structure

The governance structure of ACEHSA will be re-

organized with the new CAHME becoming the corporate entity and a Board of Directors its single governing body. This requires, of course, a revision in the current ACEHSA articles of incorporation and bylaws. The current dual governance structure of ACEHSA consisting of the Corporate Sponsors and the Board of Commissioners will be supplanted by a successor entity, described in the next section, which has full fiduciary responsibility for the enterprise. Continuity will be assured by including governing authority members from existing Corporate Sponsors, current ACEHSA Commissioners, and others familiar with ACEHSA accreditation processes.

B. CAHME Corporate Membership Components (See BRTF Recommendation R16)

Corporate membership of the new CAHME will be comprised of three co-equal components that comprise the Corporate Members [with vote] and a set of invited organizations as At-Large Members [without vote]:

1. **The Market**—This component is defined as those organizations that are the major sources of employment of health management education graduates.
2. **The Profession**—This component is defined as those organizations that focus upon life-long education, leadership development, career maintenance, career enhancement, and advancement of the interests of healthcare.
3. **Academia**—This component is defined as those organizations that formally train the health services managers/leaders and offer formal undergraduate, graduate, and/or doctorate degrees.
4. **At-Large Members**—This component is defined as those organizations that are important and integral operating entities of the healthcare field that by nature of their mission are limited in resources but rich in purpose. This special member category serves to provide balance to the new CAHME consistent with the general composition of the healthcare field.

Of the organizations within the components outlined in 1 through 4, those that become Corporate Members of CAHME initially will be des-

ignated as founding members of CAHME. Examples of each of the four membership components noted here appear in the next section.

C. Numbers of CAHME Corporate Members with Examples

1. **The Market**—Approximately 15 organizations will be invited from the **Market** component to become Corporate Members of CAHME. These members will be drawn from a broad spectrum of healthcare organizations including health systems, medical group practices, health care plans, healthcare consulting firms, pharmaceutical companies and medical supplier/medical device corporations, and related types of organizations. These Corporate Members as a group will be the source of up to five persons to serve on the Board of Directors on a staggered term basis.
2. **The Profession**—Approximately 15 organizations of the **Profession** component will be invited to become Corporate Members of the CAHME. These organizations will be drawn from a broad spectrum of professional organizations in health administration related to hospital and health system management, medical group management, healthcare financial and information management, healthcare consulting, trade associations, quality-oriented organizations, and national management development entities. These organizations as a group will be the source of up to five persons to serve on the Board of Directors with staggered terms. In implementing this change, all existing corporate sponsors will be invited to become part of the Profession components.
3. **Academia**—AUPHA will be invited to serve as a Corporate Member of the Commission. Faculties of the AUPHA member programs and the officers of the AUPHA Board will be the source of up to five persons to serve on the Board of Directors with staggered terms. Conceivably, other academically oriented organizations could become members of CAHME (e.g., AcademyHealth, the healthcare component of the Academy of Management).
4. **At-Large Members**—A number of selected organizations will be invited to become **At-Large Members**. This membership category

will ensure that a broad range of organizations characteristic of the field as a whole will participate in CAHME. Examples of organizations that represent disadvantaged groups that might be considered include the National Association of Health Services Executives (NAHSE) and The Institute for Diversity in Management. Yet other examples of categories to be considered are community health centers and long-term care organizations. Up to two seats on the Board of Directors will be filled from the ranks of At-Large Members. There will be an alternative fee structure for At-Large Members.⁵

D. Board of Directors and Corporate Members

The Board of Directors has the sole responsibility for offering a membership to and admitting a member into the corporation. The ACEHSA Board of Commissioners and the ACEHSA Corporate Sponsors have determined that the existing ACEHSA Corporate Sponsors will handle the selection of initial members of the Board of Directors as an interim governance mechanism.

E. CAHME Governance Composition

1. The current Board of Corporate Sponsors and the current Board of Commissioners are dissolved in favor of a new structure. In place of the Corporate Sponsors, each of the four components outlined earlier will comprise most of the governance membership as set forth below:
 - The Market**—Up to five appointees (practitioners or academicians)
 - The Profession**—Up to five appointees (practitioners or academicians)
 - Academia**—Up to five appointees (practitioners or academicians)
 - At-Large Members**—Up to two appointees (practitioners or academicians)
2. These appointments will take place in a fashion so as to be consistent with the U.S. Department of Education (DOE) requirements and best practices of the healthcare accreditation field.
3. The CEO of the Commission will serve as a voting member of the Board of Directors.
4. At least two persons from the general public

will be invited to serve as public voting members by the Board of Directors. The definition of Public Members will be drawn from the U.S. Department of Education.

F. Roles of Board of Directors and Corporate Members

Beyond the function of formally electing the Board of Directors, the Corporate Members of CAHME will have only those reserve powers required by law. The Board of Directors will govern CAHME consistent with the bylaws of the enterprise. The Board of Directors will appoint and serve as the reporting line for the President/CEO of CAHME. The Board of Directors will make all decisions on awarding, changing, or withdrawing accreditation based on recommendations of the Accreditation Council. The Board of Directors will set the standards of accreditation taking into account recommendations of the Standards Council. The Board of Directors will oversee the business affairs of CAHME. Among other fiduciary functions and accreditation decisions, the Board of Directors will also approve the competencies that underlie the standards of accreditation in health administration, based upon recommendations of the Standards Council. The Board of Directors will be accountable to the public with appropriate influence by its public representatives (see BRTF Recommendations R4 and R15).

In addition to the governance powers of Corporate Members outlined previously, CAHME will be structured to engage Corporate Members in the activities of the Commission. Formal and informal means will be used to encourage interested Corporate Members to learn about and participate in CAHME. One such example could be membership and participation in the councils and committees described subsequently.

G. Committees of the Board

Committees of the Board of Directors will be established in order to facilitate carrying out the functions of the Board. The following are committees of the Board with a brief description of each.

1. *Governance Committee:* The Governance Committee will recommend nominees to the CAHME Board and be accountable for board

evaluation and development activities. The Committee will solicit nominations from Corporate Members for appointment to the CAHME Board. The CAHME Board of Directors will appoint the Governance Committee. It will include Board as well as non-board members. The Governance Committee will include at all times at least one member from each of the Corporate Member categories except the At-Large Member category. Specifically, the Governance Committee will include the Chair, immediate Past Chair and Chair-Elect, plus additional members selected by the Board. The immediate Past Chair of the Board will serve as Chair of the Committee. In the event a Past Chair is not available, the Chair of the Board will serve as Chair of the Governance Committee.

2. *Executive Committee:* The Executive Committee will consist of select officers and members of the CAHME Board of Directors. The function of the Executive Committee will be to provide coordination and direction between Board meetings. It will also carry out special functions assigned by the Board of Directors.
3. *Other Committees:* Other committees can be appointed in the future to assist the Board of Directors as needed, such as an Audit Committee, Operations Committee, and/or Finance Committee.

CAHME ACCREDITATION FUNCTION

A. Goal of Accreditation

This Strategic Blueprint is intended to provide an opportunity for accreditation standards to be examined and updated in a timely fashion. It is recognized that CAHME must develop accreditation processes that are more efficient and less onerous. Additionally, it must provide for effective use of electronic technology that is currently available. In addition, it must address important questions facing the field of healthcare management education.

The scope of accreditation must be considered by CAHME. The historic educational focus of most programs accredited by ACEHSA has been management of health services delivery with health policy an additional focus of some programs. Recently, the number of programs emphasizing careers in the healthcare supply

chain, manufacture or distribution of healthcare products and services, and management consultation has increased. Large and historically prominent programs have designed curriculum, faculty, and other learning resources to develop graduate programs designed for this expanding market.

These developments and others require specific attention be paid to defining the scope of healthcare management practice that will be the basis for accreditation. Moreover, adaptation in the scope of accreditation is important if the Commission is to avoid the experience of other fields where accreditation has become competitive and fragmented. While the Commission must be cognizant of recent developments in the field, the transformed Commission must define and focus on the core competencies of healthcare management. The Commission will identify a set of core healthcare management 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 that allow extension beyond the core.

CAHME will give careful consideration to the ongoing work of numerous professional societies and national organizations in identifying the core competencies. Competencies will be reviewed and revised on an ongoing basis as experience is gained with the use of competencies and as new evidence becomes available.

The council structure provides a means for assessment and deliberation of accreditation recommendations by professionals who will be able to devote focused time on specific components of accreditation. While decisions concerning accreditation and accreditation standards are ultimately the responsibility of the Board of Directors, the advice and recommendations of the councils are a critical component of the decision-making process.

The goal of CAHME will be to establish "leading edge" standards and assessment mechanisms of quality at selected academic levels (degree-granting programs) of the healthcare sector. The term, "selected academic levels," is meant to apply to consideration of degree-granting programs/departments/schools at the undergraduate, master's and professional doctoral levels. The Board of Directors will determine the levels to be included and will commission special study

groups as appropriate. Consideration may also be given to accrediting pre-master's and post-master's residency and fellowship programs.

This goal is to assure the highest quality educational product across the field. While continuously improving quality of the strongest programs, CAHME will enhance the quality of all accredited programs. Accreditation or re-accreditation will be denied or withdrawn from those programs that do not meet accreditation standards. All elements of structural and procedural accreditation functions are designed to be consistent with regulations of DOE (see BRTF Recommendations R2 and R14). Also, the standards of the private agencies that accredit accreditors, the Council for Higher Education Accreditation (CHEA) and the Association of Specialized & Professional Accreditors (ASPA), are carefully considered in this proposal and will be met.

B. Accreditation Functions and Council Structure

An organizational structure of councils of CAHME will be established with consideration given to the recommendations of the Blue Ribbon Task Force. This reorganized structure will carry out accreditation processes. The new councils will develop, recommend, and, as adopted by the Board of Directors, implement accreditation criteria and other forms of accreditation standards. The accreditation criteria/standards will be developed by a component of the Council structure comprised of academicians from AUPHA and practitioners from the Market and the Profession. The Accreditation Council will also assess compliance with the accreditation criteria and make recommendations for accreditation status. The Board of Directors will develop the exact scope and definition of each council. Formal and informal means will be employed to encourage constituents of CAHME to serve on the various councils and committees.

Membership on the CAHME councils and committees will be open to individuals not otherwise affiliated with CAHME. The Board of Directors will determine the need for additional councils or committees and the membership of all councils or committees.

1. Accreditation Council—Persons will be appointed to this Council by the Board of Directors and will be designated as Commis-

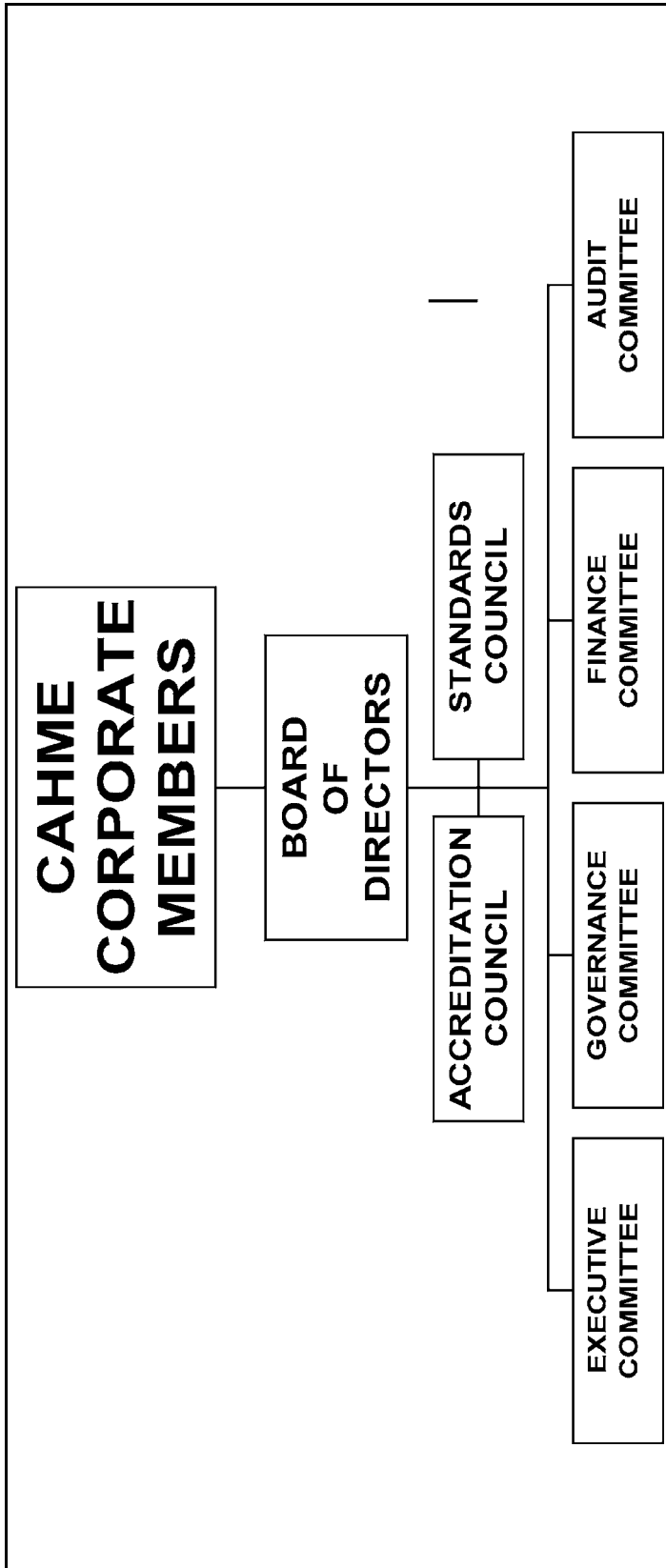


Figure 1. CAHME corporate structure

sioners. One member of the Board of Directors will serve as Chair of the Council. The Board of Directors will appoint Commissioners (academicians, practitioners, and public members), drawing from members of the Board of Directors, Corporate Members of CAHME who are not members of the Board of Directors, and others. The Board of Directors will ensure that the Commissioners comprising the Accreditation Council are in equal proportions academicians and practitioners.

The role of the Accreditation Council will be to oversee the accreditation process and to make recommendations to the Board on individual accreditation decisions. The Accreditation Council will also make decisions relative to accreditation matters as delegated to it by the Board of Directors. A logical source for initial membership and leadership of the Accreditation Council is the membership and leadership of the Commissioners.

2. *Standards Council*—This council will have composition and leadership formulated in a manner similar to that of the Accreditation Council. The Board of Directors will appoint members of the Standards Council. CAHME will consider qualifications of members as it appoints members of the Standards Council to assure sufficient overlap with current developments in the Accreditation Council. The role of the Standards Council will be to maintain and continuously improve the accreditation standards, and to recommend standards for consideration and action by the Board of Directors (see BRTF recommendations R8 and R13).
3. *Other Councils and Committees*—Other councils will be established as needed. For example, a council on CAHME Fellowships could be established. Factors to be considered before establishing councils will be the ability to secure financial support required to create these bodies, provision of adequate staff support, reimbursement of members for travel expenses related to meetings, and funding telephone conference calls. Work of the councils/committees will be done electronically, but each body will meet at least annually, and the Accreditation Council will probably meet more often.

C. Accreditation Decisions

The Board of Directors, and only that entity, will make decisions for accreditation of selected levels of degree-granting university programs in healthcare management, except as delegated to the Accreditation Council. As a *modus operandi* the Board of Directors will act on recommendations of the Accreditation Council. The Board may decide to delegate selected actions to the Council as appropriate.

D. Expanded Model for Accreditation— Definition and Terms of Accreditation Levels

The change needed in healthcare leadership and the new vision for ACEHSA make it imperative that accreditation actions taken by the Board of Directors (on accreditation recommendations from the Accreditation Council) go beyond the current choices of either Accredited or Not Accredited. While the specific expanded accreditation options desirable for addressing the new vision will be considered and adopted by CAHME, strong consideration will be given to the following three possible options and to means for enhancing continuous quality improvement (see BRTF Recommendation R13):

1. Accreditation

- This credential is awarded to those programs that meet all of the criteria for accreditation.
- An accreditation site visit will be conducted once every five to eight years, as determined by the Commission. An earlier site visit may be required by the Commission if there is material change in the program, indicators of complacency in the program, or as the result of a desk audit.
- An accreditation desk audit will be conducted at the end of three years, along with regular review of the annual reports currently required (keyed to BRTF Recommendation R10).

2. Accreditation with Probationary Status

- This credential is assigned to those programs that meet accreditation criteria but in such a marginal way as to call for early corrective action. This probationary status carries with it requirements for specific action by the university program.

Unless compliance is achieved within 12 months, accreditation will be withdrawn.

- The program must satisfy CAHME of having corrected the conditions upon which the probationary status was assigned, prior to the end of the 12 months.

3. Withdrawal or Denial of Accreditation

- The Commission takes this action when programs are determined not to meet the accreditation criteria of the Commission. The Commission either before or after a probationary period can withdraw or deny accreditation.
- A program that has had its accreditation withdrawn or denied may appeal such a decision by the Commission consistent with the policies and procedures of the Commission.
- If it does not appeal the decision by the Commission, a program may pursue accreditation through the Candidacy Program, or, if it was previously accredited, the program has two options. One is to pursue re-accreditation through the Candidacy Program; the second is to petition the Commission for a new accreditation process at a later time, again consistent with the policies and procedures of the Commission.

4. Other Means for Continuous Quality Improvement

- In addition to the foregoing three options, the Commission will carefully consider creative, effective means for continually elevating improved performance by health-care management education programs.

E. Other Accreditation Factors

Other factors of accreditation site visits and processes will also need to be strengthened and adopted by CAHME. The following are recommended:

1. Site visits will be required of all new programs that are established by currently accredited programs or departments.
2. The entire accreditation process, including self-studies, conduct of the site visit, and decision processes, will be streamlined and made more efficient. This will be accom-

plished via a CAHME-appointed task force, in collaboration with the Standards Council, and will incorporate not only the best practices of other accrediting bodies but also create leading-edge programs and processes (see BRTF Recommendations R10 and R11).

F. CAHME Fellows Program

1. Purpose—The primary purpose of the CAHME Fellows Program will be to develop leaders in education and practice over lifelong careers. A valuable byproduct is provision of quality services by CAHME Fellows to the ongoing processes.
2. Program—CAHME Fellows will serve as integral personnel in accomplishing the accreditation processes, conducting various research and analytical projects, and engaging in other career development experiences that also serve the mission of CAHME. In consideration of the service provided by the Fellows, and consistent with its commitment to career enhancement, CAHME will provide attractive opportunities along several lines for career developmental experiences by the Fellows.
3. Requisite Resources for the Fellows Program—The financial requirements necessary to fulfill the purpose of the CAHME Fellows Program as stated previously will be met through the additional resources described in the next section.

FINANCE AND MEMBER BENEFITS

This section outlines the means by which CAHME will become financially strong and will sustain its financial strength. Importantly, it also addresses the benefits to corporate members whose continuing support is crucial to the achievement of the transformational objectives.

A. General

1. Approximately one-third of the CAHME operating budget will be drawn from the **Market**.
2. Approximately one-third of the CAHME operating budget will be drawn from the **Profession**.

3. *Approximately one-third of the operating budget will be derived from **Academia**, taking into account the annual corporate member fee of \$20K paid by AUPHA, along with several means of financial support and in-kind support provided by the AUPHA and its accredited-program members, including fees. The accreditation site visits and desk audits will be priced so that, at a minimum, the fees paid by the programs that participate in the accrediting processes cover the direct costs of these functions.*
4. *The Board of Directors will determine the nature of the fee structure for **At-Large Members**. It is intended that a marginal supplement of augmenting resources will derive from **At-Large Members**.*

B. Funding/Budget Base

1. **The Market**

*The financial objective of the Market is to achieve approximately 15 members of CAHME from the **Market**. Each member will contribute \$20K per year as a membership fee of CAHME.⁶ This will yield annual revenues of approximately \$300K.*

2. **The Profession**

*The financial objective of the **Profession** is to achieve approximately 15 members from the **Profession**. Each member will contribute \$20K per year as a membership fee of CAHME. This will yield annual revenues of approximately \$300K.*

3. **Academia**

*The financial objective relative to **Academia** is to generate financial benefit at a level comparable to that of the **Market** and the **Profession**. AUPHA will serve as an initial organizational base for membership in the Commission by **Academia**. As a Corporate Member, AUPHA will contribute the annual Corporate Member fee each year. As noted previously, **Academia** also will contribute to support of the Commission through payment of fees for the site visits and desk audits that cover the direct costs of these accreditation processes, along with the in-kind support of AUPHA.*

4. **At-Large Members**

There will be a category of organizations that

qualify for an alternative fee structure to be determined by the Board of Directors. There may be some marginal contribution to financial strength; however, the purpose of this category is to include the important elements of the field that characteristically lack sufficient funds to participate in voluntary efforts. In addition to the examples previously identified, others that might be considered include: the National Association of Public Hospitals, Community Health Centers, the Veterans Health Administration, the National Association of Health Services Executives, the Institute for Diversity in Management, the Indian Health Service, and the U. S. Department of Defense.

5. **Federal Government Support (see BRTF Recommendation RI7)**

Given national and international pressures for critical improvements in the health industry, this is an ideal time for a new federal grant program to support health services administration education. Funds could 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. There are indications within the federal establishment of support and state of readiness to consider such a grant program.

6. **Philanthropic Support**

In addition to the core support of CAHME members, there could be substantial potential support by individuals and organizations with abiding concern for enhanced quality of education and practice in healthcare management. The correct timing and skillful approach to such individuals and organizations could yield major resources to CAHME toward an unprecedented margin of excellence. This philanthropic support could also provide resources for the CAHME Fellows program as well as other components and projects of CAHME.

C. Benefits to Corporate Members

- Identification of Benefits—The most impor-*

tant consideration in identification of member benefits is to “ask the customer” (see BRTF Recommendations R15 and R16). Some market testing has already been fruitful, but more must be done. What follows are ideas that serve to stimulate discussion. These ideas have received mixed reviews to date, and continue to be a component of this strategic blueprint on a highly contingent basis—to be confirmed or set aside based on market reaction. In this context, a set of ideas follows.

- *Annual Colloquy of Corporate Members*—This invitation-only event is intended to have major significance for the field. Key speakers will be the knowledgeable and respected leaders. The Annual Members Colloquy will feature practitioner-academician work sessions and seminars on topical issues.

The invitees to the Colloquy will be CEOs of the organizational members of the Market and the Profession and senior educational leaders of Academia. A goal of this Annual Colloquy will be to create a nexus of relationships among leaders of the three major components of the field. Key speakers and resource persons will enhance the value of the Annual Colloquy to attendees. A major benefit to, and motivation for, Corporate Members to attend the Annual Colloquy will be the opportunity to interact with leaders in other major components of the field around a shared interest.

- *Career Services*—CAHME, along with programs earning accreditation with best practices acknowledgment, would implement career services for the benefit of all stakeholders. This could be done in conjunction with the Annual Members Colloquy as well as individual career days on campuses accorded the status of accreditation with best practices acknowledgment. The goal of these career days could be to facilitate recruitment and placement of the best candidates for filling positions with the members of the Market, members of the Profession, and members of Academia.
- *Work Force Needs*—In return for support of CAHME, Corporate Member organizations could benefit through encouragement by CAHME that accredited programs collaborate directly with employers of choice in

placing the best-qualified graduates. A requirement for citation as accredited with best practices acknowledgment could be that a program conducts annual career services that brings students and prospective employers together. CAHME could serve as a resource for organizing and administering this process.

- *Organized Collegial Contact*—It may be that the greatest reason for an organization to become a CAHME Corporate Member is to be a part of a highly collegial, committed circle of very well regarded enterprises and individuals who come together around CAHME to shape the future of healthcare management education.
- *Benefits from the CAHME Fellows Program*—Over the years, various organizations have attested to the value of developing organizational leadership and management skills by those who have served as ACEHSA Fellows. The new CAHME Fellows Program will build upon and add value to Corporate Member organizations through heightened performance by CAHME Fellows.

CONCLUSION

The provisions outlined in this paper are designed to achieve the objectives identified jointly by the Corporate Sponsors and members of the Board of Commissioners. The ideas in this paper are supportive of the recommendations from the BRTF and provide means for realizing the vision of the BRTF. Not all recommendations of the BRTF are addressed in this paper as some are related to, but not central to, the thrust of this paper. The Board of Commissioners and its successor organization, the CAHME Accreditation Council, is addressing those BRTF recommendations not specifically addressed herein.

The product of this Joint Task Group work centers upon a coherent strategic blueprint for the future of accreditation in healthcare management. The vision and goals of CAHME will best be met by adoption of the basic principles that formulate the strategic blueprint and enable moving on to accomplish the next steps toward implementation.

This strategic blueprint is a bold vision for the future with an aggressive plan to strengthen substantially the accreditation function of healthcare

management education. ACEHSA and its legion of volunteers, supporters, Commissioners and Fellows have served the field very well for over 40 years. The rapid pace of change, the pressures

of the times and the challenges of the future make corporate restructuring imperative. Time is short, much is to be done, the needs are compelling, and the moment is now.

Notes

1 Inquiry's style generally is to use two words for "health care"; however, this document, which is printed as adopted by the ACEHSA, uses "health-care" as one word.

2 JTG membership, with affiliations at the time the group convened, was as follows:

Howard Berman, M.H.A.

Vice Chairman

The Lifetime Healthcare Companies

Richard L. Clarke, M.B.A., F.H.F.M.A.

President & CEO

Healthcare Financial Management Association

Jeptha W. Dalston, Ph.D., F.A.C.H.E.

President & CEO

AUPHA and ACEHSA

Thomas Dolan, Ph.D., F.A.C.H.E.

President

American College of Healthcare Executives

William F. Jessee, M.D., F.A.C.M.P.E.

President & CEO

American College of Medical Practice Executives

S. Robert Hernandez, Dr. P.H.

Professor

Department of Health Services Administration

University of Alabama at Birmingham

Peggy Leatt, Ph.D.

Chair

Department of Health Policy and Administration

University of North Carolina at Chapel Hill

Lawrence D. Prybil, Ph.D., F.A.C.H.E.

Associate Dean and Professor

College of Public Health

University of Iowa

Catherine J. Robbins, M.B.A., F.H.F.M.A.

Vice President

Cain Brothers

ACEHSA Fellow Analysts were:

Kanak Gautam, Ph.D.

Associate Professor of Health Administration

School of Public Health

St. Louis University

Jörg Westermann, Ph.D.

Assistant Professor, Department of Health Management and Policy, and

Director, Continuing Education Center for Public Health Practice
University of Iowa

ACEHSA staff officers were: Lydia M. Reed, C.A.E., M.B.A., vice president, accreditation operations; and Pamela S. Jenness, director, accreditation operations.

3 This report was a joint effort of the Accreditation Commission on Education for Health Services Administration and the National Center for Healthcare Leadership (NCHL). This report was completed in the summer of 2003. Copies are available from CAHME, 2000 14th Street North, Suite 780, Arlington, VA 22201-2543; website: www.cahme.org

4 These annotations are denoted by reference numbers (R1,R2, etc.) that apply to the BRTF report. Interested readers can find this BRTF report in the *Journal of Health Administration Education* 2004 21(2), special issue called *Accreditation in Health Administration Education: A Call for Change*.

5 The new CAHME Board of Directors will determine the nature of an alternative fee structure. Examples might be shared annual fees with other similar organizations, discounted fees, or even waived fees. For example, group medical practices without individual resources to meet the full corporate member annual fee might join through shared arrangements to achieve presence in the new CAHME structure. Also, such at-large members could be a consortium of safety-net delivery organizations with a mission oriented to the underserved and the uninsured. For instance, members of the National Association of Public Hospitals are possible examples. Other at-large members might be organizations advancing the interests of disadvantaged groups, which thus advance the interests of the field as a whole.

6 Members of the Market and the Profession will be invited to commit to contributions at the level indicated for two years. During these two years, the new CAHME will demonstrate seriousness of purpose and ability to "get the job done." The first year will be devoted to "process," but the second year will have to yield results in order to inspire confidence of members to continue their support and participation. Following the first two years of CAHME implementation, the level of annual membership fee (\$20K per year) will be assessed annually by the Board of Directors.