

Accreditation of emerging oral health professions: options for dental therapy education programs

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Keywords

accreditation; dental health education; dental health services; health occupations; allied health; delivery of dental care; dental auxiliaries.

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Abstract

Objectives: The study explored the options for accreditation of educational programs to prepare a new oral health provider, the dental therapist.

Methods: A literature review and interviews of 10 content experts were conducted. The content experts represented a wide array of interests, including individuals associated with the various dental stakeholder organizations in education, accreditation, practice, and licensure, as well as representatives of non-dental accrediting organizations whose experience could inform the study.

Results: Development of an educational accreditation program for an emerging profession requires collaboration among key stakeholders representing education, practice, licensure, and other interests. Options for accreditation of dental therapy education programs include establishment of a new independent accrediting agency; seeking recognition as a committee within the Commission on Accreditation of Allied Health Education Programs; or working with the Commission on Dental Accreditation (CODA) to create a new accreditation program within CODA. These options are not mutually exclusive, and more than one accreditation program could potentially exist.

Conclusions: An educational accreditation program is built upon a well-defined field, where there is a demonstrated need for the occupation and for accreditation of educational programs that prepare individuals to enter that occupation. The fundamental value of accreditation is as one player in the overall scheme of improving the quality of higher education delivered to students and, ultimately, the delivery of health services. Leaders concerned with the oral health workforce will need to consider future directions and the potential roles of new oral health providers as they determine appropriate directions for educational accreditation for dental therapy.

Introduction

Accreditation of educational programs is complex and requires high levels of collaboration among professional accrediting agencies, educational and practice organizations, and state regulators. The fundamental principle of accreditation is protection of the public. Systems of accreditation are predicated upon the development of educational standards agreed upon by interested stakeholders. It provides the foundation for quality assurance and continuous improvement in the delivery of health care through preparation of a competent and relevant workforce, and standardized competencies.

This article reports the results of a study conducted for the American Association of Public Health Dentistry (AAPHD)

panel on dental therapist curriculum development, convened in January 2010 with the support of the W.K. Kellogg Foundation and the Josiah Macy, Jr. Foundation. The study summarized here is based upon an extensive report on the accreditation of dental therapy programs and certification of dental therapists, presented to the AAPHD panel in September 2010 (1).

The field of dental therapy is emerging in the United States. Educational programs currently exist in Washington and Minnesota, and programs are being discussed in other states in order to create new oral health professionals to reach underserved populations. As stated by the W.K. Kellogg Foundation, "internationally and in Alaska, dental therapists have a history of successfully expanding proven high-quality

care to underserved children and families as part of a comprehensive system of care managed by dentists. Dental therapy is well-established in more than 50 countries around the world, including countries with advanced dental care systems similar to the U.S.” (2).

At present, there is no national accrediting body for dental therapy education, so as programs begin, there are inevitable questions related to individual licensure at the state level to regulate the quality of dental therapists. In the absence of a national accrediting agency, states may feel a need to set up their own quality review processes. Multiple state-level processes could undermine future attempts to create a consolidated professional approach to dental therapist education, resulting in fragmentation and variations in scope of practice among states.

Thus, the charge from the AAPHD panel was to investigate alternative approaches to educational accreditation and identify options for the future for ensuring the quality of dental therapy education.

Methods

The research team conducted an extensive literature review exploring Web sites and reports from various accrediting, educational, professional and government organizations, as well as the peer-reviewed and public domain literature about accreditation, the health professions, and regulation of scope of practice in the health professions. The research team then conducted interviews with 10 content experts. The experts represented a wide array of interests, including individuals associated with the various dental stakeholder organizations in education, accreditation, practice, and licensure, as well as representatives of non-dental accrediting organizations whose experience could inform the study.

The purpose of the interviews was to investigate the various perspectives on accreditation of dental therapist education programs. The two members of the research team conducted all of the interviews and were the only people who had access to the original recordings and transcripts of the interviews. The interview strategy and protocol was reviewed and approved by the Portland State University Human Subjects Research Review Committee (the institutional review board).

Current context of the dental workforce

In 2000, the report entitled *Oral Health in America: A Report of the Surgeon General* described a national oral health care crisis (3). The report concluded that the infrastructure for the oral health system is insufficient to meet the needs of many disadvantaged population groups in the United States. It also reported disproportionate access to dental care based on race, ethnicity, and socioeconomic factors within the US popula-

tion. In response, new workforce models are being introduced, in the hopes of balancing the provider distribution in the future to better address these disparities. Increases in aging and immigrant populations, rural residents, and the needs of children are all placing pressure on the US oral health system and exposing its inequalities (4).

In Alaska, the Alaska Native Tribal Health Consortium developed the strategy of the Dental Health Aide Therapist (DHAT) practitioners, who are now trained in the DENTEX program at the University of Washington (5). The DHATs work in a coordinated system of oral health care in order to reach remote populations who receive episodic dental care or no professional care at all (6). The University of Minnesota recently started the bachelor of science in dental therapy and the master of dental therapy programs (7). Metropolitan State University (8), also in Minnesota, is offering the master of science in oral health care practitioner program for licensed dental hygienists and collaborates with Normandale Community College (9) to offer two dental hygiene degree completion programs. None of the aforementioned programs is accredited by an educational program-specific accreditor.

The development of these programs has been welcomed by many in the oral health workforce who see the dental therapist as a viable solution for expanding oral health services for populations. There has also been opposition by others who feel that any new oral health professionals undermine the singular position of dentists in the health workforce and may affect both scope of practice and income generation. The American Dental Association (ADA) initiated unsuccessful legal action against the Alaska initiative; the details of that action are beyond the scope of this paper, but the action itself is emblematic of the position expressed by the ADA and others with regard to dental therapists and concerns about scope and authority for dental practice and service delivery.

More recently, three high-profile reports have been issued, addressing the current state of the oral health workforce and recommending actions including new practitioner models. *The U.S. Oral Health Workforce in the Coming Decade: Workshop Summary* (10) provides a summary of a workshop sponsored by the Institute of Medicine (IOM) in February 2009. The workshop provided a forum for experts from all oral health disciplines to discuss the state of oral health care in America and how it needs to evolve in the coming years. The report stated, “the current oral health workforce fails to meet the needs of many segments of the U.S. population” (10). The conclusions that resulted from the workshop led the IOM to state that “variability in access to oral health services . . . often related to geography, insurance status, socio-demographic characteristics, and income levels . . .” creates many challenges (10).

Help Wanted: A Policy Maker’s Guide to New Dental Providers (11) provided objective information for consideration of

three new workforce models currently under discussion in many state legislatures: dental therapists, community dental health coordinators, and advanced dental hygiene practitioners. The report called on policy makers to weigh carefully the concerns of all stakeholders when considering how to develop new providers to join the dental team and potentially expand the safety net for dental health care.

Training New Dental Health Providers in the U.S. (12) addressed training considerations for new dental health providers and their scope, supervision requirements, and placement options. The report provides details on eight criteria for developing dental therapy training programs: recruitment, curricula, length of training, supervision and placement, cost, training experiences, care for the underserved populations, and certification and accreditation (12).

Content experts interviewed for this report emphasized that the purpose of dental therapists is to provide access for the underserved to the oral health system. In order to assure services to underserved, rural, and other marginalized populations, more diverse populations of students should be recruited from those groups and provided with fiscal support and incentives to return to their home area to practice upon graduation. The experts also emphasized the opportunities and need to expand the scope of the oral health workforce by effectively using various levels of providers who are appropriately trained, are certified for a defined scope of practice, and work with the relevant amount of autonomy and/or supervision. In all cases, the concerns for enhancing access and service provision were closely coupled with the need for attention to ensuring quality and safety.

Accreditation of dental education

The Commission on Dental Accreditation (CODA) currently accredits all educational programs that train the oral health workforce, including dentists and dental hygienists (13). The mission of CODA is to “. . . serve the public by establishing, maintaining and applying standards that ensure the quality and continuous improvement of dental and dental-related education and reflect the evolving practice of dentistry” (13). CODA accredits programs in predoctoral dental education, dental specialties, and allied dental education. The latter category includes dental hygiene, dental assisting, and dental laboratory technology programs. In total, CODA accredits approximately 1,300 education programs (13).

As part of its recognition by the US Department of Education (USDE), CODA is required to function autonomously in all matters related to the accreditation process. Although autonomous, the commission is an agency of the ADA, which houses it and contributes to its staffing and resource needs. Members of the commission are selected by the participating organizations; these selections are not subject to review by any other organization. The commission membership is

intended to reflect a diversity of geography, gender, and underrepresented ethnic groups.

The scope of CODA's activities relates to educational accreditation at the programmatic level, and not to licensure or certification of individuals. Decisions are made based upon evidence provided in a self-study, explored during a site visit by expert peers, and reviewed against professionally established standards. CODA leadership has indicated it is trying to be more transparent by holding open hearings at ADA and the American Dental Education Association meetings, as well as webinars, in order to enable interested parties to learn more about the processes and practices of the agency (according to an interview with Dr. A. Ziebert, September 2010).

CODA is formalizing new criteria to judge new types of programs. These include that the new discipline be aligned with CODA's mission and scope; there are sufficient benchmarks and performance measures to serve as a basis to develop accreditation standards; the educational programs are part of institutions that are accredited by an agency recognized by the USDE or Council for Higher Education Accreditation (CHEA); there is sufficient level of activity and expertise to establish standards and sustain a quality review process; and there is evidence of need for the new programs and support from the public and professional communities to sustain educational programs in the discipline (14). However, until such criteria and related procedures for accreditation of new programs are adopted, it is not within CODA's scope to review new dental therapy programs for consideration for accreditation. Criteria for current accreditation programs (such as the predoctoral or dental hygienist programs) are not specific to dental therapy and therefore would not be relevant.

Options for accreditation of dental therapy programs

The majority of sources reviewed and content experts consulted point to a consensus that there must be a consistent, coordinated national program of accreditation of dental therapy education. This is important to ensure quality and to remove any bias or variation that may occur if a single organization or jurisdiction is controlling the process. Such a program should be organized to be broadly representative of the key stakeholders in dental therapy education and practice, and more broadly in terms of the oral health workforce.

The strengths of an accepted accreditation process include assurance of quality; promotion of self-assessment and continuous improvement; establishment of standards derived by educators and practitioners that serve as a baseline for entry to professional practice; and peer review and consultation (15). Arguments against accreditation include concerns about the fragmentation of professions through multiple

accreditors; the perceived inflexibility and inability of accreditation to respond to societal changes; perceptions of accreditation as a barrier to educational innovation; and a concern about a compliance and process focus as compared with an improvement and outcomes focus (16).

Another issue that is raised about accreditation is the lack of evidence that it is effective in identifying substandard schools or improving educational quality, and, concomitantly, that it protects students from deficient education or the public from deficient services (17) – in this context, oral health care. The problem of evidence has at least two parts: a) linking educational programs to outcomes, in particular, the competency of graduates; and b) identifying desirable educational processes, methods, or structures (such as curricular approaches, faculty qualifications, or performance monitoring systems) (1). There have been few, if any, systematic studies of the processes and outcomes of accreditation, including studies of rater bias or validity, in particular, because of the fact that few programs would be willing to serve as the “controls” for such a study.

This review resulted in identification of four feasible options for organization of an accreditation program for dental therapy education. In all cases, the work that is required to establish such a program must involve key stakeholders representing multiple interests who will work together to define the common standards for accreditation, the accompanying procedures to manage the accreditation program, and the organizational and governance structures to manage it. The options are: a single new program that is created and operated through the existing structures of CODA; a single new program that seeks to become one of the joint review committees within the Commission of Accreditation of Allied Health Education Programs (CAAHEP); a new stand-alone accrediting agency; or creation of two or more new programs, within CODA, CAAHEP, or a new stand-alone model. The primary advantage of working with either CODA or CAAHEP is that these organizations have long track records and experience in accreditation, and bring resources and expertise.

Option #1 – CODA

CODA offers connections to dental education and linkage to the “dominant” interest in the dental profession. For CODA to begin accreditation of dental therapy programs, it would need to work with a group of stakeholders who represent the dental therapy educational programs and collaboratively develop standards for curriculum, faculty, resources, and the other elements that are generally included in accreditation programs. It would be unusual for an accreditor to develop such a program in isolation from those in education and practice; the norm is that the profession goes to the accreditor, demonstrating that there is a critical mass of programs

and indicating a willingness to provide leadership to establish an accreditation program in collaboration with the accrediting agency. The profession and other key stakeholders would have input on all the necessary elements of the accreditation program not only in terms of programmatic issues but also in terms of the structure of the accreditation body, governance, representation, staffing, and decision-making processes.

Some content experts expressed concerns about affiliation with CODA because of perceptions that CODA’s close ties to the ADA prevent truly independent operations because of the size, power, and influence of the ADA, and the ADA’s public opposition to dental therapy education programs.

Option #2 – CAAHEP

Developing a new committee within CAAHEP may be a more agreeable option for some stakeholders, offering the stability of a long-established agency yet separate from “organized” dentistry. In order to become a committee of CAAHEP, an organization representing a health profession must represent a well-defined and distinct field, be national in scope, have programs already established with enrolled students, have standards for the programs, and demonstrate that graduates have obtained the necessary skills to enter practice (18). CAAHEP-affiliated accrediting agencies review programs that range from the 9-month technical degrees through associate and baccalaureate degrees to graduate degrees.

Accrediting agencies that have left CAAHEP and established independent operations have achieved a greater degree of flexibility and adaptability that allows their independent agency to respond to the needs of its specific profession (cited in confidential interviews).

The breadth of programs covered under the CAAHEP umbrella may raise concerns as to whether CAAHEP can adapt its review processes to consider the specific context of a profession and the relevant depth and breadth of the educational program. “Allied health” agencies that operate outside of CAAHEP believe that they have a greater degree of professional autonomy and that their accreditation decision-making processes respond to their specific professional stakeholders, and not the multiple interests of the broad CAAHEP community. These agencies also speak to the value of being separate from the perceived control of the American Medical Association (AMA), because CAAHEP is housed at the AMA.

Option #3 – a new independent agency

Some individuals think that linking a new accreditation program to an existing organization will dilute the interests of dental therapy and that there needs to be a new stand-alone agency. If that option is chosen, leaders in the profession will need to engage with accreditation experts from various fields

to ensure careful guidance on all matters involved in establishing a new accreditation agency – both in terms of dental therapy education specifically as well as addressing all of the necessary logistical, political, and organizational considerations and decisions regarding recognition by/affiliations with the USDE, the CHEA (19), and the Association of Specialized and Professional Accreditors (ASPA) (20).

As with the option for developing a new committee in CAAHEP, a stand-alone accrediting agency would need to represent multiple education and practice interests in dental therapy, and have sufficient resources to create a new non-profit organization that could independently conduct the accreditation program. Many observers have noted the proliferation of accrediting agencies (21) and caution against developing a new accrediting agency that may increase burden on educational institutions and be duplicative of other organizations that offer many of the needed services. Establishing a new accreditation agency is often seen as a path to increasing control over a profession's future and its identity and prestige, which would be desirable to better establish dental therapy as a unique profession (22).

Option #4 – develop multiple programs

The choice to develop multiple new programs of accreditation is offered only as a consideration should there be an inability to agree on a single preferred model, and various groups develop, each of which decides to pursue accreditation. In a field as small as dental therapy is at present, with a limited number of educational programs, this latter option is unlikely to be feasible or viable specifically for dental therapy. However, a new accreditor serving the multiple emerging oral health providers might also be an option. Should the deliberations on accreditation go on over a period of time during which new educational programs develop, then considerations of the benefits and consequences of multiple accreditors will need to be carefully assessed. Experience in other fields such as nursing, teacher education, the mental health professions, and business education has not demonstrated clear benefit when there is apparent replication of effort.

Strategies for developing a new accreditation program

In order to move forward to develop an accreditation program, there needs to be consensus among leaders in the field on the common curriculum for dental therapy education and the defined scope of practice, so that programs can prepare graduates for the relevant practice environment and control entry of practice to those who have demonstrated competency (as defined by the field). This will involve ongoing conversations among those leading national accreditation efforts, professional workforce strategic planning, edu-

cational programmatic development and core curriculum conversations, and state-level licensure and/or certification groups. This suggests leadership from the oral health education and practice communities, and cultivation of stakeholders to gain buy-in to development of an accreditation program (assuming there is agreement on the need for dental therapists). Leaders would be well advised to think beyond the traditional “family” of oral health workforce interests (23) and consider additional stakeholders from government, health services delivery organizations, insurance, associations, public health, the long-term care industry, and minority population groups – all of whom could have an interest as potential employers, payers, or consumers of the services of dental therapists. An accrediting agency also must have “public” representation in order to be recognized by the US Secretary of Education (24).

Overall, critics of the current accreditation process argue that its costs in time, money, and institutional disruption are excessive for its positive results. There are criticisms that accreditation is duplicative and wasteful – a concern to keep in mind if multiple accreditors are responsible for the various dental education programs, many (if not all) of which are likely to be housed in common academic units on university or college campuses (25). This concern is further manifested when academic units are expected to respond to multiple sets of standards, each of which has different data requirements and different presentation formats, and those units are expected to be available for multiple accreditation visits that require substantial investment of time, money, and human resources. Streamlining data requirements and synchronizing formats for submission of information, especially if there is synergy among professions with common roots (such as dentistry, dental hygiene, and dental therapy), could respond to the concerns of institutional administrators and create a more receptive environment for specialized accreditation on campuses (26).

Establishment of a new accrediting agency will require not only considerable deliberations within the oral health community, but also consultations with established accrediting agencies with regard to organizational structure, governance, legal issues, resource implications, and operational issues. Consultation with the USDE, CHEA, and ASPA will be essential. A concern to address is the variability of titles assigned to various practitioners and the related variation in educational preparation and graduate scope of practice, which may cause considerable confusion and difficulties in agreeing upon a coherent set of standards for the new accreditation program. If this variation results in fractionation among educational programs, this may also preclude identification of the critical mass of similar programs that will form the basis for the new accreditation program. Given discussions of new practitioners such as dental therapists, community dental health coordinators, advanced dental hygiene practitioners, and oral

preventive assistants, there clearly needs to be stakeholder agreement upon naming the practitioner and the core curriculum for educational preparation in order to establish the foundation upon which an accreditation program to be established.

Some content experts suggested that a major facilitator of moving forward will be pressure from the states; if states begin to recognize dental therapists as a key oral health services provider, then there will be a need to develop multiple education programs and subsequently develop a coherent accreditation program. If the new practitioners develop as a core part of the dental team, then there will be pressures from established oral health providers who will want the structure of accreditation to ensure the quality of the educational preparation of the new providers and that they are graduates of reputable educational institutions.

Many content experts also spoke to the uncertainty regarding development of a “dental home” within the evolving healthcare reform activities in this country, with some concerns regarding the lack of advocacy on behalf of the oral health workforce in positioning itself as a core element of the new efforts in health reform. While detailed discussion of this is beyond the scope of this report, changes in health insurance coverage (i.e., children, adults, seniors) and in perceptions of oral health as a core element of basic primary health care could help to facilitate support of dental therapists, leading to pressures for educational program development and the resulting need for systems of programmatic accreditation and individual licensure.

Conclusion

Some content experts interviewed believe that the “train has left the station” with regard to developing dental therapy programs and accreditation – the process is already underway and cannot be stopped. Accreditation can only be as “good” or as “bad” as the direction and guidance given to the accrediting agency by the professional stakeholders, which should be responsible to shape, mold, and/or alter accreditation functions (27). An accrediting agency should conduct its activities in collaboration with all key interest groups, and not act completely independently in the development of standards and procedures. Independence is essential in the process of evaluation and decision making, and accreditors must ensure that these functions are conducted at arm’s-length from key interested parties. The responsibility for guiding accreditation directions rests with the profession and its willingness to either provide or abdicate direction to the accrediting body. Accreditation and accreditors should not drive educational or practice mandates, but should reflect current education and practice needs. Collaboration is essential to ensure that accreditation fulfills its fundamental purposes with regard to educational quality and professional preparation, and that

accreditation processes complement (rather than interfere with) institutional and programmatic cycles of planning and evaluation (28).

The fundamental value of accreditation is as one player in the overall scheme of improving the quality of higher education delivered to students and ultimately the delivery of health services to individuals and populations, through quasi-regulation of educational programs. Systems of individual licensure at the state level provide another means of improving quality through control of entry to, and scope of, practice. Ultimately, public accountability is a core value of both accreditation and licensure, and can serve to connect the educational process, the evolving healthcare system, and the changing demands of the public, employers, professional organizations, educational institutions, and students (25). These strategies will be important to pursue as leaders concerned with the oral health workforce consider future directions and the potential roles of new oral health providers.

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Conflict of interest

The authors have no conflicts of interest to declare.

References

1. Gelmon SB, Foucek Tresidder A. *Dental therapy education programs: accreditation and certification issues*. Springfield, IL: American Association of Public Health Dentistry; 2010.
2. W.K. Kellogg Foundation. New workforce options [Internet]. 2010 [cited 2010 Sep 20]. Available from: <http://www.wkcf.org/what-we-support/healthy-kids/dental-therapy.aspx#2>.

3. United States Department of Health and Human Services. *Oral health in America: a report of the surgeon general*. Rockville, MD: National Institutes of Health; 2000.
4. McKinnon M, Luke G, Bresch J, Moss M, Valachovic RW. Emerging allied dental workforce models: considerations for academic dental institutions. *J Dent Educ*. 2007;**71**(11): 1476-91.
5. DENTEX Dental Health Aide Therapist Training Program. DENTEX: dental health aide therapist [Internet]. 2010 [cited 2010 Aug 4]. Available from: <http://depts.washington.edu/dentexak/index.html>.
6. Williard M. Dental workforce changes, access, and state practice acts: what's new? Alaska DHAT update. Paper presented at National Oral Health Conference; 2010 April 25; St. Louis, MO.
7. University of Minnesota, School of Dentistry [Internet]. 2010 [updated 2010 Aug 2; cited 2010 Aug 10]. Available from: http://www.dentistry.umn.edu/programs_admissions/DentalTherapyPrograms/home.html.
8. Metropolitan State University. Oral health care practitioner (MSOHCP) [Internet]. 2010 [cited 2010 Sep 10]. Available from: <http://www.metrostate.edu/msweb/explore/gradstudies/masters/msohcp/index.html>.
9. Normandale Community College. Advanced degree and degree completion programs in dental hygiene [Internet]. 2010 [cited 2010 Sep 10]. Available from: <http://www.normandale.edu/dental/degrees.cfm>.
10. Harris TA. *The U.S. oral health workforce in the coming decade: workshop summary*. Washington, DC: National Academies Press; 2009.
11. Gehshan S, Takach M, Hanlon C, Cantrell C. *Help wanted: a policy maker's guide to new dental providers*. Washington, DC: Pew Center on the States; 2009.
12. Edelstein BL. *Training new dental health providers in the U.S.* Battle Creek, MI: W.K. Kellogg Foundation; 2010.
13. Commission on Dental Accreditation (CODA). Commission on Dental Accreditation (CODA) [Internet]. 2010 [cited 2010 Aug 2]. Available from: <http://www.ada.org/117.aspx>.
14. Commission on Dental Accreditation. *Report of the CODA Task Force on new dental team members*. Chicago, IL: Commission on Dental Accreditation; 2010. p. 1616-7.
15. Gelmon SB. Intentional improvement. *Assessing impact: evidence and action*. Washington, DC: American Association of Higher Education; 1997. p. 51-65.
16. Gelmon S, Thomsen C, Berkman A. Task force on the accreditation of health professions. Working papers. San Francisco, CA: UCSF Center for the Health Professions; 1998.
17. Eaton JS. Accreditation in the U.S. *New Directions in Higher Education* 2009;**145**(145):79-86.
18. Commission on Accreditation of Allied Health Programs (CAAHEP). CAAHEP eligibility brochure. [Internet]. 2010 [cited 2010 Sep 7]. Available from: <http://www.caahep.org/>.
19. Council for Higher Education Accreditation (CHEA). CHEA at-a-glance [Internet]. 2010 [cited 2010 Aug 8]. Available from: http://www.chea.org/pdf/chea_glance_2006.pdf.
20. Association of Specialized & Professional Accreditors (ASPA). The Association of Specialized & Professional Accreditors [Internet]. 2010 [cited 2010 Aug 2]. Available from: <http://www.aspa-usa.org>.
21. Millard RM. Whither accreditation in the health professions? *Educ Rec*. 1984;**65**(4):31-5.
22. Trufant JE. Proliferation of new health professions and accrediting bodies. In: Gelmon S, O'Neil E, Kimmey J, editors. *Strategies for change and improvement: future directions for health professions education accreditation*. San Francisco, CA: UCSF Center for the Health Professions; 1999. p. 35-38.
23. Gelmon SB. Accreditation and core curriculum: barriers and opportunities in allied health education. In: Finocchio LJ, Johnson CD, editors. *Pew Health Professions Commission: core curricula in allied health*. San Francisco, CA: UCSF Center for the Health Professions; 1995.
24. United States Department of Education. Accreditation in the United States [Internet]. 2010 [cited 2010 Aug 3]. Available from: <http://www2.ed.gov/admins/finaid/accred/index.html>.
25. Gelmon S, O'Neil E, Kimmey J. *Strategies for change and improvement: future directions for health professions education accreditation*. San Francisco, CA: UCSF Center for the Health Professions; 1999.
26. Kimmey JR, Bulger RJ. Challenges for administrators. In: Gelmon S, O'Neil E, Kimmey J, editors. *Strategies for change and improvement: future directions for health professions education accreditation*. San Francisco, CA: UCSF Center for the Health Professions; 1999. p. 32-34.
27. Gelmon S. Accreditation as a stimulus for continuous improvement in health management education: a case study of ACEHSA [fellowship thesis]. Chicago: American College of Healthcare Executives; 1995.
28. Crow SD. The collaborative imperative. In: Gelmon S, O'Neil E, Kimmey J, editors. *Strategies for change and improvement: future directions for health professions education accreditation*. San Francisco, CA: UCSF Center for the Health Professions; 1999. p. 39-43.