Commission on Collegiate Nursing Education

Achieving Excellence *in* Accreditation

THE

First 10 Years *of* CCNE

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Core Values

Foster trust in the process, in CCNE, and in the professional community.

•

Focus on stimulating and supporting continuous quality improvement in nursing education programs and their outcomes.

•

Be inclusive in the implementation of its activities and maintain an openness to the diverse institutional and individual issues and opinions of the interested community.

•

Rely on review and oversight by peers from the community of interest.

•

Maintain integrity through a consistent, fair, and honest accreditation process.

•

Value and foster innovation in both the accreditation process and the programs to be accredited.

•

Facilitate and engage in self-assessment.

•

Foster an educational climate that supports program students, graduates, and faculty in their pursuit of life-long learning.

•

Maintain a high level of accountability to the publics served by the process, including consumers, students, employers, programs, and institutions of higher education.

•

Maintain a process that is both cost-effective and cost-accountable.

•

Encourage programs to develop graduates who are effective professionals and socially responsible citizens.

•

Ensure autonomy and procedural fairness in its deliberations and decision-making processes.

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Foreword

The vote on October 28, 1996 that created the Commission on Collegiate Nursing Education (CCNE) was an historic event, the result of courageous work by members of the American Association of Colleges of Nursing (AACN) who challenged the status quo and developed an accrediting body focused exclusively on baccalaureate and graduate degree nursing programs. This action was a clear sign of our belief, as an organization, that education does make a difference, and that baccalaureate and graduate degree nursing programs have unique goals and outcomes that should be supported and encouraged through an effective accrediting body. Indeed, the strong history of support both by AACN members and nonmembers demonstrates that the emergence of CCNE met a real need—to move nursing education in the nation's universities and 4-year colleges to a new level of readiness for the changes in a new millennium.

AACN's entry into accreditation came only after years of careful, thorough analysis of a spectrum of accreditation issues that had circulated for decades. For several years, nursing educators and higher education officials had communicated their concerns to AACN's Board of Directors about the processes in place not only for general accreditation, but nursing and other specialized accreditation as well. As early as 1989, the AACN Board commissioned a special report by staff on the issues surrounding specialized accreditation and, for years afterward, continued to receive requests to explore accreditation issues further.

Moreover, the volume of questions over accreditation had grown to include federal concerns. In 1992, as members of Congress learned of higher numbers of defaults among holders of federal student loans, lawmakers began to investigate whether regional accreditation was effectively ensuring that colleges and universities were fulfilling their missions. Although the highest default rates were in for-profit, non-degree-granting schools, Congress put all postsecondary institutions under greater scrutiny. Indeed, when the Higher Education Act was reauthorized in 1992, new federal criteria were established for monitoring student aid programs and achieving positive outcomes.

Amid the mounting push for change, and with the numbers of specialty nursing accrediting bodies already projected to increase, the AACN Board of Directors in March 1995 moved to have AACN study whether it should assume some role in the accreditation process. The Board's vote was not an isolated action, but part of the association's existing strategic planning initiative. Shortly afterward, the Board established the AACN Task Force on Nursing Accreditation to assess the fiscal, professional, regulatory, and statutory aspects of specialized accreditation; and to report to the membership with recommendations on what role, if any, AACN should play in the accreditation of baccalaureate and graduate degree nursing.

As part of its wide-reaching examination, the task force surveyed member schools, sponsored open forums to hear members' concerns and recommendations about the future directions for accreditation, interviewed representatives of 25 specialized accrediting agencies, and reviewed the literature on accreditation in nursing and higher education, as well as on certification, credentialing, and licensure.

The findings revealed a clear and wide consensus. As the task force detailed in its report to the membership, the encroaching pressures from rising accreditation costs, financial strains in higher education, proliferating numbers of specialized accrediting bodies within nursing, and the duplicative activities associated with the various review entities called for a more coordinated and streamlined accreditation process for baccalaureate and graduate nursing education.

With their overwhelming affirmation of the task force's recommendations in October 1996, members validated the pressing need to create a more cohesive, uniform approach to accreditation—one that is less redundant, less burdensome, and more unique for our nursing schools—and to do so by putting into place common standards, common data sets, and a common process. Also, the membership's vote authorized AACN to assume the lead role in establishing a groundbreaking alliance of 14 credentialing bodies—of which CCNE is a founding member—that works to bring collaborative

reviews and other improved efficiencies to the accreditation of educational programs in advanced nursing specialties. Originally named the Alliance for Nursing Accreditation, the group has since expanded into a membership of 15 organizations and agreed to focus primarily on credentialing issues related to advanced practice nursing with the approval of a name change in 2006 to the Alliance for Advanced Practice Registered Nurse (APRN) Credentialing (Alliance for APRN Credentialing, 2006).

Consistent with AACN's mission, CCNE accreditation assures students, employers, and other stakeholders that the nation's baccalaureate and graduate nursing programs are providing a quality product, one that meets the standards set by the professional nursing community. CCNE's first annual report highlighted why this distinction is so critical:

> With patient care growing progressively complex, moving into a constellation of new settings beyond the hospital, and requiring more intensified care for hospitalized patients who are increasingly elderly and acutely ill, demand has escalated for registered nurses with advanced levels of education and skills. Specifically, the health system faces an accelerating need for bachelor's-degreed nurses prepared in critical thinking, leadership, case management, health promotion, and in care across a variety of inpatient and outpatient settings, and for graduate-prepared RNs for roles in teaching, research, and an array of advanced clinical specialties. (CCNE, 2001a, p. 2)

As of June 2008, 76% of baccalaureate degree programs and 86% of master's degree programs at U.S. nursing schools had selected CCNE as their accrediting agency. In just the Commission's first few years, such growing collaboration reaffirms CCNE's model for assuring that the public benefits from the highest quality nurse preparation—in programs that produce effective and sophisticated clinicians, educators, and scientists. Looking ahead to the next 10 years, CCNE is poised to maintain its leadership position in nursing education accreditation by moving to accredit Doctor of Nursing Practice programs, working with quality assurance entities in the international arena, and implementing accreditation for post-baccalaureate nurse residency programs located in acute-care settings.

I am proud to introduce this important report of the CCNE History Project and the landmark achievements it documents.

Geraldine Bednash, PhD, RN, FAAN
Chief Executive Officer and Executive Director
American Association of Colleges of Nursing
Washington, DC

Preface

The Commission on Collegiate Nursing Education (CCNE) is a nationally recognized nursing accrediting agency established in 1998 by vote of the American Association of Colleges of Nursing (AACN) membership. This membership action established CCNE as an autonomous arm of AACN, the national organization representing baccalaureate and graduate nursing education programs. CCNE's scope includes baccalaureate and graduate nursing programs in the United States and its territories.

The CCNE History Project was commissioned by the CCNE Board of Commissioners (Board of Commissioners [Board], 2003a). The purposes of the History Project were to document the evolution of CCNE as a nationally recognized accrediting agency and to provide perspectives on the development and achievements of CCNE in its first 10 years (1998-2008); these purposes were based on the Board's belief in the value of having an historical record to document the original intent that guided the organization's evolution. In addition, writing a history would provide an opportunity for CCNE's constituencies to reflect on the organization's origins, characteristics, and achievements in the initial 10 years and to suggest the direction for future activities.

Suzanne Van Ort agreed to serve as History Project Director, with Jennifer Butlin, CCNE Director, as Associate Project Director. An Editorial Advisory Board was appointed comprised of CCNE leaders who served the organization from its inception. The Editorial Advisory Board members were: Charlotte Beason, Mary Jo Clark, Mary Collins, Timothy Gaspar, and Susan Woods. A list of contributors identifying the members of the Editorial Advisory Board is provided in the front of this document. The Editorial Advisory Board members brought a wealth of knowledge and experience to the project. Throughout the History Project, Suzanne Van Ort and Jennifer Butlin served on the Editorial Advisory Board and assumed leadership roles in completing the Project. Therefore, when mentioning the Editorial Advisory Board in this publication, all seven members are included.

Three mechanisms were used by the Editorial Advisory Board in documenting CCNE's first 10 years. First, a review of available documents from various sources provided a record of actions taken and issues identified both internally and in collaboration with other organizations. The Editorial Advisory Board members reviewed multiple AACN and CCNE documents to provide information for the History Project, including: AACN Board minutes validating the parent organization's actions in initiating CCNE; CCNE Board and committee minutes; correspondence with individuals and organizations; and correspondence with the U.S. Department of Education (USDE) as well as records of related actions by that agency.

Second, a Web-based survey was used to elicit responses from constituents regarding their perspectives on the first 5 years of CCNE's evolution. The perspectives of the respondents are incorporated throughout the publication.

Third, the Editorial Advisory Board interviewed leaders who played an important role in CCNE's evolution. The five past chairs of the CCNE Board of Commissioners (Linda Amos, Lynda Davidson, Charlotte Beason, Mary Margaret Mooney, and Jill Derstine) and the current Board chair Harriet R. Feldman were interviewed. Geraldine Bednash, Executive Director of AACN, was interviewed representing the parent organization. Carole Anderson, President of AACN when CCNE was established, and former member of the CCNE Board, was interviewed for her historical perspective.

Long-time CCNE staff members, Jennifer Butlin, Margaret Jackman, and Libby Cooperman were interviewed to gain the staff's perspectives on CCNE's evolution. Also, e-mail interview questions were sent to Jay Levrio, former CCNE Director, Judith Eaton, President of the Council for Higher Education Accreditation (CHEA), and Cynthia Davenport, Executive Director of the Association of Specialized and Professional Accreditors (ASPA), for their perspectives on CCNE's evolution.

The Editorial Advisory Board members considered input gathered through all three mechanisms identified above in preparing this publication. The six chapters in the publication focus on "Overview of Accreditation," "Creating the Organization," "Incorporating the Values," "Serving the Community of Interest," "Celebrating the Achievements," and "Influencing Nursing's Future." Included within the chapters are perspectives offered by constituencies in response to individual contacts, interviews, and surveys of members of the community of interest. A vellum page is featured at the end of this publication to recognize the institutions whose nursing programs were accredited by CCNE as of June 30, 2008. The Editorial Advisory Board wishes to recognize these institutions that have traveled with us and been a part of CCNE's development.

Chapter 1

Overview of Accreditation

Suzanne R. Van Ort

The Commission on Collegiate Nursing Education (CCNE), established in 1998, is a specialized accrediting agency whose scope includes baccalaureate and graduate nursing education programs in the United States and its territories. Before describing the evolution of CCNE as a nationally recognized nursing accrediting agency, an overview of higher education accreditation and nursing education accreditation is provided.

Higher Education Accreditation

Accreditation is a process of peer evaluation of educational institutions and programs to ensure an acceptable level of quality. Accreditation is granted to an educational institution or a program that meets stated criteria of educational quality. Higher education accreditation in the United States is a unique process that is both voluntary and nongovernmental. In contrast to many nations in which there are national governmental agencies that oversee the quality of higher education, the United States relies on voluntary accreditation to serve this important role. Accreditation has two primary purposes: to ensure educational quality and to assist in improvement of the institution or program.

Higher education in the United States is comprised of approximately 7,000 accredited degree-granting and non-degree-granting institutions. The institutions may be public or private, 2- or 4-year, nonprofit or for-profit (Eaton, 2006). Accrediting agencies evaluate institutions in all 50 states and in U.S. territories. In addition to evaluating institutions as a whole, accrediting agencies review educational programs in certain professions and specialized fields.

Types of Accreditation

As noted above, higher education accreditation includes both institutional and specialized accreditation. Institutional accreditation indicates an institution as a whole demonstrates achievement of quality standards. Institutional accreditation is conducted by six regional accreditors, faith-based accreditors, private career accreditors, and/or programmatic accreditors (Eaton, 2006).

The six regional accrediting bodies represent colleges and universities in specific geographic regions of the United States: Middle States Association of Colleges and Schools, New England Association of Schools and Colleges, North Central Association of Colleges and Schools, Northwest Commission on Colleges and Universities, Southern Association of Colleges and Schools, and Western Association of Schools and Colleges (Council for Higher Education Accreditation [CHEA], 2007). Each of these regional accrediting agencies evaluates institutions in its region according to established standards. According to CHEA, institutions accredited by regional associations are mainly degree-granting and nonprofit (Eaton, 2006). Institutions that do not have regional accreditation can exist legally by meeting state requirements for approval as designated by individual states.

Faith-based accreditors evaluate religiously affiliated and doctrinally based institutions, mainly nonprofit and degree-granting. Private career accreditors evaluate mainly for-profit, career-based, single-purpose institutions, both degree and non-degree granting. Programmatic accreditors evaluate specific programs, professions, and free-standing schools (e.g., law, medicine, engineering, and health professions) (Eaton, 2006).

Programmatic accreditation, also known as specialized or professional accreditation, evaluates the quality of programs in specific professional disciplines. Typically, programs seeking specialized or

professional accreditation must be located in colleges or universities holding institutional accreditation. The umbrella organization for specialized accreditation is the Association of Specialized and Professional Accreditors (ASPA). ASPA was established in 1993 to function as a strong voice for specialized accrediting agencies (Davenport, 2000). The Code of Good Practice for Accrediting Bodies (ASPA, 1995) was unanimously endorsed by the ASPA members in 1995 and has subsequently been adopted by each new member. The Code serves as the cornerstone of membership in ASPA and guides the accreditation processes of specialized accrediting agencies. The CCNE Board endorsed the Code on August 1, 1998. Membership in ASPA adds to the credibility of the programs an agency accredits by ensuring that the accrediting agency implements good accrediting practices. At the present time, ASPA has 50 members who represent specialized accrediting agencies in various fields (ASPA, 2008).

Evolution of Higher Education Accreditation in the United States

In the United States, accreditation is more than 100 years old. Prior to the establishment of accrediting agencies, review of institutions and programs was conducted by the institution itself rather than by an outside organization. For example, Harvard University initiated external review of its programs as early as 1642. Regional accreditation of educational institutions evolved between 1885 and 1924 with the establishment of the current six regional associations. However, although these regional associations conducted accreditation activities, they did not initially establish accreditation standards; it was not until many years after their establishment that the regional associations identified specific accrediting standards to be met by the institutions they accredited (Davenport, 2000).

Specialized accreditation evolved more rapidly and systematically than regional accreditation. In 1840, the first dental school was established, and the first state statute requiring a license to practice dentistry was passed. The American Medical Association, founded in 1847, and the American Dental Association, founded in 1859, continued the commitment to state licensing and improving educational quality in those programs (Davenport, 2000). The American Medical Association, reorganized in 1905 and 1907, began to classify medical schools and became the first specialized program accreditor. In 1910, the Flexner Report on medical education provided the impetus for systematic evaluation of medical schools (Flexner, 1910). In that Report, sponsored by the Carnegie Foundation, 155 medical schools were ranked. Five years later, 60 schools closed, and 12 of the remaining 95 were classified as unapproved (Davenport). This outcome paved the way for medical education and other professions to evaluate their programs and to ensure program improvement through the accreditation process.

In the period from 1918 to 1937, 21 additional specialized accrediting agencies were established. Some of the health-related disciplines that initiated accreditation processes in this era were: nurse anesthesia, dentistry, pharmacy, and podiatry (Davenport, 2000). Although development of new agencies slowed during World War II, many new specialized accrediting agencies have formed since that time.

Accreditation, Recognition, and Approval

Governmental Recognition: United States Department of Education

As a voluntary nongovernmental process, higher education accreditation is complementary to several federal and state mechanisms that promote quality in higher education. At the federal level, the U.S. Department of Education (USDE) grants recognition to accrediting agencies that meet its criteria. The Secretary of Education, through the USDE, is required to publish a list of nationally recognized accrediting agencies that are reliable authorities in evaluating the quality of the institutions or the programs they accredit.

Accreditation functions focus on protection of students, the public, and institutions. In addition, the USDE relies on accreditation for ensuring the quality of institutions and programs that receive federal funding and that provide federal student aid (Eaton, 2006).

The first federal requirement for recognition of accrediting agencies was implemented in 1952 (Davenport, 2000). The federal requirements are part of the Higher Education Act of 1965 as amended, which is periodically reauthorized by Congress, usually at 5-year intervals. The focus of USDE recognition is to ensure that federal student aid funds are provided for quality educational programs. Institutions obtain eligibility for federal funds by holding accredited status with one of the accrediting agencies recognized by USDE. USDE's recognition of an accrediting agency is based on 10 standards that address student recruitment and admission practices as well as fiscal and administrative capacity and facilities (Eaton, 2006). The USDE itself does not accredit institutions or programs. However, the agencies on the published list of accrediting agencies that meet the USDE's standards are recognized as authorities on the quality of educational institutions and programs. Thus, recognition by the USDE is a critical element in validating the credibility of an accrediting agency.

Governmental Regulation: State Approval

At the state level, individual states grant approval/accreditation to educational institutions and programs that meet certain regulatory criteria. The goal of state regulatory approval is protection of the public. States vary in their control over higher education, but typically institutions are given the right to grant degrees; beyond that institutions can operate quite independently. In most states, regulatory mechanisms such as licensure and certification provide oversight for individuals in designated fields, but state control over institutions as a whole is limited. With respect to approval of specific educational programs, state regulatory processes range from basic program approval to highly regulated practice.

Nongovernmental Recognition: Council for Higher Education Accreditation

Complementary to USDE recognition and state approval, nongovernmental agencies provide recognition and approval of accrediting agencies. The Council for Higher Education Accreditation (CHEA) is a private, nonprofit national organization that coordinates accreditation activity in the United States. Founded in 1996, CHEA provides a national voice for higher education accreditation to the federal government, the public, students, and families (CHEA, 2006). As the largest higher education institutional membership organization in the United States, CHEA serves approximately 3,000 institutions and more than 60 accrediting organizations. CHEA is the only nongovernmental higher education organization that examines the quality of national, regional, and specialized accrediting organizations. CHEA recognition standards are designed to: "advance academic quality; demonstrate accountability; encourage, where appropriate, self-scrutiny and planning for change and needed improvement; employ appropriate and fair procedures in decision-making; demonstrate ongoing review of accreditation practice; and possess sufficient resources" (CHEA, 2006, p. 2).

Accreditation Process

There are multiple steps in the accreditation process. Although these may differ from agency to agency, typical steps in the process include:

- establishment of minimum accreditation standards by the accrediting agency;
- preparation of a self-study by the institution or program seeking accreditation;
- on-site peer review of the applicant institution or program by volunteer representatives of the accrediting agency;
- action by the accrediting agency regarding whether or not the applicant institution or program meets the agency's established standards;
- publication by the accrediting agency of a list of accredited institutions or programs;

- ongoing monitoring of the institution or program to verify continuing compliance with the established standards; and
- regular review of the accrediting agency to ensure its ongoing compliance with established standards for accrediting agencies (Eaton, 2006).

Benefits of Accreditation

Accreditation offers multiple benefits to an institution or program. The focus of this section is on programs rather than institutions. Accredited programs demonstrate their quality and effectiveness. Accreditation grants students in specific programs eligibility for certain funding mechanisms, notably federal agency funding. Accreditation can assist prospective students to identify appropriate programs for their goals, as well as assist programs in evaluating the acceptability of transfer credits. Accreditation provides educators and practitioners an opportunity to build consensus on learning outcomes and competencies of the graduates. Accreditation assures employers that prospective employees have graduated from a quality program. Also, accreditation provides one indicator of quality for lawmakers and others considering investment of public and private funds for higher education (ASPA, 2002).

In addition, accreditation provides external agencies a measure of program quality. Accreditation is required for eligibility for state licensure or certification in many disciplines. For example, accreditation in nursing is used by certain state boards of nursing as an indicator of program quality; a given state board of nursing may elect to accept national accreditation in lieu of a separate state approval mechanism. Qualified graduates of accredited nursing programs have ready access to graduate education in nursing. Thus, accreditation by a specialized accrediting agency offers benefits to both nursing programs and individual students/graduates.

The public benefits from accreditation in that it is informed of the quality of institutions and programs. Accreditation provides an avenue for stakeholders' participation in the educational process and, ultimately, an opportunity to affect the outcomes of education.

In designing the accreditation process, consideration is given to the potential consumers of accreditation as well as other stakeholders in the process. The costs and benefits to the accrediting agency and programs are an important consideration. Measures of outcomes that indicate program quality and effectiveness are other critical elements in the accreditation process. The intended outcome of accreditation is assuring the community of interest that accredited programs have demonstrated both quality and effectiveness.

Nursing Education Accreditation

Evolution of Nursing Education Accreditation

Accreditation of nursing education programs began in 1893 with the founding of the American Society of Superintendents of Training Schools for Nurses whose purpose was to establish universal standards for training of nurses (Kalisch & Kalish, 1978). In 1912, this organization became the National League of Nursing Education (NLNE) (Roberts, 1954). In 1917, the National League of Nursing Education published *A Standard Curriculum for Schools of Nursing* in its attempt to raise nursing school standards (Kalisch & Kalisch).

In the 1920s and 1930s, nursing education accreditation was begun by many different agencies using the standard curriculum guidelines developed by NLNE. Beginning in 1938, NLNE provided accreditation services for programs preparing registered nurses. Subsequently, a separate organization, the National Nursing Accrediting Service, acted as an accrediting agency for registered nurse programs from 1949 until its dissolution in 1952 when the National League for Nursing (NLN) was established and assumed accrediting functions for nursing education (National League for Nursing Accrediting Commission [NLNAC], 2008a).

In 1952, the Association of Schools of Nursing, the NLNE, and the National Organization for Public Health Nursing merged to become the National League for Nursing. In the reconfigured National League for Nursing, accrediting services were provided by the NLN Division of Nursing Education. This process continued until 1958 when the NLN Councils each assumed accreditation for their programs; the Council of Baccalaureate and Higher Degree Programs thus assumed responsibility for its constituent programs. In 1997, the National League for Nursing Accrediting Commission (NLNAC) was formed as an arm of NLN specifically focused on accreditation activities (NLNAC, 2008a). The NLNAC continues to offer accreditation services for various types of programs: practical nursing, diploma nursing, and associate degree nursing as well as baccalaureate and higher degree nursing programs (NLNAC, 2008b).

Concerns about Nursing Accreditation

During the 1980s and 1990s, several issues of serious concern began to emerge in the world of nursing accreditation. Among those issues were concerns about both the process and outcomes of accreditation. Higher education was moving to a focus on assessment of educational outcomes. As nursing education adopted this focus on assessment of outcomes, accreditation processes needed revision to reflect this emphasis. Also, higher education was moving from a focus on what students are taught to a focus on what students learn and how students actively participate in the teaching-learning process to achieve expected learning outcomes. In response, nursing education revised curricula to address this emphasis. Innovation in nursing education characterized many baccalaureate and graduate programs.

Concurrently, the community of interest, particularly higher education administrators, expressed concerns with the costs and benefits of accreditation. Administrators acknowledged that specialized accreditation in agencies such as those related to health care provided monitoring of degree offerings tied to licensure and provided oversight of practitioner organizations. For the most part, these administrators agreed that these accreditation activities could be justified as necessary to protect the public. However, these administrators criticized fields in which "the accreditors, regulators and professional societies combine powerfully not only to assure quality, but also to establish turf and to protect jobs, status, and incomes" (Dill, 1998, p. 20). At the same time, the public would benefit from greater input into accreditation processes and dissemination of accreditation outcomes (Dill).

In this climate of conflict and confusion, nursing leaders expressed concern over nursing education accreditation. Beginning in the 1980s a number of nursing leaders suggested that the AACN explore the possibility of establishing a new accrediting agency that would focus specifically on baccalaureate and graduate nursing programs. Since the mission of AACN is to serve baccalaureate and graduate nursing education, this focus was consistent with the AACN mission. In 1989, the AACN Board commissioned a special report by staff on issues surrounding specialized accreditation (AACN, 1996a). Although no action by the AACN membership occurred then, periodic requests related to accreditation issues were received by the AACN Board. In the 1990s, the issues resurfaced through AACN, and the AACN's membership actions in 1996 led to the subsequent formation of the Commission on Collegiate Nursing Education as it exists today.

In commenting on the beginnings of CCNE, Jay Levrio, first Director of CCNE stated,

> Given the many advances in the nursing profession and the concomitant impact these advances have had on the growth of undergraduate and graduate education for nurses, it is no wonder…that leaders in the field of nursing education came together and made a definitive commitment to developing a new accreditation process …one that…would help to enhance professional nursing education and enable its continued growth and development. (personal communication, June 26, 2005)

Among the considerations in designing the new CCNE accreditation entity were that the agency be mission-driven, values-based, and responsive to its constituencies. The values on which the agency was based included ensuring fairness, demonstrating consistency in actions, and fostering trust in the process. Openness to innovation and creativity were additional values incorporated into the accreditation process. A strong emphasis on continuing improvement guided the accreditation process and the standards for evaluation of programs. In developing the accreditation standards, a commitment to nonprescriptive standards was adopted. Responding to its constituencies, the CCNE Board developed mechanisms to ensure a meaningful, cost-effective, efficient accreditation process that has been evaluated by constituencies to be highly effective.

In commenting on the success of CCNE in its first 5 years, Carole Anderson, AACN President at the time CCNE was established, stated,

> AACN has a long history of what they do, they do very well, so I think we were anticipating that it would be a quality operation, but I think it has exceeded the expectations and certainly done so in a much shorter period of time. I think all of us thought this would take longer to get off the ground than it did, and it would financially be not as successful as it was. It has really, I think, had a remarkable 5-year history. (personal communication, February 9, 2005)

In commenting on CCNE's success in its second 5 years with a caution for the future, Mary Margaret Mooney, chair of the Board in 2005-2006, stated, "CCNE was born with a spirit of freedom and flexibility…As it grows to become more institutionalized, it will have more rules…As it becomes part of the establishment, it needs to keep roots in that freedom…." (personal communication, July 16, 2008).

Chapter 2

Creating the Organization

Suzanne R. Van Ort and Mary S. Collins

During the 1990s, members of AACN became increasingly committed to the creation of a national nursing accrediting agency to serve baccalaureate and graduate nursing programs. According to Geraldine Bednash, Chief Executive Officer and Executive Director of AACN, this was a time of great turmoil, and accreditation concerns had been expressed for some time by baccalaureate and higher degree nursing programs (personal communication, October 23, 2004). The desire for change stemmed in part from AACN's emphasis on quality baccalaureate and graduate nursing education. In the 1990s, AACN developed two documents that articulated the embodiment of quality nursing education: *The Essentials of Baccalaureate Education for Professional Nursing Practice* (1998b) and *The Essentials of Master's Education for Advanced Practice Nursing* (1996c).

During this time, AACN members sought an accrediting organization that reflected AACN's values and focused specifically on baccalaureate and graduate nursing education. In addition, AACN members identified among their priorities an accrediting agency committed to the autonomy of individual programs and one that valued collegiality. Values-based accreditation was the earliest theme of the emerging organization to evolve. Among the values central to AACN's commitment were demonstration of fairness and consistency in decision-making and nonprescription in the accreditation process. As discussion continued, the value of innovation was developed in recognition of the vast variety of nursing programs and how individual programs met their areas' educational needs.

Beginnings in AACN

The desire for change in accreditation of nursing programs expressed by AACN members led the AACN Board to explore the establishment of a separate accrediting agency focused specifically on baccalaureate and higher degree nursing education. According to Carole Anderson, then-president of AACN, "Many people were feeling the need to have accreditation that was specifically directed toward baccalaureate and higher degree [programs]" (personal communication, February 9, 2005). To facilitate the creation of what later became the Commission on Collegiate Nursing Education, the AACN Board appointed the AACN Task Force on Accreditation in October 1995, chaired by Linda Amos (AACN, 1996a). A list of task force members is in Appendix A. The task force was charged with examining and reporting to the membership on the feasibility of AACN's assumption of accreditation activities, including the possibility of the creation of a new agency. As described by Geraldine Bednash, AACN Executive Director, this was considered by many as a "challenge to what was considered the comfortable status quo" (personal communication, October 23, 2004). In accomplishing its work, the task force surveyed member schools, held open forums with AACN members, interviewed representatives of 25 specialized accrediting agencies, and reviewed the literature related to accreditation and other credentialing mechanisms (AACN, 1996a).

AACN Chief Executive Officer and Executive Director Geraldine Bednash

Linda Amos, chair of the AACN Task Force on Nursing Accreditation, speaking at 1998 AACN Fall Semiannual Meeting.

The task force survey of AACN member schools yielded considerable data related to members' experience, both positive and negative, with the accreditation process. Respondents expressed concern with the costs of accreditation, the proliferation of specialized accrediting bodies for nursing, the duplicative processes of various agencies, and the increasing financial pressure on higher education to seek a more streamlined accreditation process (AACN, 1996a). In the survey, respondents identified needed changes in the accreditation process, including the need to clarify standards and have clear criteria; to be cost-effective; to provide consistency in expectations and outcomes; to facilitate better relationships between programs, on-site evaluators, and the Board of the accrediting agency; to develop reliable and valid measures of quality; to partner with other accrediting agencies; and to provide trained, unbiased, supportive on-site evaluators. Respondents identified the need for an accrediting process that would be meaningful in helping programs plan strategically and evaluate quality. In addition, a number of respondents indicated a need for a "new direction" in accreditation—one that would result in a learning experience rather than a punitive experience. As one respondent stated, the accreditation process needs to be "…more evaluative. The accreditation [process] should have an educational evaluative focus. The outcome of the process should lead to long-term fulfillment, not short-term satisfaction" (AACN, 1996b).

The AACN Task Force on Nursing Accreditation Report, submitted to the AACN Board and membership in 1996, supported a move by AACN to develop a new accrediting agency. Specifically, the task force report recommended that AACN take the lead role in creating a new entity that would accredit baccalaureate and graduate nursing education programs only. This recommendation was consistent with the AACN mission and its commitment to baccalaureate and graduate nursing education; therefore, the mission and organizational structure of AACN remained unchanged. In October 1996, the AACN membership, by a vote of 246 to 59, approved a proposal for AACN to establish a new entity whose sole purpose would be to provide accreditation services for baccalaureate and graduate nursing programs (AACN, 1996a). Seventy-six percent of the members who were present voted to establish the new organization.

This action represented an historic moment for AACN and for the nursing profession. Carole Anderson, then President of AACN indicated,

> With this action, educators have validated the pressing need to bring cohesion, uniformity, and a more coordinated approach to accrediting baccalaureate and graduate nursing programs—an approach that is less redundant and less burdensome for our schools—and to do so by putting into place common standards, common data sets, and a common process. (AACN, 1996a, p. 1)

Once the AACN membership's affirmative vote was obtained, the AACN Board initiated activities to create the new organization. As Geraldine Bednash exclaimed, "Now we had to do something!" (personal communication, October 23, 2004). In January 1997, the AACN Board appointed a Steering Committee, chaired by Linda Amos, to facilitate development of the new accrediting agency (AACN, 1997a, p. 1). Steering Committee members are listed in Appendix B. In response to this action, Carole Anderson stated, "Bringing that vision into reality is greatly enhanced by this steering committee that gathers the richness of talent, experience, and perspective of widely respected leaders

in nursing, health care, and higher education" (AACN, 1997a, p. 1). Later that year, the AACN Board appointed the first Standards Committee and Nominating Committee (AACN, 1997d). In addition, the AACN Board approved $300,000 in venture capital to support initial organizational development of what was to become CCNE (AACN, 1997c).

Establishing Mission, Goals, Values

The Steering Committee adopted a mission, purposes, goals, and a set of values that today continue to guide the agency and ground its actions. In 1997, the Steering Committee drafted a mission and goals statement for a new accrediting agency and discussed the name, structure, and use of standards (Steering Committee, 1997a). Initially, the new agency was named the Nursing Education Accrediting Commission; later the name was changed to the Commission on Collegiate Nursing Education. Importantly, the Steering Committee subscribed to the belief that CCNE was to be a mission-driven agency that valued innovation, autonomy, and creativity. The Steering Committee was committed to establishing a meaningful accreditation process with outcomes focused on program quality and program effectiveness.

The unique mission of CCNE was written, as follows:

> CCNE is an autonomous accrediting agency contributing to the improvement of the public's health. The Commission ensures the quality and integrity of baccalaureate and graduate education programs preparing effective nurses. The Commission serves the public interest by assessing and identifying programs that engage in effective educational practices. A voluntary, self-regulatory process, CCNE accreditation supports and encourages continuing self-assessment by nursing education programs and the continuing growth and improvement of collegiate professional education. (CCNE, 2000a, p. 2)

AACN members congratulating Linda Amos, chair of the AACN Task Force on Nursing Accreditation, after the 1996 AACN vote to establish CCNE.

CCNE carries out its mission by providing an accreditation process grounded in peer review of nursing programs to ensure program quality and program effectiveness. During its first 5 years, CCNE conducted an impressive number of on-site evaluations; a total of 569 nursing programs were reviewed during 360 comprehensive on-site evaluations. The number of institutions seeking new applicant status grew significantly as well, from six new applicants in 1998 to 17 in 1999 to 32 in 2000. The number of institutions granted new applicant status each year from 2001 to 2007 ranged from 18 to 29. By the end of 2007, there were 228 institutions whose programs had received new applicant status as a precursor to accreditation.

Growth in accredited programs was significant throughout the 10-year period. As of June 2003, 485 nursing programs at 306 institutions held CCNE accreditation. By June 2008, CCNE had accredited 837 nursing programs (490 baccalaureate and 347 master's degree programs) at 505 institutions. An additional 56 nursing programs at 44 institutions held new applicant status. Overall, 78% of institutions with baccalaureate and/or master's degree nursing programs nationwide were affiliated with CCNE by the summer of 2008.

In fall 2008, CCNE will conduct the first on-site evaluations of Doctor of Nursing Practice (DNP) programs, with four programs scheduled for accreditation review during that cycle. As of this writing, more than 50 DNP programs are scheduled for review in 2009 and 2010. During fall 2008, and spring and fall 2009, CCNE will conduct its largest review cycles, with approximately 60 institutions' nursing programs scheduled for on-site evaluations in each of the three cycles (J. Butlin, personal

communication, July 16, 2008). This dramatic increase in number of affiliated programs attests to the credibility of the CCNE accreditation process among constituencies in the community of interest.

Based upon the CCNE mission, CCNE accreditation has five general purposes:

1. To hold nursing education programs accountable to the community of interest—the nursing profession, consumers, employers, higher education, students and their families—and to one another by ensuring that these programs have mission statements, goals and outcomes that are appropriate for programs preparing individuals to enter the field of nursing.
2. To evaluate the success of a nursing education program in achieving its mission, goals and outcomes.
3. To assess the extent to which a nursing education program meets accreditation standards.
4. To inform the public of the purposes and values of accreditation and to identify nursing education programs that meet accreditation standards.
5. To foster continuing improvement in nursing education programs—and thereby in professional practice. (CCNE, 1998b, p. 3)

In addition to the mission and purposes, CCNE formulated 12 goals to serve as the premises for the accreditation process:

1. Developing and implementing accreditation standards that foster continuing improvement within nursing education programs.
2. Enabling the community of interest to participate in significant ways in the review, formulation, and validation of accreditation standards and policies and in determining the reliability of the conduct of the accreditation process.
3. Establishing and implementing an evaluation and recognition process that is efficient, cost-effective, and cost-accountable with respect to the institution and student.
4. Assessing whether nursing education programs consistently fulfill their stated missions, goals, and purposes.
5. Assuring that nursing education program outcomes are in accordance with the expectations of the nursing profession to adequately prepare individuals for professional practice, life-long learning, and graduate education.
6. Encouraging nursing education programs to pursue academic excellence through improved teaching/learning and assessment practices and in scholarship and public service in accordance with the unique mission of the institution.
7. Assuring that nursing education programs engage in self-evaluation of personnel, procedures, and services, and that they facilitate continuous improvement through planning and resource development.
8. Acknowledging and respecting the autonomy of institutions and the diversity of programs involved in nursing education.
9. Ensuring consistency, peer review, agency self-assessment, due process, identification and avoidance of conflict of interest, and confidentiality, as appropriate, in accreditation practices.
10. Enhancing public understanding of the functions and values inherent in nursing education accreditation.
11. Providing to the public an accounting of nursing education programs that are accredited and merit public approbation and support.
12. Working cooperatively with other agencies to minimize duplication of review processes. (CCNE, 1998b, pp. 3-4)

This last goal particularly highlights the AACN membership's second charge to the Board regarding a commitment to collaboration. An example of collaboration with other agencies is the Alliance for Nursing Accreditation. Concurrent with the 1996 AACN decision to establish an accrediting agency was the AACN membership's recommendation that AACN take the lead in establishing an alliance of nursing accrediting agencies. The purposes of the Alliance were to encourage collaboration among specialty organizations to coordinate the accreditation review process, avoid redundancies in accreditation review, and decrease the rising costs that nursing programs incur to prepare for accreditation reviews (CCNE, 2003a). The Alliance, consisting of 15 nursing credentialing organizations, offers an avenue for collaborative activities, including developing guidelines for collaborative reviews by Alliance member agencies.

The Alliance was first convened by AACN in 1997, its creation driven by the development of CCNE as an autonomous accrediting arm of AACN and the desire to have a forum to discuss issues related to credentialing in nursing. Initially, AACN coordinated the activities of the organization, but later the decision was made to rotate organization and coordination of meetings. CCNE hosted the October 2005 meeting of the Alliance, when discussions began about a model for reconceptualization of the Alliance (Alliance for Nursing Accreditation [Alliance], 2005). At that meeting, a task force was established and charged to re-examine the mission, goals, objectives, and composition of the Alliance. Discussion ensued through the March 2008 meeting, when Alliance members promulgated an official document formalizing the organization and its operation, with a renewed purpose to "provide a forum for national nursing organizations whose primary mission or major work concerns the issues related to credentialing of nurses in advanced practice roles" (Alliance, 2008a, p. 1). AACN agreed to be the official archive agency for the Alliance, and recommendations were made to expand membership to include additional accreditation and certification bodies (Alliance, 2008b). The Alliance name was changed in March 2006 to the Alliance for Advanced Practice Registered Nurse (APRN) Credentialing. Current membership of the Alliance for APRN Credentialing is provided as Appendix C. CCNE continues active participation in this collaboration.

Among the most important actions taken by the Board, based on the work of the Steering Committee, was the adoption of a set of values to guide CCNE in all its deliberations. These values have been incorporated into the CCNE standards and are reflected in all CCNE documents and decision-making processes. The values of CCNE were developed through early and continuing discussions regarding core beliefs about accreditation. While the values are discussed extensively later in this document, a brief introduction to the values lends context to the emerging organization. The Steering Committee not only adopted a set of values but declared that they would be used as the foundation for the values-based nursing accreditation process. The values identified as integral to the CCNE accreditation process were:

- Foster **trust** in the process, in CCNE, and in the professional community.
- Focus on stimulating and supporting **continuous quality improvement** in nursing education programs and their outcomes.
- Be **inclusive** in the implementation of its activities and maintain an openness to the **diverse institutional and individual issues and opinions** of the interested community.
- Rely on **review and oversight** by peers from the community of interest.
- Maintain **integrity** through a consistent, fair, and honest accreditation process.
- Value and foster **innovation** in both the accreditation process and the programs to be accredited.
- Facilitate and engage in **self-assessment**.
- Foster an educational climate that supports program students, graduates, and faculty in their pursuit of **life-long learning**.
- Maintain a high level of **accountability** to the publics served by the process, including consumers, students, employers, programs, and institutions of higher education.
- Maintain a process that is both **cost-effective and cost-accountable**.

- Encourage programs to develop graduates who are **effective professionals and socially responsible citizens**.
- Assure **autonomy and due process** in its deliberations and decision-making processes. (CCNE, 1998b, p. 3)

Although the language in the CCNE mission, purposes, goals, and values has been modified as the organization has evolved, the intent has been retained.

Making the Transition—the Preliminary Review Process

In 1997, discussions were held regarding a mechanism by which the new accrediting agency might recognize those programs in colleges and universities that already had recognition from another accrediting agency and wished to be a part of the emerging organization. To meet these needs, a preliminary review process was designed, preliminary approval requirements drafted, and the preliminary approval process approved. Preliminary approval was defined as a form of initial recognition that was provided to baccalaureate and graduate programs during the transitional phase of CCNE's development. Preliminary approval was considered a temporary status that was awarded to selected nursing education programs that met the following general requirements:

- The nursing education program is viable and appears, based upon the review of submitted materials, to be conducted in a manner that would enable eventual compliance with CCNE accreditation standards.
- The institution has a history of seeking and ensuring continuing accreditation and program recognition by appropriate accrediting and regulatory agencies.
- The institution has ensured the continuing viability of the nursing education program by being responsive to the concerns of accrediting and regulatory agencies. (CCNE, 2001b, p. 4)

Preliminary approval provided certain advantages to those programs that met the preliminary approval criteria. For example, the approved programs would have voting privileges in CCNE and would be eligible for up to 10 years of accreditation. In addition, programs awarded preliminary approval subsequently paid a lower fee for their first review than new applicant programs, thereby decreasing their accreditation costs.

Nursing programs were invited to apply for preliminary review by completing and submitting an application along with documents that supported the program's current accreditation status with other agencies. The information on prior accreditation status included dates and the length of time for which the program was accredited. Based on that information, the preliminary review panel projected the next on-site evaluation and the date an accreditation action would be needed to continue a program's accreditation status without interruption.

Preliminary review was carried out by a four person panel, the Preliminary Review Panel, chaired by Betty Johnson (see Appendix D). Using the values identified by CCNE, the panel met on two occasions to review applications. CCNE was unsure of the number of applications that would be received in this one-time activity. It was predicted that around 100 applications would be received by this new organization before the December 31, 1997 deadline. At its first meeting on October 13-14, 2007, the panel reviewed 59 applications. By the deadline, however, CCNE had received 323 applications from nursing programs nationwide (Preliminary Review Panel, 1998). The overwhelming response by nursing programs challenged the small Preliminary Review Panel. "While we were hoping to receive 100 applications, we were overwhelmed with over 300. We concluded that we had received applications from approximately 70% of the then existing baccalaureate and graduate programs in nursing" (L. Amos, personal communication, October 23, 2004). The panel decided that, although the remaining number of applications appeared tremendous, each application would receive the same attention as the first ones.

Panel members were surprised to receive as many as 10 large boxes of applications each, all of which needed to be reviewed in a short period of time.

The Preliminary Review Panel completed its work within 3 months, during which time the Panel examined and evaluated extensive materials to complete a comprehensive and equitable review for all applicants. Programs had been required to submit statements of the institutional and nursing program's missions; an overview of the current goals and initiatives of the nursing program; a description of all nursing degree programs offered; a list of all courses, all faculty, administrators, and academic and support services; a summary of outcomes from existing evaluation plans; NCLEX-RN® pass rates for the previous 3 academic years; a copy of the institutional catalog; and an application fee.

The Panel communicated with the Board and endorsed "the consistency, relevance, and usefulness of the proposed standards and processes that help identify and implement the best practices in assessment, judgment, and decision making" (Preliminary Review Panel, 1998, p. 2). The Panel also made recommendations for the composition and length of the on-site evaluations.

In April 1997, the first Standards Committee was appointed, and a framework for standards was identified (Steering Committee, 1997b). The Standards Committee, chaired by Lynda Davidson, developed guidelines that included objectives, goals, and expectations for CCNE Standards. In informing nursing programs about CCNE accreditation and in inviting participation in the process, Linda Amos emphasized that CCNE was a values-driven agency. The work of the Standards Committee is discussed further in a subsequent section of this history.

By October 1997, CCNE was operational and had three staff members in place. The Steering Committee held its last meeting and CCNE became a fully functioning accrediting agency as an autonomous arm of AACN (Steering Committee, 1997c). In a matter of months, CCNE was launched, with a fully functioning staff, a clear mission statement, organizational goals and processes, and a set of distinctive values and standards, supported by a significant number of nursing education programs.

Defining the Organization

In defining the organization, the governance structure was designed with a Board of Commissioners (hereafter, "the Board") and four standing committees. The Board, elected by CCNE-affiliated programs, was identified as the final authority on all policy and accreditation matters. The Board was composed of 13 members representing chief nurse administrators and faculty of nursing education programs affiliated with CCNE, practicing nurses, professional consumers representing employers of nurses, and public consumers (CCNE, 2001b).

The four standing committees were: the Accreditation Review Committee, the Report Review Committee, the Budget Committee, and the Nominating Committee. All standing committees were composed of appointed members, except for the Nominating Committee, whose members were elected by the CCNE-affiliated nursing programs. In addition, the Standards Committee, appointed by the Board, was scheduled to be convened every 5 years to evaluate the CCNE Standards and propose revisions as necessary (CCNE, 1998a). Also, a Hearing Committee could be convened on an ad hoc basis by the Board to consider appeals of accreditation actions. (During the first 10 years of existence, there was only one appeal hearing; that hearing provided an example of procedural fairness in carrying out CCNE's values and processes.) Membership on the Board from 1998 to 2008 is listed in Appendix E. Membership on standing committees from 1998 to 2008 is presented in Appendix F.

The first meeting of the CCNE Board was held in February 1998 (Board, 1998a). At that meeting, the budget, draft standards, and draft procedures were adopted. The draft procedures that were adopted included the governance structure of the Board and standing committees. In addition, the Board acted on recommendations of the Preliminary Review Panel, granting preliminary approval to 317 nursing programs. Also, the Board approved a list of potential evaluators and appointed a task force for developing a training program for on-site evaluators.

At its July 1998 meeting, the Board adopted revised procedures, acted not to re-open the preliminary review process, approved a fee structure, and discussed the USDE recognition process (Board, 1998b). The Board took a number of other important actions at this meeting. One of these was the decision that evaluation teams would not make recommendations regarding accreditation. In addition, the Board decided to have one Accreditation Review Committee (ARC) with co-chairs who were also Board members, and to assign primary and secondary reviewers to each nursing program under review for accreditation. The purpose of having two reviewers for each program was to ensure consistency in reviews. Also, the Board decided to have an accreditation cycle of up to 5 years for initial accreditation and up to 10 years for continuing accreditation, with ongoing monitoring of all programs through various reports and documents. As noted earlier, programs with preliminary approval were eligible for a maximum 10-year term in their initial accreditation.

Examples of CCNE values used as a basis for decisions in this early stage of CCNE development included honesty, openness, and integrity. For example, the importance of honesty was reflected in the agency's expectation that accurate information be provided in a program's self-study. Similarly, accuracy in information provided by CCNE staff to programs stressed this value's importance. The value of openness was a basis for the decision to have CCNE staff provide access to programs' self-studies in the CCNE office. The value of integrity was evident in the decision that consultation would not be provided through CCNE; rather, if programs requested consultation, they would be referred to AACN; this decision was made in order to avoid a potential conflict of interest (or even the appearance of a conflict) for Board or committee members or evaluators.

Members of the first CCNE Board of Commissioners and staff at a meeting in Washington, DC, 1999.

The Board and the standing committees were structured around these central values. Through developing procedures and incorporating values in its activities and actions, CCNE became a mission-driven, values-based accrediting agency.

Developing and Revising the CCNE Standards

In its first 10 years, CCNE had three Standards Committees, hereafter addressed as the first, second, and third Standards Committees (see Appendix G). The first Standards Committee, appointed by the CCNE Steering Committee in 1997, developed the initial CCNE standards. In accordance with CCNE procedures, the second Standards Committee was appointed in 2002 to evaluate the original standards and propose revisions as necessary. The third Standards Committee convened in 2007 to revise the standards, with particular focus on their application to DNP programs.

The first Standards Committee was responsible for drafting the standards and designing the key elements to evaluate compliance with the standards. The Standards Committee worked through multiple drafts, developing the standards based on support from a wide community of interest. The Standards Committee was guided by the values of ensuring fairness, providing consistency, fostering trust, and being nonprescriptive. A decision was made that programs would be required to select and demonstrate use of professional nursing standards and guidelines in their program; CCNE would not require

use of specific sets of standards and guidelines. In keeping with the agency's focus thus far, continuous quality improvement was an overriding value in designing the standards. After much deliberation, the Standards Committee identified four standards with several key elements related to each standard. Compliance with the key elements indicated that the overall standard was met (CCNE, 1998b).

Three of the four standards focused on program quality. The first standard emphasized congruence between institutional and program mission, philosophy, and goals/objectives, as well as their relationship to professional nursing standards and guidelines. Further, the mission, philosophy, and goals/objectives were expected to reflect the needs and expectations of the community of interest. Involvement of faculty and students in governance of the program was addressed in this standard.

The second standard emphasized institutional and program commitment and resources. Commitment of the parent institution to making adequate resources available to the program was addressed in this standard. Program resources were important considerations in the development of this standard. Qualifications of the chief nurse administrator were identified in relation to leadership of the nursing program. The faculty roles, qualifications, and number of faculty were also reflected in this standard.

The third standard focused on curriculum and teaching-learning practices. Development of the curriculum in accordance with expected results and with clear congruence between the teaching-learning experiences and expected results was emphasized. The teaching-learning environment as essential to student performance and evaluation was a critical component of this standard.

The fourth and final standard focused on program effectiveness. In this standard, student performance and faculty achievement were addressed. Also, satisfaction with the program as indicated by students, alumni, and employers was emphasized. Measurement of outcomes as required by the USDE, including NCLEX-RN® pass rates, certification pass rates, job placement rates, and graduation rates, was also addressed.

Once the standards were drafted, extensive feedback was sought from the community of interest, regional hearings were held, and a Centernet telenet broadcast provided feedback from constituents. All of these activities reflected the agency's commitment to the values of accountability, fairness, and fostering trust. The community of interest was invited to provide comments on the proposed standards, and the regional hearings provided an avenue for participation by multiple stakeholders in the CCNE process. The interactive television conference, led by the Standards Committee, involved many nursing programs throughout the country and offered the programs an additional opportunity to provide input into the development of the standards. The standards were approved by the Board (1998b) and implemented in fall 1998. These standards guided the CCNE accreditation process in its initial 5 years.

In accordance with the value of continuous quality improvement and the CCNE Policies and Procedures, the standards were reviewed after the first 5 years. In 2002, the second Standards Committee was appointed by the Board to review the standards and propose revisions. Once again, input from the community of interest was solicited and considered in proposed revisions. Among the most critical changes made in the standards, based upon that input, was the decision to require three specific sets of professional nursing standards and guidelines: *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 1998b), *The Essentials of Master's Education for Advanced Practice Nursing* (AACN, 1996c), and the *Criteria for Evaluation of Nurse Practitioner Programs* (National Task Force on Quality Nurse Practitioner Education [NTF], 2002) (CCNE, 2003e). The amended standards were approved by the Board for implementation beginning in January 2005 (Board, 2003b).

A similar process was employed with the 2008 revision of the CCNE accreditation standards led by the third Standards Committee. The 5-year review process mandated by the CCNE Policies and Procedures document coincided with the decision of the Board to begin accreditation of DNP programs, necessitating a review of the standards and adaptation for use with DNP programs. The Board discussed what would become the charge of the third Standards Committee at its October

Carole Anderson, chair of CCNE's second Standards Committee, presenting at a standards forum at the 2003 AACN Fall Semiannual Meeting.

AACN members learn about the amended accreditation standards at the CCNE forum at the 2003 AACN Fall Semiannual Meeting.

2006 meeting (Board, 2006). Taking subsequent action, the Board confirmed the chair's appointments to the committee, including representatives from education, the practice arena, and a graduate of a DNP program (Board e-mail, 2007a). The work of the committee began with a general call for comments on the existing (2003) standards and areas requiring revision. Input from constituents, as well as recommendations from the Accreditation Review and Report Review Committees was considered in the revision of the accreditation standards, and proposed revisions were presented at the fall 2007 AACN business meeting and AACN baccalaureate, master's and doctoral education conferences where input was requested from attendees. In addition, an extensive call for comment on the proposed standards revisions was sent to more than 1,000 constituents, including CCNE-affiliated education programs, state regulatory agencies, federal agencies, and other professional organizations and accrediting bodies.

Once again, the revisions made in the 2008 standards document were relatively few, attesting to the soundness of the existing standards, and consisted primarily of clarification, relocation, and reordering of key elements. Several new definitions were included in the glossary, which replaced the previous "operational definitions." Two major changes in the 2008 document were the requirements for DNP programs to incorporate *The Essentials of Doctoral Education for Advanced Nursing Practice* (AACN, 2006) and the inclusion of a specific key element related to the use of preceptors. Efforts were made, with the addition of "elaboration" statements under each key element, to clarify the intent of the key elements (CCNE, 2008h). These elaborations were developed in response to questions frequently asked of CCNE staff by programs engaged in self-study development. Attention was also given to clarifying the relationship between expected and actual program outcomes, which had been an area of confusion for programs in the past.

The proposed revisions were used, in tandem with the existing 2003 standards, at the March 2008 workshop on writing self-studies, because some participants would be writing to the existing standards and some to the revised standards. Participants were encouraged to comment on the proposed revisions and their input was subsequently shared with the Standards Committee. Following this lengthy process, the revised standards were approved by the Board at its April 2008 meeting for implementation beginning in January 2009 (Board, 2008b).

Developing and Implementing Training Programs

From its inception, CCNE has been committed to providing high-quality training programs for CCNE evaluators and team leaders. A program for the training faculty was held on May 29-30, 1998, in Washington, DC, to prepare eight individuals for their roles as trainers. Four training programs were held during summer 1998 to establish a strong evaluator base. Evaluator training has been held as often as needed to maintain a cadre of competent evaluators, with teleweb retraining held in 2003 and planned for 2008 to address the amended standards. Evaluator training programs focus on the

role of the evaluator, assessment of a program's compliance with the CCNE Standards, conduct of the on-site evaluation, and preparation of the team report. More than 850 individuals have been trained as CCNE evaluators, and 653 remain active in CCNE service. Approximately 72% of evaluators represent academe and 28% represent nursing practice. Fifty-four percent of current evaluators are faculty, 28% represent nursing practice, and 18% are chief nurse administrators. Overall, CCNE evaluators represent faculty and administrators from a wide variety of nursing programs and practitioners from practice settings throughout the United States. Table 1 shows the training programs for new evaluators conducted by CCNE during its first 10 years.

Table 1. CCNE Evaluator Training Programs, 1998-2008

Date	Location	Number Trained
June 12-13, 1998	Dallas, TX	40
June 26-27, 1998	Pittsburgh, PA	47
July 10-11, 1998	Seattle, WA	32
July 29-30, 1998	Washington, DC	52
January 8-9, 1999	Philadelphia, PA	56
September 10-11, 1999	Fort Lauderdale, FL	64
April 9-10, 2000	San Diego, CA	77
August 18-19, 2000	Alexandria, VA	67
July 20-21, 2001	Alexandria, VA	83
July 12-13, 2002	Alexandria, VA	66
July 11-12, 2003	Alexandria, VA	90
July 22-23, 2005	Alexandria, VA	93
June 27-28, 2008	Alexandria, VA	96
Total Evaluators Trained		**863**

Evaluator training was designed to ensure consistency in the use of the CCNE standards and to provide reliability in the accreditation process (CCNE, 2003a). The training program "familiarizes evaluators with the practices unique to specialized accreditation, promotes dialogue about the interpretation of CCNE standards, and fosters collegial relationships among individuals dedicated to enhancing the quality of collegiate nursing education" (CCNE, 2003a , p. 7). Participants in evaluator training have commented consistently on the excellence of the program and the usefulness of the program in preparing them for on-site evaluations. Among the comments by participants were that evaluator training "…provided very practical insights into the process," "reinforced the values of continued improvement process," and was "very collegial" (CCNE 2003c). More recent feedback has reaffirmed the quality of the program, "The materials were comprehensive; the video was very helpful in providing very practical information about the visit; the trainers were intelligible and effectively conveyed materials" (CCNE, 2008d, p. 1). On October 25, 2002, based on suggestions from the ARC, previously trained evaluators and evaluator training faculty, CCNE held a team leader training program to prepare CCNE evaluators to serve as team leaders and to enhance the skills of current team leaders. Seventy-one evaluators participated in team leader training. Participants evaluated this training program as excellent. Examples of comments by participants included, "Opportunities to

Participants at the first CCNE evaluator training program, Dallas, Texas, July 1998.

share perceptions with peers; to use the variations in approaches and interpretations, [to] critique model agendas" were helpful (CCNE, 2002b, p. 3); "The whole program was **very** informative and helpful" (p. 2).

In addition to training evaluators and team leaders, CCNE developed workshops to assist nursing programs in writing self-studies. The need for some discussion regarding writing self-studies was identified by the programs themselves. Programs voiced the need to hear about the process(es) of developing the self-study and the writing activities needed. Both nursing education administrators and faculty members from schools who were about to begin the process of writing a self-study were invited to participate in a workshop, the first of which was held in December 2000. In conjunction with the AACN Spring Annual Meeting, CCNE offers writing workshops with the expected outcome of clear, accurate, and relevant self-studies written by nursing programs. As of March 2008, 805 individuals had participated in nine writing workshops. Among the comments offered by workshop participants were that the workshop "content was pertinent and clearly presented" (CCNE, 2008e, p. 4), "it was good to hear from the people who actually worked with standards and have done visits," "loved the questions and interactions with peers" (p. 3), and "presenters were very knowledgeable, experienced, clear and concise" (p. 5).

Taking Risks

Several examples of risk-taking in the initial stages of implementing CCNE can be cited. For example, those nursing programs that decided to affiliate with CCNE prior to CCNE's recognition by the USDE as a nationally recognized accrediting agency risked their students' eligibility for federal funding. Similarly, programs affiliating with CCNE in its initial stage risked their relationships with their state boards of nursing and with the military services. Because the National League for Nursing Accrediting Commission was often mentioned specifically in state board regulations, there was a time, initially, when CCNE was not an "approved" agency in those states. State boards of nursing did act to approve CCNE in a timely manner. However, the military services did not immediately identify CCNE as an approved accrediting agency, thus jeopardizing students' eligibility for funding or appointment in the military services.

Mary Collins, CCNE trainer, facilitating a session at the first evaluator training program, Dallas, Texas, July 1998.

In implementing CCNE policies and procedures, risk-taking was necessary and accepted by the Board. Guided by the CCNE values, the Board acted in what it considered the best interest of CCNE and nursing programs. For example, the issue of retroactive accreditation was considered and debated by the Board. Some nursing programs requested retroactive accreditation in order to ensure their graduates had graduated from an accredited program. Although the Board acknowledged that

retroactive accreditation was not approved by the USDE, the Board ultimately made the decision to approve retroactive accreditation as a one-time action for 17 nursing programs (USDE, 1999). These programs had taken the risk of participating in CCNE initially, and the Board believed that the one-time action served the nursing program students' best interests in this transition. Although the Board realized its compliance with USDE policy might be challenged, the value of serving the community of interest was an overriding consideration. In the USDE recognition process, the Board's decision was in fact challenged, but CCNE was able to assure the USDE that the retroactive accreditation action was a one-time, values-driven decision made upon careful consideration of the factors described above. No further retroactive accreditation has been taken by the Board. Accreditation terms as of this writing begin with the date of the Board's accreditation action. [Note: In April 2009, the CCNE Board voted to make the effective date of the accreditation term retroactive to the first day of the program's most recent CCNE on-site evaluation.]

Hiring Professional Staff

One of CCNE's strengths from the very beginning has been the hiring of responsible and professional staff members. Several professional staff members have come with experience in other accrediting agencies, a characteristic that has offered CCNE the benefit of their knowledge about the accreditation process. Jennifer Butlin, CCNE Director since May 1998, stated:

> One unique feature of CCNE and the staff is that none of the staff members are nurses. I think that is unusual in accreditation for none of the staff to actually come from the profession where accreditation is occurring. But our philosophy has been, and the wisdom of the people who hired us was, that we don't need to be nurses because we rely on the more than 600 highly competent, qualified nurses who serve on our Board, committees and evaluation teams to provide the nursing-specific knowledge and competency. So the staff here are expert in accreditation, quality assurance, customer service, and they understand what it means to provide customer service to the constituents, not only the deans and faculty, but to the volunteer evaluators, employers of nurses, military recruiters, colleagues in nursing organizations, and parents of prospective students. (personal communication, February 9, 2005)

Libby Cooperman, Executive Administrative Assistant, has been with CCNE since February 1998. She commented that,

> Staff had to create all the mechanisms to do all this [accreditation activities]. There was no model to follow or a program we could put in the computer that said instant evaluation. There is nothing on the market I know of that told us how to do everything, and staff had to create and devise all of these things. I think they did a good job. (personal communication, February 9, 2005)

The responsiveness and professionalism of staff members have been among the most positive comments in evaluations of CCNE by its constituents. Examples of comments from nursing programs hosting on-site evaluations were, "The staff were exceptional in their support and attention to details, concerns, and questions," and "Everyone was so very helpful. As a new Director, I felt very comfortable contacting CCNE about any and all questions" (CCNE, 2003d). These comments are a striking contrast and a positive outcome for CCNE compared with the concerns expressed in the 1996 AACN accreditation survey. In that survey, the lack of communication and the lack of support from accreditation staff were cited repeatedly as concerns that needed to be addressed in a new accrediting agency (AACN, 1996b). Based on input from current CCNE-affiliated nursing programs, these concerns have been addressed and staff are a definite strength of this organization.

Achieving Recognition and Approval

As CCNE became an accrediting agency, it needed to seek recognition from the USDE. Recognition by the USDE would enable nursing education programs accredited by CCNE to become eligible to participate in programs administered by Federal agencies. These Federal programs require schools of nursing or nursing students to be affiliated with federally recognized accredited programs. CCNE submitted its initial formal petition for recognition by USDE in April 1999. The evaluation of CCNE's petition was carried out by USDE staff and the National Advisory Committee on Institutional Quality and Integrity (NACIQI). Activities of the evaluation included observation of Board and committee meetings, workshops, and on-site evaluations. In addition, comments regarding the quality of accreditation were garnered from the public and from hearings before NACIQI (USDE, 1999).

Two issues identified by NACIQI, in its evaluation, were the need for practicing nurses on the on-site evaluation team and the retroactive accreditation for the initial 17 programs, discussed above. CCNE responded to both issues. First, CCNE changed its process and procedure to require that a practicing nurse be appointed to each on-site evaluation team. Second, CCNE stated the rationale for the retroactive accreditation of the 17 programs and demonstrated that it was a one-time action on the part of the Board as a considered response to its community of interest. The recommendation for initial recognition by the USDE was received on December 6-7, 1999; Secretary of Education Richard Riley concurred with that recommendation in February 2000 (personal communication, February 22, 2000). Following the initial 2-year recognition period, CCNE applied for and was recommended for continuing recognition on December 10-11, 2001; then Secretary of Education Rod Paige concurred with that recommendation in July 2002 (personal communication, July 10, 2002). It is important to note that the continuing recognition was for the maximum 5-year period and that no problems or issues were identified by the USDE.

In April 2007, CCNE was awarded continued recognition by Secretary of Education Margaret Spelling (personal communication, April 30, 2007) and granted an expansion of scope to include nursing programs with distance education offerings. This made CCNE the only national accrediting body for nursing education recognized for distance education.

Also, CCNE sought recognition from the Council for Higher Education (CHEA), which required an extensive application and included observation of CCNE's organizational activities, namely, an Accreditation Review Committee (ARC) meeting and a Board meeting. On January 21, 2002, the CHEA Board of Directors voted to recognize CCNE for a period of 10 years (J. Eaton, personal communication, February 4, 2002). Among the many positive comments included in the report of the CHEA observer was, "the Commission has done significant work to implement this accreditation system in 5 years and the number of programs accredited in 3 years is noteworthy" (Fenwick, 2001, p. 5).

In addition, CCNE holds membership in the Association of Specialized and Professional Accreditors (ASPA). CCNE was accepted into ASPA membership on September 27, 1999, and has continued to actively participate in the organization since that time (C. Davenport, personal communication, October 4, 1999). This organization is dedicated to specific disciplines within higher education. Members of ASPA agree to adhere to its Code of Good Practice (see Appendix H). In commenting on CCNE's use of the ASPA Code of Good Practice, ASPA Executive Director Cynthia Davenport, stated:

> The ASPA *Code of Good Practice* is the cornerstone of membership in ASPA and is reaffirmed annually by the member groups. It is my understanding that CCNE routinely distributes the ASPA *Code* to the chief executive officers of the colleges and universities whose nursing programs are under review for accreditation. This helps communicate ASPA's purposes to important stakeholders in the higher education community and reflects CCNE's strong commitment to these important values. (personal communication, June 29, 2005)

In nursing accreditation, CCNE has been an active member of the Alliance for APRN Credentialing, formerly the Alliance for Nursing Accreditation. The Alliance was originally conceived, "to promote both unification and diversity among member organizations and to minimize division and inconsistency in the accreditation function," explained then AACN President Carole Anderson (AACN, 1996a, p. 5). Since the creation of CCNE as an accrediting agency, it has demonstrated its ability to participate as a peer in nursing accreditation with the Alliance, and as a partner in academic accreditation with its recognition by USDE and CHEA. Recognition by or membership in these organizations allows CCNE to participate fully in accreditation activities and discussions on a nationwide basis. In some instances, CCNE has taken a leadership role within these organizations. For example, in 2008, CCNE initiated conversation with certifying bodies for advanced practice nursing to develop a pre-approval process for new advanced practice nursing programs (Executive Committee, 2008b). This activity was undertaken at the request of professional organizations concerned about the quality of newly established advanced practice programs and their ability to effectively prepare students for national certification.

Identifying Issues Addressed in Creating the Organization

In creating a new accrediting agency, multiple issues arose that were considered by the Board, CCNE committees, and CCNE constituencies. Six issues are presented here to illustrate the variety of issues encountered by CCNE.

One of the first issues was identification of the scope of CCNE accreditation. Consistent with the mission and scope of AACN as the parent organization, CCNE limited its scope to accreditation of baccalaureate and graduate nursing programs. Assertions made by some critics that this scope reflected exclusivity, in that other levels of nursing education were not included, were considered by the Board, but the issue was resolved with a reaffirmation of CCNE's unique focus. Comments received through the History Project Survey support and reinforce the agency's decision to focus on baccalaureate and graduate education, which is central to the parent organization's (AACN) mission. Comments regarding this decision included, "CCNE represents the only nursing organization that champions nursing education at the baccalaureate and higher degree level", and "[CCNE's] focus [is] on baccalaureate and higher degree nursing education. To me this translates to a focus on professional nursing education …" (CCNE, 2004a, p. 1).

A second issue was the inclusion of practicing nurses on each CCNE on-site evaluation team. The USDE had begun to voice a commitment to inclusion of practitioners on teams, and CCNE became one of the first accrediting agencies in the country to conform to this USDE policy. Clarification regarding the definition of practicing nurse, which was inherently different from the definition of nursing faculty members (who also may "practice" nursing) led to many discussions. On-site evaluation teams now include a practicing nurse member who serves as a full team member, participating in the entire on-site evaluation process. Among the challenges of this action has been the identification of practicing nurses who meet certain educational and experiential requirements and are available to serve on teams, particularly in the current clinical environment and nursing shortage. Among the responses from practicing nurse evaluators was,

> I felt it was very worthwhile, and I felt a valued member of the team for my input as the practicing member as opposed to the faculty member. The other team members told me that my view was different than theirs, and therefore allowed them to see things from another angle. Plus I found myself asking questions about things that were unclear to me, not being in academia, which sometimes gave us answers to things we had been looking for. (CCNE, 2003d, p. 26-27)

Another practicing nurse evaluator stated,

> My colleagues in nursing education have done wonderful work, and being able to evaluate their programs has added to my education and philosophy concerning nursing. It does take a great deal of time and preparation, and individuals should realize that we owe it to our colleagues to be prepared for the visit. I have enjoyed making these visits and hope I will be asked to do another in the near future. (CCNE, 2003d, p. 26-27)

Another evaluator shared, "As a practicing nurse (evaluator), it expands my contribution to the nursing profession. I value my role highly. The mission is important to me" (CCNE, 2008c, p. 22).

One of the most contentious issues CCNE considered was the question of requiring specific professional nursing guidelines. Central to this issue was the dilemma of requiring specific professional nursing guidelines while maintaining a commitment to being nonprescriptive. Initially, based on the work of the first Standards Committee, the Board decided that specific professional nursing guidelines would not be required (Board, 1998a). Although many in AACN expressed disappointment that the *Essentials* had not been required in the original standards, AACN Executive Director Geraldine Bednash acknowledged that in the standards revision process, change did occur, and the support for requiring the *Essentials* "bubbled up over time" (personal communication, October 23, 2004). Subsequently, based on the work of the second Standards Committee and substantial feedback from the community of interest, the Board acted to require *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 1998b), *The Essentials of Master's Education for Advanced Practice Nursing* (AACN, 1996c), and the *Criteria for Evaluation of Nurse Practitioner Programs* (NTF, 2002) (Board, 2003b). The incorporation of these particular professional standards and guidelines was required for relevant programs seeking CCNE accreditation as of January 1, 2005. The revised 2008 standards document has an additional requirement that all DNP programs incorporate *The Essentials of Doctoral Education for Advanced Nursing Practice* (AACN, 2006). CCNE has continued to encourage programs to adopt additional sets of standards and guidelines relevant to their areas of focus (CCNE, 2008h).

Another issue considered by the Board was the review of nursing programs offered by distance education and/or by technology. A Task Force on Distance Education was appointed in 1999 (Board, 1999b). Following lengthy discussion of the task force's report, the Board adopted the Alliance for Nursing Accreditation Statement on Distance Education Policies, shown as Appendix I, and decided that distance education programs would be required to meet the same accreditation standards as all other programs (Board, 2002a). As noted earlier, the continued recognition of CCNE by USDE included an expansion of scope to accreditation of distance education programs. The 2008 standards revision process also reinforced the commitment to the same level of quality in distance education as was expected in on-campus programs and included new definitions of the terms "distance education" and "distance education program" (CCNE, 2008h).

Two issues that arose in the early stages of organizational development were whether CCNE would accredit international programs and whether CCNE would accredit doctoral programs. In both instances, the Board appointed task forces to explore the issues and make recommendations to the Board (Board, 1999b). The Task Force on International Accreditation differentiated between two types of international programs: programs in foreign countries that are components of a U.S.-based nursing program, and programs entirely situated in foreign countries. Based on the task force report, the Board acted not to accredit international programs housed entirely in foreign countries at this time. Those programs that are components of U.S.-based programs are reviewed as part of the U.S.-based program's accreditation process (Board, 1999b; 2003a). In May 2007, CCNE conducted its first foreign accreditation of the nursing program at American University of Beirut. This program's application for accreditation was approved because the parent institution is registered and approved to grant degrees by the New York State Board of Regents and is accredited by a U.S. regional accrediting body,

thus meeting CCNE's criteria. The visit, however, highlighted some of the concerns with international accreditation. Initially scheduled for November 2006, the visit had to be cancelled because of growing unrest in Lebanon. Even when the visit was successfully conducted, gunfire occurred in the city while the on-site evaluators were present.

Although CCNE does not currently accredit foreign nursing programs without ties to U.S. institutions, the organization has provided consultation to other nations in their efforts to establish their own professional nursing accreditation systems. In 2006, for example, Mary Jo Clark, who has been involved with CCNE in numerous capacities, visited Taiwan and provided consultation to the Taiwan Nursing Accreditation Council. Similarly, Board chair Jill Derstine and Director Jennifer Butlin traveled to South Korea to discuss accreditation activities. In addition, several other countries have visited CCNE headquarters to consult regarding accreditation issues. As the need for professional accreditation for nursing education becomes better recognized throughout the world, the issue of international accreditation activity by CCNE will continue to resurface.

Regarding doctoral programs, the Task Force on Doctoral Accreditation (2000) recommended that CCNE not accredit doctoral programs. Subsequently, the Board acted to include entry-level prelicensure doctoral programs within its scope of operation, but not to accredit graduate-level doctoral programs at that time (Board, 2000b). In 2006, AACN approved *The Essentials of Doctoral Education for Advanced Nursing Practice* and set the stage for accreditation of advanced nursing practice programs at the doctoral level. At its October 2004 meeting, the CCNE Board voted to extend the accreditation process to Doctor of Nursing Practice programs (Board, 2004). This decision was part of the impetus for the 2008 revision of the standards document. DNP programs were being developed rapidly throughout the nation and institutions offering DNP programs were requesting CCNE accreditation. In order to meet this professional need, the Board gave the third Standards Committee a strict deadline for completion of the proposed revisions so DNP program accreditation could begin as early as fall 2008 (Board, 2007b).

Because of the number of DNP programs requesting on-site visits as soon as possible, the Board developed criteria to help prioritize the scheduling of those program reviews. Priority was given to institutions whose baccalaureate and master's programs were already scheduled for accreditation visits in fall 2008 and to institutions whose post-baccalaureate DNP programs would be graduating students in spring 2009 or earlier (Executive Committee, 2008a). These criteria were intended to protect students graduating from the programs and to ensure their eligibility to sit for national certification examinations. Four programs met the criteria and were added to an already cumbersome fall 2008 visit cycle. Other programs were notified that they could request a visit as soon as spring 2009 or later. As of June 2008, an additional 13 DNP programs had been added to the spring 2009 review schedule and 29 DNP programs had been scheduled for the 2009-2010 academic year.

During the first 10 years of CCNE's development, there have been a number of important decisions, activities, and outcomes. CCNE has evolved into a highly credible accrediting agency that has gained the support and respect of the nursing community and the community of interest it serves, as well as other accrediting agencies and professional education. In creating the organization, CCNE leaders, affiliated programs, and other individuals committed to program quality and effectiveness have come together to sustain the organization and ensure quality accreditation now and in the future.

Chapter 3

Incorporating the Values

Charlotte F. Beason and Timothy M. Gaspar

Organizational values or a value system have been studied for decades with the goal of understanding the impact that values have on an organization. Hultman (2002) described values as a set of beliefs that concern the preferred modes of conduct in an organization. These values reside along a continuum of relative importance and once they are embraced, the values become the standard of importance that serves as the criterion for decision-making and the setting of priorities. In addition, values provide direction, explain perspectives, and justify actions within an organization. Values reflect the principles by which the organization and its representatives bring to life its mission.

In October 1995, AACN appointed a task force to explore the role of AACN in accreditation. One year later, in October 1996, the AACN membership voted to create a new accrediting agency. In January 1997, the AACN Board appointed a Steering Committee to lead the development of a new accrediting agency that would become known as the Commission on Collegiate Nursing Education.

The first goal for the Steering Committee was the development of an organization that was mission-driven, values-based, and responsive to its constituencies (Steering Committee, 1997a). The resulting CCNE mission, purpose, and values had a dramatic effect on the organization's early development and guide its organizational practices today. Nurse leaders such as Linda Amos, Carole Anderson, Lynda Davidson, Charlotte Beason, Geraldine Bednash, Betty Johnson, and Mary Collins, and many other AACN members, as well as non-nurse leaders such as Jennifer Butlin, were instrumental in leading CCNE, with its multiple stakeholders, in the refinement and implementation of the CCNE mission, purpose, and values. All of the chairs of the Board—Linda Amos, Lynda Davidson, Charlotte Beason, Mary Margaret Mooney, Jill Derstine, and Harriet R. Feldman—have been focused on the values of trust, fairness, openness, quality, choice, and a balance between autonomy and compliance with respective standards (J. Butlin, personal communication, October 23, 2004, February 9, 2005). As a result, CCNE's commitment to a values-based accreditation process has been evident throughout its first 10 years.

The CCNE Values

Among the most important actions taken by the CCNE Board, based on the work of the Steering Committee, was the adoption of a set of values to guide the Commission in its deliberations. These values have been incorporated into the CCNE *Standards for Accreditation of Baccalaureate and Graduate Nursing Education Programs*, are reflected in all CCNE documents and decision-making processes, and are used as the foundation for a values-based initiative for nursing accreditation. The values of CCNE were developed through early and continuing discussions regarding core beliefs about accreditation. CCNE's core values are to:

- Foster **trust** in the process, in CCNE, and in the professional community.
- Focus on stimulating and supporting **continuous quality improvement** in nursing education programs and their outcomes.
- Be **inclusive** in the implementation of its activities and maintain an openness to the **diverse institutional and individual issues and opinions** of the interested community.
- Rely on **review and oversight** by peers from the community of interest.
- Maintain **integrity** through a consistent, fair, and honest accreditation process.
- Value and foster **innovation** in both the accreditation process and the programs to be accredited.

- Facilitate and engage in **self-assessment**.
- Foster an educational climate that supports program students, graduates, and faculty in their pursuit of **life-long learning**.
- Maintain a high level of **accountability** to the publics served by the process, including consumers, students, employers, programs, and institutions of higher education.
- Maintain a process that is both **cost-effective and cost-accountable**.
- Encourage programs to develop graduates who are **effective professionals and socially responsible citizens**.
- Ensure **autonomy and procedural fairness** in its deliberations and decision-making processes. (CCNE, 2008h, p. 3)

These values guide the accreditation, policy, and operational decisions made by the Board and its committees. They can be identified throughout the self-assessment, review, and evaluation processes undertaken by nursing education programs; the findings and reports of on-site evaluation teams; and the reviews and recommendations made by CCNE committees. The 12 values are actualized by CCNE staff's support of its multiple constituencies. From CCNE's inception, promoting continuous quality improvement has been evident in both internal and external activities. As a result, CCNE is respected by its constituents and the accreditation community for its role in fostering quality and effectiveness in nursing programs.

Developing the Values

CCNE's values, first published in a procedures document developed by the Steering Committee, established the foundation for the creation of the organization's *Standards for Accreditation of Baccalaureate and Graduate Nursing Education Programs*. Both the procedures and standards documents detailed a values-based process of accreditation (Board, 1998a). These standards and the values upon which they were based were reviewed extensively at CCNE's first Board meeting. Two Board members who were members of the Standards Committee, Lynda Davidson and Suzanne Van Ort, provided the history and context of the standards' development.

Prior to adopting the organization's values statement, the Board members engaged in a deliberative discussion of what a values-based process meant, what types of relationships the organization should develop with its constituents, and the importance of initiating processes that foster quality, growth, integrity, and trust. The Board members' vision, which focused on fostering continuous improvement in baccalaureate and graduate nursing education, was to be foundational for both professional nursing in the future and within the organization itself. Board members agreed that the process they were about to initiate should be one that promoted continuous quality improvement, not only on the part of the nursing programs being reviewed, but within the CCNE organization itself, extending to all its practices. Board members spoke of the importance of a self-evaluation process in which programs fully examine their actions and evaluate their effectiveness without fear of punitive action. Rather, the process would be viewed as one that promoted improvement and, at the same time, respected institutional missions and the needs of communities of interest. Keenly aware of the changing practice environment, the Board also recognized the importance of fostering innovation in nursing education by creating a process that encouraged programs to identify and define their own goals and objectives.

Using the Values

Evidence of the influence of CCNE's values is found in verbal communications, letters written in response to team reports, post-accreditation surveys, and training session evaluations. A consistent message has emerged from this feedback—CCNE's emphasis on its values is readily apparent in all CCNE activities, having been derived "from an imperative of excellence" (L. Amos, personal communication, October

23, 2004). Lynda Davidson, the second chair of the Board, described the values as "up front and center" at each Board meeting and as the "drivers" for policy making and decision making (personal communication, October 23, 2004). Indeed, as CCNE's third chair, Charlotte Beason, observed CCNE's values were simply "integral to the accreditation process" and have "withstood the test of time" (personal communication, October 23, 2004). In a practice that continues to the present day, all Board and committee meetings began with a discussion of each CCNE value and its meaning. This review serves to orient and focus new and continuing members on CCNE's values, overall mission, and accountability to its constituencies.

Use of the values as a guide and decision-making tool has continued from one CCNE leadership group to the next. In describing the influence of CCNE values on her leadership, Mary Margaret Mooney, CCNE's fourth chair, observed that her leadership in CCNE was probably "smoothed" by the values. "When in tight places [referring to] the values helped us find our way through" (personal communication, July 16, 2008). The organization's fifth chair, Jill Derstine, concurred, stating that in going back to the values "there was usually an answer" (personal communication, July 16, 2008). Harriet R. Feldman, current chair of the Board, offered a more personal perspective on the values, noting that the culture of the CCNE values led to her personal growth, enabling her to see the whole quality movement in progress and as a result "at my school, we have truly embraced the philosophy of CCNE" (personal communication, July 16, 2008).

To support the History Project, CCNE conducted a nationwide survey of those who comprise the organization's community of interest and asked respondents to comment on CCNE's effectiveness and its impact on education. Consistent with earlier feedback, the values encouraged participation in CCNE and, for many, were a deciding factor in their decision to seek CCNE accreditation. Respondents noted that the manner in which the values are evidenced has an impact on program quality, providing a model by which programs focus on self-assessment and defined outcomes.

Examination of each of the CCNE values as seen through the eyes of constituents confirmed that the intent of early leaders has been recognized. It is apparent that the values serve as an interrelated foundation for all actions and, through ongoing reference, the values statement has become a "living" document.

Trust

According to one survey respondent, "[CCNE] has elevated the process to a professional level and increased the level of trust in the process beyond what anyone could have imagined" (CCNE, 2004b, p. 18). The value of trust in the accreditation process has been critical to CCNE's success as an organization and to its community of interest. CCNE held multiple events and forums to promote dialogue among the potential constituents early in its history. As noted by Carole Anderson, former president of AACN, nurse leaders and chief nurse administrators of baccalaureate and master's level programs initially viewed this new accrediting agency and process as a risk-taking venture (personal communication, February 9, 2005). These nurse leaders were aware of the need for new approaches to nursing education and to foster program quality (CCNE, 2004b). Trust was demonstrated by the first two nursing programs that sought CCNE accreditation in 1998—Montana State University-Bozeman, a multi-campus nursing program, and the Decker School of Nursing at Binghamton University, State University of New York. The administrators and faculty of these and other programs reviewed in 1998 demonstrated unwavering trust in CCNE.

Continuous Quality Improvement

Throughout CCNE's first 10 years, the most frequent comments about its process and focus have centered on quality. CCNE's emphasis on quality was an issue often listed as a reason for seeking CCNE accreditation. One constituent indicated that "continuous improvement [is]…a natural for this organization" (CCNE, 2004b, p. 38). Quality improvement is dependent on self-assessment and evaluation, and those programs accredited by CCNE have identified the self-study process as a

valuable tool in the continuous quality improvement process. A program administrator noted that the "CCNE self study process [was] very beneficial [and]…generated a very productive continuous quality improvement model for program evaluation (CCNE, 2004c, p. 13). Further, one enthusiastic CCNE participant commented,

> I believe we have been given a green light to grow and develop in the way we can best serve the community. We have been encouraged to self-evaluate and make changes when needed that reflect the needs of our community. We haven't been held back…Our program has grown in enrollment and prestige over the past few years. I attribute much of that to our involvement with CCNE. (CCNE, 2004c, p. 48)

Another example of CCNE's commitment to continuous quality improvement is the development and use of Continuous Improvement Progress Reports (CIPRs). As the Accreditation Review Committee (ARC) and the Board began the process of reviewing programs for accreditation, a great deal of discussion went into defining the purpose and even naming the mid-term report, which would serve as both an interim self-assessment and communication of a program's continuing compliance with the CCNE standards. Both Board and committee members felt strongly that the CIPR should focus on continuous quality improvement while supporting the values of integrity, accountability, and self-assessment on the part of the program. There was further consensus that all programs should receive specific details regarding any particular areas of focus relative to the standards and/or key elements to be addressed in the next report. After reviewing several of the first CIPRs, Board members and staff were gratified to see multiple exemplars that validated the expectations of program improvement. Programs had indeed continued their quality-oriented progress in meeting CCNE standards and, with rare exceptions, program deficits identified by the Board had been positively addressed in these reports.

The CIPRs and other program reports are reviewed by the Report Review Committee (RRC). Twin themes related to quality have guided the RRC's assessment of reports: Is the program sustaining quality? Is the program striving to improve? Another CCNE value, innovation, figures prominently in RRC reviews. The RRC examines how well nursing programs maintain and improve quality in the face of major changes, whether in enrollment, leadership, program offerings, or financial resources. If a program continues to meet CCNE standards, creativity in its methodology is regarded positively. The RRC, in parallel with the ARC, has provided a vehicle for nursing programs to measure their educational effectiveness and, with a substantial degree of autonomy, determine how to improve it.

CCNE's commitment to quality as well as inclusion can be seen in all aspects of its internal operations. One activity central to all decisions continues to be the widespread solicitation of feedback regarding all activities in which the organization engages. For instance, after a final accreditation decision is made by the Board, programs hosting an on-site evaluation are asked to provide feedback through a Web-based survey regarding CCNE staff support, the evaluation process including activities of on-site evaluators, the pertinence of the standards, and the value of the overall process. Similarly, on-site evaluators give Web-based feedback regarding their experiences. Also, all participants in CCNE training sessions are asked to evaluate the process. Finally, the Board and all committees provide feedback regarding their own effectiveness and ways in which the process might be improved. Committees provide valued critiques of team reports, as well as the effectiveness of standards and procedures.

Data generated in the above manner are reviewed and used to drive subsequent policy and operational decisions. For example, feedback from nursing programs led to the implementation of ongoing and fully subscribed workshops on writing self-studies, while comments from on-site evaluators and ARC members led to modifications in evaluator training content and implementation of a team leader training program.

Inclusive

CCNE makes every effort to be inclusive in its activities. The value of inclusiveness has led many programs and individuals to participate in the accreditation process. Chief nurse administrators have indicated that CCNE's inclusion of all constituencies was one factor that led them to select CCNE accreditation, and some constituent programs attribute their effectiveness to the involvement of communities of interest in program decisions (CCNE, 2004b).

The first CCNE on-site evaluation conducted at Montana State University-Bozeman in September 1998. Pictured from left to right Dean Lea Acord, team leader Marcia Dale, team member Betty Porter, team member Susan Wilson, and CCNE Director Jennifer Butlin.

The process through which CCNE considered and made policy decisions during its first 10 years is highly reflective of a commitment to inclusion, as can be shown through the process used to review and revise CCNE's standards. The second Standards Committee was appointed in 2002 to review and revise the original CCNE standards. The committee conducted two national surveys of CCNE's community of interest and held forums to augment regular data sources and provide a comprehensive basis for determining revisions to be recommended. From these data provided by a wide representation of constituents, the second Standards Committee recommended and the Board made the decision to require the use of AACN's *The Essentials of Baccalaureate Education for Professional Nursing Practice* (1998b) and *The Essentials of Master's Education for Advanced Practice Nursing* (1996c), as well as the *Criteria for Evaluation of Nurse Practitioner Programs* (NTF, 2002) in the revised standards effective January 2005 (Standards Committee, 2002c). This decision, landmark in the sense that it was the first time CCNE had required the use of specific standards and guidelines established by other organizations, as well as the process by which the decision was reached, has been hailed as promoting inclusiveness as well as quality in the accreditation process (CCNE, 2003b).

The membership of the Board, as well as the selection and training of on-site evaluators and the appointment of committee members, remains one of CCNE's primary quality measures and demonstrates CCNE's commitment to be open to diverse issues and opinions. Board members, committee members, and evaluators are diverse with regard to race, gender, ethnicity, and geography. In addition, they reflect the diversity of CCNE's affiliating institutions, representing institutions that range from small private or religious colleges to large research-extensive private and public universities. Similarly, practicing nurses who serve as on-site evaluators and committee members reflect a wide range of roles including staff nurses, nurse managers, nurse executives, nurse practitioners, clinical nurse specialists, and quality management nurses. As they participate in CCNE activities, each of these nurses brings a unique perspective to the accreditation process based on his or her unique career experience.

The CCNE value of inclusiveness is best illustrated through the standards themselves; this perspective is consistently reflected in language that recognizes and seeks to meet the needs of the community of interest it serves (CCNE, 1998b, 2003e, 2008h). This value is reflected inherently within the four standards. In order to adequately meet Standard I, which addresses governance, input from the community of interest is essential if the nursing program is to align its mission and goals with the needs of the community being served. The second standard provides for the autonomy of the program, as well as the effective utilization of the program's internal community of interest—human, physical and

fiscal resources to achieve expected outcomes. The third standard is focused on curriculum and teaching-learning practices, together with the program's ability to achieve program expected outcomes that relate to the community of interest. The fourth standard focuses on the student and faculty communities of interest, evaluating effectiveness of student performance and faculty accomplishments.

As innovations in nursing education evolve and educational environments become more diverse, CCNE has remained grounded in the value of inclusiveness to meet the needs of its communities of interest. For example, in April 2008, the Board moved to accredit DNP programs with the approval and publication of *Standards for Accreditation of Baccalaureate and Graduate Degree Nursing Programs* (CCNE, 2008h). A further demonstration of this value is the inclusion of proprietary programs of nursing in the CCNE accreditation process with a total of 11 such programs accredited at this time.

Review and Oversight by Peers

The use of a diverse cadre of academic and practicing nurse volunteers as on-site evaluators is key to CCNE's value of review and oversight by peers. Respondents to post-evaluation surveys have identified on-site evaluation teams as a strength of the CCNE process, noting that teams are well prepared and that the inclusion of practicing nurses whose experiences are congruent with the program was a positive addition and a milestone within the organization. The 2008 call for nomination of people with experience related to DNP programs as evaluators is another example of CCNE's attention to a peer review process in accreditation.

Both team leader and evaluator training sessions empower volunteers to have a foundational understanding of the organization, inclusive of its standards, practices, purpose, and values. In addition, those committees having intermediate review responsibilities, the ARC and the RRC, are composed of academic and practicing nurse members who reflect CCNE's community of interest. Chief nurse administrators, faculty, and practicing nurses as well as public members are involved in all aspects of CCNE's review and oversight processes. Evaluator training sessions and subsequent updates as well as committee composition as described above, promote accountability on the part of CCNE and its volunteers and promote a consistent, fair, and honest accreditation process.

Integrity

The integrity of the accreditation process is promoted at all levels of the CCNE organization. Staff members are repeatedly acknowledged for their responsiveness, expertise, and support. The CCNE accreditation process has been described as "meaningful" and is seen as fostering an "environment of colleagueship, integrity and trust" (CCNE, 2004b, p. 2). The Board and all committee members continually reference the values during deliberations regarding accreditation and policy decisions in all areas. Members frequently ask, "Which of our values addresses this issue?" or, conversely, "Is our decision in concert with CCNE values?" Such questions can and sometimes do lead to a reevaluation of an initial decision or clarification of the points on which the decision is based. These actions lead to consistency within the CCNE process, and constituents have come to respect and trust the information, actions, and individuals associated with CCNE.

Consistency and integrity are ensured through the methods employed by CCNE committees to complete reviews of team, interim, and special reports. In each case, committees use a primary and secondary review process, with decisions being reached by committee consensus. The ARC, which routinely operated two panels reviewing separate sets of reports, opted to complete one concurrent review at each meeting as a quality assurance measure. Through this process each panel independently reviews the same report. The panels later convene in plenary session for the purpose of discussing their respective findings and recommendations. This internal validation practice continues to be used by CCNE as it has proven to be a useful tool in assessing quality in the decision-making

process and assuring consistency within and between review panels. Indeed, many constituents have praised CCNE's consistency. In CCNE's post-visit assessment survey, a program official commented, "Even though this was the first evaluation for this school, this was not my first time being involved with a CCNE accreditation. And I am very pleased with the consistent fairness of the process. Please do not change this aspect of what CCNE does" (CCNE, 2007, p. 14).

The Board and committee members are keenly aware of the need to prevent any form of conflict of interest. Therefore, members with a known or perceived conflict of interest recuse themselves from the accreditation review and decision-making process. Adherence to the conflict of interest policy is critically important when team members are assigned to participate in on-site evaluations. The intent is to preserve integrity of the review process and promote consistent evaluation of the standards without bias. In addition to routine staff "screening" when inviting evaluators to participate on evaluation teams, program officials are given the opportunity to declare a conflict of interest.

Innovation

CCNE's support of innovative program design and implementation is noted frequently as a unique attribute of the organization, and is described as promoting nursing programs becoming more innovative and responsive to their stakeholders (CCNE, 2004b). The organization is seen to promote flexibility. A survey respondent writes: "The flexibility of programs has generated some really great initiatives in nursing education" (CCNE, 2004b, p. 69). Because CCNE values and fosters innovation, nursing program officials have the assurance that alternative program, teaching, or clinical strategies will be evaluated fairly based on each program's mission, goals, and expected outcomes. Thus, students attending CCNE-accredited programs can be found completing clinical experiences in municipal housing projects, city bus stations, migrant labor camps, and myriad other sites. A number of CCNE-accredited programs offer nursing students the opportunity to complete clinical experiences abroad or to attain combined degrees such as the MSN/MBA. Such programs meet the needs of their communities of interest and develop graduates who are effective professionals and socially responsible citizens.

CCNE values have fostered innovative program design. As noted by one faculty member "CCNE's key feature is its support of creative approaches to curriculum planning and implementation" (CCNE, 2004b, p. 10). Accelerated programs that enable licensed practical nurses, associate degree nurses or second degree students to attain baccalaureate degrees or master's degrees and the growing number of online programs or international teaching sites sponsored by CCNE-accredited programs are examples of innovative programs designed to meet the national need for increased numbers of registered nurses holding baccalaureate and higher degrees. To address the national shortage of nursing faculty, many programs have entered into unique partner agreements with affiliating hospitals, medical centers, and community-based health care agencies to implement shared faculty activities in which practicing nurses teach in both classroom and clinical settings. These arrangements maximize the skills and experiences of highly qualified practicing nurses while allowing programs to maintain or increase enrollment.

Programs repeatedly indicate an appreciation of not being forced to fit a mold and indicate that CCNE is not "prescriptive" when describing the effect of CCNE's value of innovation. These attributes are viewed as allowing for and encouraging a variety of educational models.

CCNE's commitment to innovation in nursing education has been evidenced by a willingness to respond to constituents' requests for reviews of developing program initiatives, and when indicated, to make appropriate policy decisions. For example, at its April 30-May 3, 2003 meeting, the Board voted to develop a process for the accreditation of post-baccalaureate nurse residency programs (Board, 2003a). Accreditation standards for residency programs were approved by the CCNE Board in April 2008 after a 4-year standards development process conducted by the CCNE Task Force for Post-Baccalaureate Nurse Residency Program Accreditation. A list of task force members is presented in Appendix J. The procedures

Members of the 2003 CCNE Accreditation Review Committee (standing left to right) Mary Jo Clark, Carolina Huerta, Timothy Gaspar, Roy Ann Sherrod, Mary Collins, Patricia Burns, Mary Watkins (seated left to right) Charlotte Beason, Lynn Babington, Linda Niedringhaus, Mary Margaret Mooney, Renee Holleran, E. Jane Martin, and Susan Woods.

for accreditation of residency programs were developed in summer 2008, and CCNE stood poised to implement the residency accreditation process by its year-end target. As of August 2008, 44 hospitals were participating in the University HealthSystem Consortium (UHC)/AACN post-baccalaureate nurse residency program. Several of these hospitals had expressed strong interest in pursuing CCNE accreditation as soon as the process would become available. The first training program to prepare individuals for their roles as evaluators in the residency accreditation process was held on August 15-16, 2008, in Philadelphia. A total of 23 practicing nurses and educators were trained for this purpose.

CCNE constituents have indicated that innovation and vision will be required to prepare nursing graduates for the challenges of the future. Constituents are confident in CCNE's ability to lead in this area, stating that "students can be assured of a quality education in a CCNE accredited school" (CCNE, 2004b, p. 26) and "employee pools are strengthened as diversity of educational preparation and experiences are introduced into the workforce" (CCNE, 2004b, p. 19).

Self-assessment

A commitment to self-assessment is reflected by CCNE's emphasis on the preparation of self-studies and the use of aggregate data for program improvement. Programs undergoing review have indicated repeatedly that completing the self-study process resulted in a valuable learning experience and that the document itself served as an important resource for faculty. One survey respondent indicated that "CCNE has elevated the self-study process to an organized assessment that is recognized as worthy of trust." Another respondent said, "Writing the self study and experiencing the site visit were true professional experiences" (CCNE, 2004c, p. 15).

Programs are required not only to gather, but also to analyze and use aggregate outcome data to improve program effectiveness. This "closing of the feedback loop" is essential in order to demonstrate a program's accomplishment in meeting the standards, respective key elements, and self-identified expected program outcomes. CCNE's expectation of ongoing and substantive evaluation has been described as having a major impact on educational institutions and is seen to promote accountability on the part of educational programs and faculty.

The CCNE Board and committees engage in assessment of their own work and roles. These practices reflect CCNE's commitment to improvement of the organization and the constituencies it serves. Internal practices include the use of aggregate data to determine its own organizational effectiveness. Aggregate assessment data from chief nurse administrators served by CCNE accreditation, on-site evaluation team assessments, evaluation team report assessments; and feedback from evaluator training sessions, self-study workshops, and accreditation forums are exemplars of data used to promote continuous improvement within the organization.

Life-Long Learning

The fostering of an educational environment that supports the pursuit of life-long learning is promoted by CCNE. This value has a focus on the future of educational programs, faculty development, and the notion that new graduates will grow from novices to experts as professional nurses. *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 1998b), *The Essentials of Master's Education for Advanced Practice Nursing* (AACN, 1996c), the *Criteria for Evaluation of Nurse Practitioner Programs* (NTF, 2008) and the recently adopted *The Essentials of Doctoral Education for Advanced Nursing Practice* (AACN, 2006) speak directly to the professional development of nurses, educators, and practitioners at all levels of expertise. Guidelines in *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 1998b) note that faculty selection of specific course content and placement of the content in the curriculum should consider which facts and details of knowledge, cognitive skills, communication, and technical skills will serve the learner well into the future. These guidelines challenge faculty to ask themselves in what way the content they incorporate into curricula will contribute to life-long learning.

According to *The Essentials of Baccalaureate Education for Professional Nursing Practice*, "All nursing graduates will need skills and intellectual curiosity to continue learning throughout their professional careers" (AACN, 1998b, p. 17). Active learning strategies are supported as the most effective means to stimulate learning. Behaviors and values are role modeled and learned in the formative years of students' programs of study and developed during the graduates' careers. Active learning strategies challenge faculty and students as participants in multiple ways that include, but are not limited to, simulation learning, service learning activities, small group learning activities, community-based experiences, and communication exercises that develop written and verbal skills. Active learning strategies also employ the use of technology to manage data and communicate with a variety of interdisciplinary providers of care.

Future nurses have the opportunity to enhance the role of the professional nurse. The guidelines in *The Essentials of Master's Education for Advanced Practice Nursing* (1996c) and the *Criteria for Evaluation of Nurse Practitioner Programs* (NTF, 2008) provide direction for selecting course content and creating conditions that promote active learning for a lifetime professional career. The American health care system is under significant strain to change and meet the needs of an aging "baby-boomer" population that is becoming a significant consumer of the care system. Increased demand on the health care system is occurring concurrently with reductions in fiscal resources. These changes require baccalaureate, master's, and doctorally prepared nurses to adapt and expand their skills and knowledge to meet complex health care demands. The value of life-long learning is being conveyed to students in nursing programs nationally. On-site evaluators frequently encounter students who are excited by their current learning activities and are actively planning for master's or doctoral education. RN-to-baccalaureate students speak of their introduction to evaluating and using research in their practice and describe how they share findings at their work sites. In addition, graduate students enthusiastically describe formal and informal continuing education they have conducted at their work sites based on information and projects from their academic studies.

Innovation, creativity, evidence-based best practices, and service learning expertise will be essential to the provision of care to all populations in our future global society. Adapting and preparing for this important challenge is vital for practitioners of the future and will require an educational system that greatly values life-long learning.

Accountability

CCNE seeks to maintain a high level of accountability to its stakeholders by providing ready access to information, ongoing feedback, and internally consistent procedures and actions. Increasingly, CCNE has made use of Web-based information and communication to support ongoing activities in its formative years. Based on its review of evaluation team reports, the ARC has made recommendations to the

Board regarding the implementation of feedback and evaluative mechanisms to improve the performance of on-site evaluation team members (Accreditation Review Committee [ARC], 2000a; 2000b; 2001). Programs that experienced accreditation reviews early in CCNE's operation noted accountability to the program(s) and parent institutional mission. Further, CCNE demonstrated the enhancement of accountability by "walking the talk" of embracing the other values of inclusiveness, innovation, autonomy, and creativity in the accreditation standards. In addition, the focus on quality improvement, fairness, and consistency was found to be reassuring (CCNE, 2004b, 2004c). These early experiences were exemplary and earned the trust, confidence and support of CCNE's community of interest. Credibility as an agency was indeed established by CCNE's commitment to accountability to its accredited programs in these areas.

CCNE's commitment to remain accountable to the public served by the accreditation process is addressed in all evaluator activities. Each evaluator training session begins with an orientation to CCNE's values and uses those values as a framework for interpreting CCNE standards, discussing the evaluation team process, and indicating the components of an accurate and useful team report. The extensive diversity in the evaluator pool enables CCNE to select evaluation team members who are familiar with and appropriate to the type of institution and program being reviewed. Survey comments from programs that have undergone CCNE review consistently reflect positively on the appropriateness of on-site evaluation teams and their excellent understanding of the programs being evaluated (CCNE, 2003d).

CCNE-accredited programs have indicated that the accreditation process has promoted accountability on the part of faculty and educational programs. Positive comments by program officials indicate that they are accountable, through the CCNE accreditation process, for their own outcomes. CCNE is seen to "strengthen the profession and hold schools accountable for quality programs while at the same time allowing for individuality among schools" (CCNE, 2004b, p. 20). Accountability is viewed as promoting continuous quality improvement and enhancing program effectiveness. CCNE standards serve as the basis for programs to demonstrate that they are accountable to their constituents and are used by programs to identify strengths and areas for improvement.

Cost-effective and Cost-accountable

Since its inception, CCNE has been committed to providing cost-effective and cost-accountable services. CCNE's fee structure was established in concert with this value. During the organization's first 5 years, Board members were cognizant of the burden accreditation costs could impose, and they initiated a number of discussions regarding fair and equitable fee schedules to support the activities of the organization. CCNE responded to its constituents by establishing an innovative, single flat-fee paid by all programs to support the cost of on-site evaluation. Further, ongoing implementation of cost-effective administrative practices has resulted in fees remaining flat since the organization's inception. In addition, under its first treasurer, Brenda Cherry, attention to cost accounting practices led to the organization's reaching a major milestone—achieving strong financial solvency. CCNE exceeded expectations by moving to repay an initial operating loan from AACN in the amount of $113,561 in December 1999. Subsequently, the organization initiated an investment of reserve capital (Board, 2003a; 2003b).

With the advent of a third level of accreditation, that of DNP programs, CCNE adjusted its fee schedule to a three-tier structure. This structure retains the flat-fee mechanism, but applies it at three levels—institutions that have only one program level accredited, those that have two levels, and those that have three levels of programs seeking accreditation (baccalaureate, master's, and DNP). In addition, evaluation visit fees continue to be based on the number of visitors required in teams, with three visitors for evaluation of one program level, four visitors for two levels, and five on-site evaluators for three program levels (Board, 2007c).

Effective Professionals and Socially Responsible Citizens

CCNE's values-based accreditation has allowed programs to define their mission, goals, and expected outcomes in a manner consistent with the missions of their parent institutions, their community of interest, and selected professional nursing standards and guidelines. This program autonomy benefits the consumer and the public by ensuring that CCNE-accredited programs educate effective professionals and socially responsible citizens who ultimately serve the public good through providing high quality care and health care policy to serve the people of this world. Constituents state that CCNE standards serve as guidelines that "are more reflective of changes in health care" and promote "outcomes…that positively impact professional nursing practice and the quality of health care" (CCNE, 2004b, p. 33). CCNE is seen to "encourage education of nurses better prepared to care for future needs …not only in health but also in 'people issues'" (CCNE, 2004b, p. 66). The CCNE standards and values have encouraged programs to structure classroom and clinical experiences appropriate to local geographic regions, as well as state, national, and international arenas. This standards framework promotes meaningful opportunities for students to take part in political, health policy, civic, and social action programs to promote the health and wellness of individuals, communities, and the nation. Over the years, evaluation team reports have documented both undergraduate and graduate students who shared their excitement in being able to effectively interact not only with individuals needing health care, but also with those social and political systems that influence health care.

Autonomy and Procedural Fairness

CCNE ensures autonomy and procedural fairness in all its deliberations. For example, in its relationship with AACN as the parent organization, systematic attention is given to ensure CCNE's autonomy in accreditation. Although CCNE shares office space and selected administrative support functions with AACN, the parent organization has no role in or authority over accreditation processes or actions. The CCNE Board acts as an autonomous body in all accreditation processes.

Enabling autonomy in the implementation of educational programs was a central tenet of CCNE's organization. The standards were viewed as the framework that would support a program's ability to address unique needs in a consistent and quality focused manner. One chief nurse administrator made the following statement that illustrates the success of this approach, "CCNE adheres to a set of values that are supportive of nursing education being a collegial environment, while upholding a core of meaningful standards. Programs have the autonomy they need to meet the needs of their community of interest" (CCNE, 2004b, p. 12).

CCNE's support of program autonomy evolved through the early deliberations of the Board and committees. The organization's ability to successfully promote autonomy is due not only to its standards and values but also to those individuals who were willing to critically examine and reexamine issues and decisions in light of these newly adopted documents and the values upon which they were based.

As was anticipated, not all programs CCNE reviewed were in full compliance with all standards and/or key elements. In such cases, Board, ARC, and RRC members relied on the values to ensure autonomy and procedural fairness in all deliberations and decision-making. Those programs meeting all standards and key elements were granted the full 5- or 10-year term of accreditation for which they were eligible. Those deemed not to be in compliance with all key elements or not meeting all standards received careful review, always accompanied by thorough discussion and deliberation. During initial deliberations, the Board determined not to have an accreditation "formula." That is, no formula was adopted that would indicate that a program's failure to meet a specified number of key elements would result in an automatic judgment that a standard is not met, or in a predetermined length of the accreditation term. The decision to consider each program separately, without benefit of a predetermined formula, was unprecedented, yet the individual consideration of each program

remains one of CCNE's strengths. Consistent with the values, each program is viewed as a unique entity, and the standards and key elements are considered in light of the program's defined mission, goals, and expected outcomes, together with the program's ability to meet them.

From its beginning, CCNE has ensured procedural fairness in its processes. For example, an appeal process is available to nursing programs. A hearing panel may be convened if a nursing program initiates a formal appeal of a CCNE Board action. To its credit, CCNE received only one appeal and held only one hearing in its first 10 years.

Today, CCNE is recognized nationally and internationally as an organization that is fair and nonprescriptive, and promotes "clarity of program evaluation in terms of outcome assessment" (CCNE, 2004b, p. 70) and "peer evaluation at its best" (CCNE, 2007, p. 10). This reputation has been realized as a result of diligent efforts on the part of Board and committee members and the CCNE staff who have implemented the mission of CCNE. In addition, CCNE would have not been the reality of today without those nurse leaders who voted to initiate the new accrediting agency.

Actions such as soliciting feedback from the community of interest in developing standards and providing a clear articulation of CCNE expectations and values to prospective on-site evaluators have enabled constituents to take part in fair and objective evaluations based on self assessment and on-site observations. When that process is followed by disclosing the team report to the program with a request for feedback and later, conscientious decision-making by two tiers of committed professionals, a climate of trust, procedural fairness, and collegiality is the inevitable result.

The Values Affirmed

During CCNE's first 10 years, the effect of each value has left an imprint throughout the organization and on its actions. The interrelationship of multiple values has had a very powerful effect on the accreditation process, bringing life and relevance to the mission of CCNE. Again, the values of continuous quality improvement, inclusiveness, integrity, review and oversight by peers, self-assessment, accountability, and autonomy and due process demonstrate how trust was fostered among members of the community of interest. Most importantly, nursing program administrators report that the values-based approach used by CCNE promotes continuous quality improvement that comes alive in their programs. The CCNE process guides programs in weaving self-assessment and program evaluation directly into the program's semester-to-semester or year-to-year activities (CCNE, 2004c). Due to its values-based approach, CCNE has become known to other accreditation agencies as an organization that is fiscally solvent, cost-effective, and a promoter of high quality learning and high quality program outcomes. The values of CCNE reflect the principles by which the organization and its representatives bring life to its mission.

Chapter 4

Serving the Community of Interest

Mary Jo Clark and Suzanne R. Van Ort

Accountability as envisioned by the CCNE founders has two major aspects: nursing programs must be accountable and responsive to their communities of interest, and CCNE must be accountable to its own community of interest.

Nursing Education Programs and Their Communities of Interest

CCNE's mandate for accountability arose from responses to the initial AACN survey of accreditation issues and needs and was incorporated in CCNE's first general purpose—"to hold nursing education programs accountable to the community of interest" (CCNE, 1998b, p. 3). Despite the recognized need to foster differences in nursing education programs based on local needs, the concept of "community of interest" was new in the context of nursing accreditation, and was identified as one of the unique aspects of the CCNE accreditation process. In a response to a CCNE survey conducted as part of the development of this history, one constituent commented:

> The most unique feature of CCNE, and one that I don't think schools capitalize on, is the concept of 'community of interest.'….To me, 'community of interest' gives a school the ability to have an identity based on student need, geography, institutional characteristics, etc. Within the parameters of meeting standards, all schools do not have to look exactly alike. (CCNE, 2004b, p. 13)

An on-site evaluator expressed it slightly differently: "CCNE has almost given the permission these schools may have needed to publicly proclaim they are good schools in their own unique way" (CCNE, 2004b, p. 12).

Because serving the community of interest was a new concept, unaddressed by prior nursing accreditation processes, considerable confusion arose during CCNE's first 5 years over which groups or individuals constituted a program's community of interest. In fact, CCNE staff report that questions regarding the "community of interest" comprised some of their most frequent contacts with programs preparing for on-site evaluations. In the original *Standards for Accreditation of Baccalaureate and Graduate Nursing Education Programs* (CCNE, 1998b), the definition of "community of interest" addressed separate internal and external constituencies. The internal community of interest was defined as "institutionally-based individuals and groups that include administration, faculty, and students as well as the groups that govern the activities of faculty and students" (p. 15). The external community of interest included:

> Individuals and groups that influence or participate in the nursing education program to ensure the achievement of expected results of the program. Examples of external groups that may comprise the program's community of interest include: prospective students and their families, organizations of professional nurses and nurse educators, credentialing agencies such as the National Council of State Boards of Nursing, employers, legislators, health care providers, volunteer organizations, and consumers. (CCNE, 1998b, p. 15)

Given the widespread confusion among programs, clarifying the term "community of interest" was one of the major objectives of the second Standards Committee, the group charged with reviewing and revising the standards after 5 years of implementation. The committee debated whether to continue with separate definitions of internal and external communities of interest and discussed the value of

providing additional examples to clarify the meaning of the terms. At length, the committee decided that providing specific examples defeated the initial intent of encouraging programs to identify their own communities of interest. In addition, the committee believed that specifying particular communities of interest might be perceived as prescriptive, when its very nonprescriptiveness had often been described as one of CCNE's major strengths (Standards Committee, 2002b). In the end, the committee chose to redraft the definition of communities of interest in more global terms, retaining but de-emphasizing the concept of internal and external communities and making it clear that the examples provided were just that—*examples*. The committee also incorporated the concept of a diverse student body and consumer constituency into the revised definition and emphasized clients of nursing services as a specific element of a program's community of interest. A revised definition was drafted:

> Community of interest: The groups and individuals who have an interest in the mission, goals, and expected outcomes of the nursing unit and its effectiveness in achieving them. The community of interest comprises the stakeholders of the programs and may include both internal (e.g., current students, institutional administration) and external constituencies (e.g., prospective students, regulatory bodies, practicing nurses, ***clients***, employers, and the community/public, etc.). The community of interest might also encompass individuals and groups of ***diverse backgrounds, races, ethnicities, genders, values, and perspectives who are served and affected by the program*** (emphasis added). (CCNE, 2003e, p. 14)

This definition was retained virtually unchanged by the third Standards Committee in 2008. In the interim, self-study documents seem to indicate reduced confusion by programs in defining their own communities of interest, although the call for comments on the proposed standards revision elicited a question from a CCNE evaluator as to what constitutes "an appropriate community of interest" (CCNE, 2008f).

The second Standards Committee also added an element in the Examples of Evidence related to Standard I directing programs under review to "define the community of interest and describe how the needs and expectations of the community of interest are reflected in the mission, goals, and expected outcomes of the program" (CCNE, 2003e, p. 14). Similar language was adopted by the third Standards Committee in the elaboration of Key Element I-B in the 2008 standards revision, indicating that the "community of interest is defined by the nursing unit" and that "the needs and expectations of the community of interest are reflected in the mission, goals, and expected student outcomes" (CCNE, 2008h, p. 8). The elaboration statement also specified that "input from the community of interest is used to foster program improvement."

CCNE's Community of Interest

The second aspect of accountability is CCNE's commitment to meeting the needs of its own community of interest, including both its external and internal communities of interest. The external community of interest incorporates entities outside of the CCNE organization itself; the internal community of interest is comprised of CCNE's committees, staff, and cadre of evaluators.

External Community of Interest

CCNE's external community of interest includes the accredited educational programs as well as those considering accreditation, current and potential nursing students, the nursing profession, and employers of graduates of nursing education programs. Other professional and non-nursing organizations and agencies are also part of this external community.

Educational Programs

Educational programs accredited by CCNE and those programs considering applications for accreditation review are a significant component of the organization's external community of interest. Specific means by which CCNE accommodates this community of interest include obtaining their input into accreditation policies and processes, providing information and assistance regarding accreditation, limiting accreditation costs, and meeting the needs of special types of nursing education programs.

Obtaining Input

The U.S. Department of Education (USDE) criteria for recognition of accrediting bodies mandate policies and procedures for soliciting input from the community of interest. The emphasis placed on this requirement can be seen in the Department's initial response to CCNE's petition for recognition as an accrediting body. Although CCNE employed a variety of mechanisms for obtaining input, the lack of a specified time frame for public comment on proposed new or revised standards was one of a few concerns identified by USDE staff in their review of CCNE's petition for recognition. To address this concern, CCNE included a 21-day comment period in the relevant policy in its *Internal Operating Manual of Rules and Procedures* (CCNE, 1999a).

Initial input regarding the creation of the new accrediting body was solicited in a 1995 article published in AACN's *Syllabus* (AACN, 1995). In response to mandates arising from the AACN Survey (AACN, 1996b, p. 55) to "streamline and select only the very most salient criteria", the first Standards Committee embarked on a process of developing accreditation standards that met the needs of CCNE's community of interest. CCNE staff and the original Standards Committee were strongly cognizant of the need to consider the input of students, faculty, administrators, and the general public in the development of the accreditation standards (Standards Committee, 1997).

CCNE also sought input during its early development through an informational Centernet teleweb on September 29, 1997. Because registration for the teleweb was institution-based, AACN member schools were encouraged to open participation to faculty, staff, and students, as well as area clinicians and executives. In addition, CCNE held widely attended regional hearings on the proposed accreditation standards throughout 1997 (CCNE, 1997). Other initiatives included a call for comment on the Steering Committee's planning document included in the February 1997 *Accreditation News Notes* (L. Amos, personal communication, March 5, 1997) and broadcast e-mails to inform CCNE constituents of developments in policies and procedures.

A similar process of soliciting broad-based input from the community of interest was undertaken from 2002 to 2003 in the review and revision of the accreditation standards. For example, CCNE held response forums in conjunction with AACN's October 2002 fall business meeting (Board, 2002b) and the AACN baccalaureate education conference (Standards Committee, 2002d) and conducted an extensive Web-based survey of a variety of CCNE constituents in 2003 (Standards Committee, 2003c). In October of 2003, the Board adopted the revised standards proposed by the second Standards Committee and arranged to make them available on the CCNE Web site for comment by the community of interest, in keeping with its internal policies (Board, 2003a). After considering the comments received, the Board formally adopted the proposed standards at its October 2003 meeting (Board, 2003b).

During the revision process, one issue hotly debated by the second Standards Committee was a proposal to require the use of the relevant AACN *Essentials (The Essentials of Baccalaureate Education for Professional Nursing Practice*, 1998b, and *The Essentials of Master's Education for Advanced Practice Nursing*, 1996c) for all baccalaureate and master's degree programs in nursing and the *Criteria for Evaluation of Nurse Practitioner Programs* (NTF, 2002) for nurse practitioner programs (Standards Committee, 2002a, b, c, d, e; 2003a, b). Meeting minutes indicate that most committee members were initially opposed to such a requirement. Their ultimate decision to recommend requiring the use of these

three sets of guidelines was heavily influenced by input from a variety of sources, including a broad-based survey of nursing education programs (both those affiliated with CCNE and those that were not [Standards Committee, 2002e]), consultation with former USDE staff and legal counsel, and numerous letters from other nursing organizations and CCNE constituents favoring the requirement (Standards Committee, 2002a, b, c, d, e; 2003a, b). This one action, more than any other in CCNE's first 5 years, demonstrated the organization's commitment to responding to input from its community of interest.

Reflecting on the history of the organization and its development, Carole Anderson, AACN president at the time of CCNE's inception, noted that many AACN members originally expected that the accreditation standards would be based on the two *Essentials* documents in existence at that time. In retrospect, she concluded, "The fact that we waited as long as we did [to incorporate the *Essentials* as a requirement] almost made the changes more palatable, and we may not have been able to do it any sooner" (personal communication, October 23, 2004).

The process involved in the development of the 2008 accreditation standards document followed a similar path. Constituents from multiple areas, including accredited programs, the AACN membership, CCNE evaluators, boards of nursing, professional organizations, the National Student Nurses Association, and others, were invited to comment on the existing (2003) standards and indicate areas for improvement. These comments and those from the Accreditation Review and Report Review Committees informed the initial deliberations of the third Standards Committee and resulted in proposed revisions that were shared in several venues, including presentation at the AACN business meeting in fall 2007 and presentation at the AACN baccalaureate, master's, and doctoral education conferences. Proposed changes were also shared with other constituencies in a broadly disseminated call for comments. A few comments were received suggesting modification of the proposed revisions, but constituents in general found the proposed standards to clarify areas of confusion while supporting a commitment to quality education.

CCNE also has fostered one additional avenue for input into its accreditation processes that affects both educational programs and the organization itself. In accord with USDE requirements, CCNE mandates that nursing education programs inform their communities of interest of the opportunity to provide third-party comments to CCNE prior to an on-site evaluation. In addition, CCNE established procedures whereby complaints can be filed about the accreditation process or the agency itself. As noted by Director Jennifer Butlin, "To date, CCNE has never received a formal complaint against itself, and I think that speaks volumes to the satisfaction that our constituents are feeling about the CCNE accreditation process" (personal communication, June 15, 2008).

CCNE has also sought feedback on satisfaction with the accreditation process from its constituents. To that end, each institution visited is asked to complete an evaluation following an accreditation site visit. Evaluators complete a similar evaluation form after each visit.

Providing Information And Assistance

One of the requests of the AACN membership in its 1996 survey on accreditation issues was for better orientation of nursing education programs to the accreditation process. Other requests highlighted the need for a responsive staff that would help applicants with questions regarding the process (AACN, 1996b).

CCNE took these requests to heart and created an array of mechanisms by which nursing programs can obtain necessary information on CCNE's accreditation standards and processes. In addition to responses to specific questions posed by applicant programs, CCNE has made self-studies available as examples. CCNE also provides programs with a variety of printed materials regarding the accreditation standards and processes. Finally, CCNE has conducted a series of invitational workshops on writing self-studies for programs within 2 years of an anticipated on-site evaluation. The first of these workshops was held in Chicago in December of 2000 (CCNE, 2000b). Evaluations by participants in

the annual workshops have been uniformly favorable, with the "wonderful accreditation workshops" identified as one of the significant outcomes of CCNE's first years of operation (CCNE, 2004a, pp. 2-3). A participant in the March 2008 workshop evaluated the program, as follows:

> [I] appreciate CCNE's desire not to [be] overly prescriptive and [the training faculty's] supportive, helpful attitude with occasional levity. [This approach] stands in stark contrast to what I've experienced through the process of seeking approval from our state board of nursing. Your collective comportment allows me to be energized about seeking accreditation, rather than wishing I could avoid the entire process. (CCNE, 2008e, p. 3)

Knowing that information is a two-way path, AACN members in the initial accreditation survey requested that mechanisms be developed to streamline data collection by multiple agencies, using existing documents whenever possible (AACN, 1996b). CCNE and AACN responded to such requests with their decision to use the same annual report form, which was modified to address the needs of both organizations.

The extent of CCNE's success in responding to its constituents' requests is probably best captured in comments from its staff. Libby Cooperman, Executive Administrative Assistant, noted that "from the beginning, people were amazed that we actually returned calls and that we actually answered questions" (personal communication, February 9, 2005). This perception was supported by a comment from a participant in the most recent self-study workshop, "Meeting the CCNE staff [members] was very beneficial. Their willingness to be ongoing resources was refreshing" (CCNE, 2008e, p. 3). In a similar vein, Director Jennifer Butlin recalled a letter from a dean thanking CCNE for sending an appropriate evaluation team. "That almost brought tears to my eyes because our staff work so hard to find a good fit between the evaluation team members and the type of institution that's being reviewed" (personal communication, February 9, 2005). Numerous other comments on CCNE's responsiveness are found in evaluations of evaluator training and self-study workshops, as well as in the evaluations completed by on-site evaluators and program officials after each on-site evaluation.

Limiting Costs

As noted in chapter 3, CCNE has engaged in a number of initiatives to decrease accreditation costs for its constituent programs, such as efforts to minimize duplication of accreditation activities by incorporating the National Task Force *Criteria for Nurse Practitioner Education* into the revised accreditation standards and conducting joint on-site evaluations with other agencies and organizations. Another measure to limit costs was CCNE's move to a flat-rate, rather than per diem, fee schedule for on-site evaluations.

CCNE staff provided another example of minimizing the cost of accreditation to participating programs—the decision to separate accreditation fees from AACN membership dues. This was a deliberate decision on the part of the Board to prevent financial penalties for schools that are not AACN members, but are accredited by CCNE (J. Butlin, personal communication, February 9, 2005).

Meeting Special Program Needs

A number of programs that did not fit under the initial scope of the organization, to accredit baccalaureate and master's programs in nursing, have requested CCNE review. These requests have come from associate degree programs in nursing, international nursing programs, entry-level doctoral programs, and nurse residency programs. Although CCNE has not been able to accommodate all of these requests, in each instance the decision to reject or accede to the request was based on careful consideration of CCNE's purpose, goals, and values.

One specialized program issue revolved around distance education programs and the extent to which they could demonstrate compliance with CCNE's accreditation standards. In the early years of implementing the accreditation process, questions arose regarding the applicability of the accreditation

standards to distance education programs and whether or not their review was within the purview of on-site evaluation teams. In 1999, the Board appointed a task force to examine the issue of distance education (Board, 1999b). Then in 2002, the Board accepted a *Statement on Distance Education Policies* proposed by the former Alliance for Nursing Accreditation (now the Alliance for APRN Credentialing) (Board, 2002a). In the most recent revision of the CCNE accreditation standards (April, 2008), their applicability to distance education programs is further delineated.

CCNE also has received requests for accreditation review from nursing education programs outside the United States. There was consensus among the members of the Board that CCNE was not ready to undertake accreditation of international programs, and the Board voted not to change the scope of review, but established a task force to explore the issue of international program accreditation. The task force reported to the Board in spring 2003, noting two separate issues related to accreditation of international programs: accreditation of overseas satellite campuses of U.S. educational programs, and accreditation of programs in foreign institutions. The Board determined that satellite campuses of U.S. institutions should be addressed in the same way as satellites within the U.S.—as a component of the overall program being reviewed. The task force recommended that CCNE not undertake accreditation of nursing programs in foreign institutions at that time (Board, 2003a). As noted in chapter 2, CCNE has accredited one program located in another country and has been active in promoting international nursing accreditation efforts. Given the effects of globalization in many aspects of life, it is possible that at some point in the future, CCNE may very well be involved in the accreditation of programs that are wholly independent of U.S. educational institutions. In fact, the need to continue to consider the international aspects of accreditation was one of the issues for the future identified by former Board chair, Jill Derstine in a 2008 interview (personal communication, July 16, 2008).

Another program issue that arose periodically during CCNE's early history was that of doctoral program accreditation. In the initial AACN survey that prompted the creation of CCNE, there were isolated calls to include doctoral programs in the accreditation process (AACN, 1996b). Other respondents indicated that they did not want doctoral programs included in the organization's scope of activity. At the time of CCNE's initiation, the Steering Committee determined that doctoral programs would not be included in CCNE's accreditation activities.

At its March 2000 meeting, in response to requests for accreditation review from pre-licensure doctoral programs, the Board agreed to establish a Task Force on Doctoral Accreditation to explore the issue (Board, 2000a). In its September 2000 report to the Board, the task force recommended that CCNE not accredit research (or academic) doctoral programs, but should gather additional information regarding professional doctorates in nursing. At the same meeting, the Board was informed that AACN had established a task force to differentiate types of doctoral programs in nursing and was recommending that CCNE consider accreditation of pre-licensure doctoral programs on a case-by-case basis. CCNE's Board agreed to explore the feasibility of doing so (Board, 2000b), but it was not until spring 2003 that the Board agreed to include pre-licensure doctoral programs in its scope of accreditation (Board, 2003a). This change necessitated a revision to the standards document. In 2003, the second Standards Committee proposed that CCNE append a clarifying statement to its use of the terms "baccalaureate and graduate nursing programs" indicating that this designation "also applies to entry-level post-baccalaureate degree programs in nursing" (CCNE, 2003e, p. 2).

In October 2006, AACN approved *The Essentials of Doctoral Education for Advanced Nursing Practice*, initiating a move toward advanced practice nursing preparation at the doctoral level via a new degree, the DNP. Many graduate nursing programs began the transition of existing advanced practice master's programs to the DNP level. These and other programs also initiated or began to plan for post-baccalaureate DNP programs for entry into advanced practice. By summer 2008, there were already 79 institutions accepting students into DNP programs with many more in the planning stages (AACN, 2008b). In 2004,

the Board made the decision to develop a process for the accreditation of DNP programs, and the third Standards Committee was later charged, in its scheduled review of the standards and key elements, with examining the standards in light of their applicability to DNP programs (Board, 2006). The committee recommended requiring *The Essentials of Doctoral Education for Advanced Nursing Practice* for all DNP programs seeking accreditation (Standards Committee, 2008). As of this writing, CCNE has already scheduled more than 50 DNP programs for accreditation review from fall 2008 to fall 2010.

Institutions offering DNP programs wanted accreditation as an indicator of program quality and were concerned about the eligibility of their graduates, particularly those completing post-baccalaureate DNP programs, to sit for advanced practice certification examinations. Because of these concerns, they began to ask when CCNE would begin to accredit DNP programs and were clamoring to be visited. In order to address constituents' concerns, the CCNE Board moved with dispatch to finalize the 2008 education standards document with a target date for implementation in all programs reviewed after January 1, 2009. At the same time, the Board encouraged the CCNE staff to begin the process of identifying and training qualified evaluators so that DNP evaluation could progress in a timely fashion. Some DNP programs, however, were already graduating students, and although the certifying bodies were allowing graduates from non-accredited programs to sit for examinations during the transition, the CCNE Board acted to permit four institutions to host evaluations of DNP programs in conjunction with already scheduled baccalaureate and/or master's program visits in the fall of 2008 (Board, 2008b). All programs (baccalaureate, master's, and DNP) in these institutions will be reviewed in accord with the revised accreditation standards, since the prior standards do not address DNP education. Early implementation of the revised standards to accommodate these DNP programs is another example of CCNE's response to its constituent institutions as well as to the students they represent.

Nursing faculty participating in the CCNE workshop on writing self-studies, March 2002, Washington, DC.

Accreditation of nurse residency programs was another issue that surfaced in the first 5 years of CCNE's activities. At the request of the University HealthSystem Consortium (UHC), the Board agreed to develop programs and processes to accredit nurse residency programs (Board, 2003a). This effort was temporarily postponed at the request of the UHC, but a task force was eventually formed to draft standards for nurse residency accreditation. The task force included representatives from both nursing education and practice, particularly those who were familiar with residency programs. The resulting standards were opened to constituents for comments just as the standards for educational program accreditation have been over the years. In April 2008, the CCNE Board approved the Standards of Accreditation for Post-Baccalaureate Nurse Residency Programs and mandated the development of policies and procedures for accreditation to parallel those for accreditation of nursing education programs (Board, 2008b). A call for nomination of potential evaluators for nurse residency programs was issued in spring 2008 (CCNE, 2008b) and the first evaluator training session was held on August 15-16, 2008. At this time, several residency programs have inquired about the accreditation process, and residency program accreditation will begin as soon as the accreditation procedures have been approved by the Board (J. Butlin, personal communication, August 20, 2008).

Perhaps the thorniest request for accreditation was that of the American Association of Community Colleges (AACC) to accredit Associate Degree Nursing (ADN) programs. When approached by the AACC president, AACN Executive Director Geraldine Bednash pointed out that if AACN had attempted to include ADN programs in the scope of the new accrediting body, AACC would have questioned AACN's presumption in evaluating programs with which it had no experience and for which it did not set standards (personal communication, October 23, 2004). Subsequent AACC presidents were not content to let the issue rest and continued to pursue their request. After considerable deliberation, the Board reaffirmed CCNE's scope of activity as accreditation of baccalaureate and graduate programs in nursing in accord with the clear mandate received from the AACN membership.

The AACC continued to press for inclusion of ADN programs in CCNE's accreditation process and mounted a campaign of articles and editorials challenging CCNE's right to exclude ADN programs. Minutes of the CCNE Board's September 2001 meeting note USDE's receipt of third-party comment letters regarding CCNE's petition for recognition as an accrediting body for nursing. CCNE's continued denial of their request to include ADN programs in the accreditation process led the AACC to testify in the USDE National Advisory Committee on Institutional Quality and Integrity (NACIQI) hearings against renewal of CCNE recognition as an accrediting body. Transcripts of the hearing included AACC contentions that CCNE was an "elitist organization" that attempted to devalue associate degree education in nursing, impaired the abilities of ADN graduates to continue their education, and created negative implications for diversity in the profession (USDE, 2001, pp. 83-85). Questioning by members of NACIQI credibly established that ADN graduates are not prohibited from access to the profession nor from opportunities to pursue further education and that establishment of a separate body for accreditation of baccalaureate and higher degree programs did not impair the diversity of the profession. NACIQI subsequently voted unanimously to recommend renewal of CCNE recognition by the Secretary of Education (USDE, 2001, p. 111). At the time of this writing, Florida has given community colleges the right to grant baccalaureate degrees in nursing, and one such baccalaureate program has been awarded CCNE accreditation.

Selected members of the CCNE Task Force for Post-Baccalaureate Nurse Residency Program Accreditation at the 2008 training program for residency evaluators (left to right) Sharon Barton, Cathleen Krsek, Cynthia Richardson, Kathy McGuinn, Jennifer Butlin, and task force chair Mary Ann McGinley.

Treatment of new programs that had not yet graduated their first classes of students was another special program issue that demanded CCNE's attention. Standard IV, which deals with program effectiveness, asks programs and on-site evaluators to assess program outcomes based on specific kinds of data (e.g., NCLEX-RN® results, certification examination pass rates, etc.). Early in the process of implementing the accreditation standards, many on-site evaluators were judging new programs to be non-compliant with regard to the relevant key element (IV-B in the 1998 Standards document) because these programs could not yet demonstrate effective outcomes. Both the Report Review Committee (RRC) and the Accreditation

Review Committee (ARC) identified these issues and requested clarification from the Board. In response, the Board ruled that in the absence of outcomes to date, compliance with this key element should be judged on the adequacy of a new program's plans for program evaluation, anticipating demonstration of expected and actual outcomes in subsequent Continuous Improvement Progress Reports. In the 2008 standards revision, this ruling was incorporated into the supporting documentation section for Standard IV to further clarify the issue for both education programs and evaluators (CCNE, 2008h).

Evidence for the effectiveness of CCNE's response to its educational program constituents is seen in the comments of three of its Board chairs. Harriet R. Feldman, Board chair at the time of this writing, described CCNE's second 5 years of operation as a time of "tremendous growth in both numbers and types of programs" (personal communication, July 16, 2008). Despite this level of growth, however, Mary Margaret Mooney, former Board chair, indicated that this period was "a time of relatively calm waters," during which program constituents became more relaxed and less anxious about the new accreditation process (personal communication, July 16, 2008). Jill Derstine, another Board chair during CCNE's second 5 years, summed up this response by constituents by noting that "CCNE was talked about" and the favorable nature of that word-of-mouth conversation led many other schools to become part of its official community of interest (personal communication, July 16, 2008).

Students

Enrolled and prospective nursing students are another significant element of CCNE's community of interest, and CCNE has made concerted efforts to solicit input from students regarding its processes and procedures. For example, representatives from the National Student Nurses Association (NSNA) participated in the development of CCNE's initial accreditation processes and standards (USDE, 1999). The Board met annually with representatives of the NSNA. For example, in discussions with Erin Beesley, NSNA vice-president, at the Board's September 2001 meeting, members explored strategies for involving students in program governance. Consensus was reached that participation in governance includes more than student participation on committees (Board, 2001). NSNA officers have periodically provided input to CCNE through conference calls scheduled during Board meetings. Finally, the welfare of students was an important consideration in the decisions to grant retroactive accreditation to a small number of programs and to make early DNP program accreditation visits discussed earlier.

Nursing Profession and Employers

As an accrediting body for professional nursing programs, CCNE must particularly address the needs of the nursing profession and employers of nursing graduates. In part this need was met through the inclusion of practicing nurses in on-site evaluation teams. Incorporation of nurses whose primary employment was in practice settings on evaluation teams was one of the issues of concern for USDE staff in their initial review of CCNE's petition for recognition (CCNE, 1999b). As a result, the Board appointed a Task Force on Ensuring Involvement of Practicing Nurses to address this issue (Board, 1999b). The task force redefined a practicing nurse as "someone who practices nursing as his or her primary role" in keeping with Department parameters.

The CCNE response to the USDE (1999b) also included a statement from the CCNE Web site, that the "composition of a comprehensive evaluation team includes trained CCNE evaluators appointed in accordance with the type and specialty orientation of the program. All evaluation teams must consist of one or more educators and one or more practicing nurses." At its March 2000 meeting, the Board officially approved the report of the task force and reviewed a call for nominations of practicing nurse evaluators (Board, 2000a). As a result, CCNE's first evaluator training session to incorporate practicing nurses was held in April 2000, and practicing nurse evaluators have been included in each

subsequent evaluator training. The advent of DNP programs has led to emphasis on recruiting and training evaluators with a DNP background (Board, 2007c).

Incorporation of a practice perspective in the revision of the accreditation standards was accomplished by including a practicing nurse on the second Standards Committee (Board, 2001). This practice perspective was particularly important in CCNE's decision to require graduate programs educating nurse practitioners to use the National Task Force *Criteria for Evaluation of Nurse Practitioner Programs*. Similarly, the practice representative on the third Standards Committee was herself a practicing DNP (Board, 2007a), bringing this new practice perspective to the discussion of revisions to the standards.

Other Organizations

CCNE also considers a number of other organizations and agencies to be part of its external community of interest. Among these are the representatives of other accrediting bodies, particularly those involved in the Alliance for APRN Credentialing (formerly the Alliance for Nursing Accreditation) of which CCNE is a founding member, national nursing organizations, state regulatory bodies, and the USDE. All of these groups were informed of the initial development of CCNE as an accrediting body for baccalaureate and higher degree programs. Others have been involved in the discussion of specific issues faced by the organization.

In an effort to meet the needs of the educational programs it accredits, CCNE also has participated in a variety of joint evaluations with state regulatory bodies and other review and accrediting agencies. More than 60 joint on-site evaluations were conducted in the organization's first 10 years with 20 state boards of nursing (or other statewide approval entities), as well as several regional and specialized accrediting agencies. In fact, the ability to work collaboratively with other agencies for assessment "without interfering with each other's goals" has been identified by constituents as one of CCNE's unique strengths (CCNE, 2004b, p. 13).

Since its initiation, CCNE has been involved in a number of activities involving other organizations within and outside of the profession. For example, CCNE provided testimony about approaches to incorporating diversity in professional education. Similarly, CCNE requested, and was granted, representation on the AACN task force that drafted *The Essentials of Doctoral Education for Advanced Nursing Practice* (AACN, 2006), and members of the CCNE Board and committees reviewed and provided input into the document. CCNE was also actively involved in developing the proposed revisions to *The Essentials of Baccalaureate Education for Professional Nursing Practice*. Another example of CCNE involvement with other professional organizations lies in the development of the Regulatory Model of Advanced Practice Registered Nursing.

CCNE has also been involved in international activities with other professional organizations. For example, CCNE staff and Board members have provided consultation regarding accreditation activities to professional organizations in Taiwan and South Korea. In addition, in November 2004, in Toronto, CCNE entered into a Mutual Recognition Agreement on Accreditation with the Canadian Association of Schools of Nursing (CASN). CASN's Board of Accreditation is CCNE's Canadian counterpart. The intent of the agreement is to recognize the credibility of the accreditation process as implemented by both organizations, to facilitate transfer of educational credit and credentials across borders, and to engage in mutual dialogue regarding accreditation issues (CASN & CCNE, 2004). The agreement is currently under review for continuation by both organizations (J. Butlin, personal communication, July 24, 2008).

Internal Community of Interest

CCNE has been committed to meeting the needs of its internal community of interest. This internal community includes its on-site evaluators and team leaders and its committee members.

Evaluators and Team Leaders

Responses to AACN's initial survey of accreditation issues highlighted the need for training and consistency among on-site evaluators. Respondents also voiced the need for evaluators to receive periodic updates on accreditation policies and procedures (AACN, 1996b). In response to the need for training, CCNE embarked on a comprehensive training program for on-site evaluators. Initial training sessions were held in 1998 prior to the implementation of the first on-site evaluations, and the first training program to incorporate practicing nurse evaluators was held in 2000. In order to meet the growing need for trained evaluators, CCNE has held subsequent training programs periodically throughout its 10-year history. CCNE has also modified the training provided to evaluators based on evaluator input and recommendations from the ARC (ARC, 1999).

CCNE has taken to heart requests that evaluators, as well as CCNE's Board and committees, be representative of the kinds of programs being evaluated. CCNE has made a concerted effort to ensure diversity in its Board and committees and to assign on-site evaluators from programs similar to those being evaluated.

In addition, CCNE works to ensure that evaluators remain up-to-date regarding changes in policies and procedures through periodic e-mail messages from CCNE staff. Moreover, the need for retraining of evaluators on the 2003 revisions to the accreditation standards figured importantly into the timeline for their implementation and led to the scheduling of CCNE's first Web-based training session in September 2004. Minutes of the second Standards Committee referred frequently to the need to ensure that evaluators were conversant with the requirements of both the Baccalaureate and Master's *Essentials* and the National Task Force *Criteria for Evaluation of Nurse Practitioner Programs* (Standards Committee, 2003b, c). A similar teleweb retraining for all current evaluators will be held in late 2008 to acquaint evaluators with changes in the standards approved by the Board in April of that year.

Evaluators were not the only ones to need training. Inconsistency in applying the accreditation standards and in the quality of on-site evaluation team reports led the ARC to recommend team leader training workshops. The first of these workshops was held in October 2002 with a panel of experienced team leaders, as well as members of the staff and the ARC.

On-site evaluators themselves have not been shy in making their needs known to CCNE and through the CCNE's early years have requested a variety of modifications in processes and procedures to make their work more effective. As early as 1998, routine evaluations of the accreditation process by on-site evaluators indicated needs for feedback to evaluation teams. In fact, evaluators requested feedback from both program officials and CCNE regarding the conduct of their evaluations as well as information about the final outcome of the accreditation process (CCNE, 1998c). In addition, evaluators requested specific feedback on "how well our report met the expectations of CCNE and if there are areas to be strengthened in any future written reports" (p. 30).

The ARC, in its winter 2000 meeting, recommended development of a systematic approach to providing written feedback to on-site evaluation teams on the quality of their reports (ARC, 2000a). The ARC drafted an evaluation instrument at its summer 2000 meeting (ARC, 2000b) that was approved by the Board that September (Board, 2000b). At each subsequent ARC meeting, the quality of the on-site evaluators' reports has been evaluated by the members of the committee and specific feedback and suggestions for improvements, if needed, communicated to members of the team.

Committees

Committee Composition

CCNE's committee members constitute part of its internal community of interest; however, the composition of the committees is specifically planned to address the diversity of its external community of interest. For example, the Steering Committee determined that the composition of the Board should include faculty, deans, practitioners of nursing, consumers of health care (employers of graduates), and public members to represent CCNE's broad constituency (Steering Committee, 1997b). Similarly, the RRC, ARC, and Standards Committees included gender, ethnic, and geographic diversity as well as representation from deans, faculty, consumers, and employers.

CCNE Board chair Jill Derstine and CCNE Director Jennifer Butlin with Korean nursing deans, faculty, and Korean Accreditation Board of Nursing representatives, November 2007, Seoul, South Korea.

As an organization, CCNE sometimes struggled to maintain diverse representation on its committees. For example, early minutes of the RRC detailed an extensive discussion of a member's eligibility to continue serving after a change of employment and constituency represented (RRC, 2001). Similar discussions occurred at the ARC and Board levels. In each case, adjustments were made to maintain the representative diversity of the committees and the Board.

The initiation of accreditation of nurse residency programs led to the creation of a Residency Accreditation Committee (RAC). The composition of this committee particularly reflects its constituents, with representation from nursing education and practice settings that are involved in nurse residency programs. In addition, experience with a CCNE-affiliated residency program has been identified as a desirable attribute in one of the professional consumer members of the Board.

Committee Operations

CCNE has routinely responded to requests from its internal committees that would improve their effectiveness. For example, both the Board and the ARC requested that reviewer worksheets be made available electronically to facilitate program reviews (Board, 2000b). In 2002, the ARC pilot tested electronic review of on-site evaluation team reports. Later that year, committee members requested the ability to access all reports, as well as committee worksheets and report rating forms, online.

CCNE has also employed technology to meet the needs of other communities of interest. For example, CCNE developed a Web-based survey to streamline assessments by program officials and evaluators following the on-site evaluations and to protect confidentiality of evaluative comments (Board, 1999a).

The phenomenal growth in the number of nursing education programs affiliated with CCNE has necessitated changes in committee structure and modes of operation. For example, early meetings of the RRC were conducted by telephone conference call because of the small numbers of reviews to be done. Similarly, the increase in the number of accreditation visits conducted each semester and the inclusion of DNP programs in the accreditation process led the ARC to request creation of a third panel within the committee with additional members appointed to the committee. At its spring 2008

meeting, the ARC also recommended to the Board that members who were scheduled to rotate off of the committee be retained on an ad hoc basis to assist the committee to deal with the influx of DNP evaluations without the need to train a large cadre of new committee members (Board, 2008a). This proposal was accepted, and four members scheduled to rotate off the ARC were invited to extend their terms of service for an additional year. The fact that all four members agreed to an extension of their appointments is an indication of the level of ongoing commitment by CCNE's volunteer personnel. At its summer 2008 meeting, the ARC discussed the procedural changes required to accommodate a third panel and to streamline the work of the committee to promote its continued effectiveness (ARC, 2008).

CCNE has made significant efforts to address the interests of its many and varied constituencies. CCNE's ongoing commitment to meeting the needs of its internal and external communities of interest is best captured in the opening message of CCNE's 2001 annual report. As Board chair Lynda Davidson and Director Jennifer Butlin observed, "Perhaps CCNE's most fundamental year-round activity is also the most crucial—we listen...Such regular listening is at the center of CCNE's efforts to continually adapt to better meet the needs of CCNE's constituents" (CCNE, 2001a, p. 5).

Signers of the CASN/CCNE Mutual Recognition Agreement (standing left to right) CCNE Director Jennifer Butlin, CASN President Ellen Rukholm, and CASN Executive Director Wendy McBride (seated left to right) CCNE Board chair Mary Margaret Mooney and CASN Board chair Manon Lemonde.

CCNE's success in engaging its communities of interest in developing the standards and accreditation processes is reflected in responses to a survey of the Commission's constituents in preparation for writing this history. The tenor of those responses is captured in the following examples:

Members of the CCNE Board of Commissioners and CASN Accreditation Bureau during a joint meeting, April 2006, Toronto.

> CCNE "is highly participatory, encouraging the communities of interest to contribute to its development and ongoing improvement" (CCNE, 2004b, p. 1).

> "The evaluation process allows each school to 'tell their story' and identify ways in which they meet the accreditation standards" (p. 2).

> "CCNE adheres to a set of values that are supportive of nursing education being a collegial environment, while upholding a core of meaningful standards. Programs have the autonomy they need to meet the needs of their community of interest" (p. 2).

Within the nursing community, there is every expectation that CCNE will continue this responsive stance to its community of interest through its next 10 years and beyond.

Chapter 5

Celebrating the Achievements

Charlotte F. Beason and Susan L. Woods

In its brief 10-year history, the Commission on Collegiate Nursing Education (CCNE) has attained achievements reflective of much more mature organizations. One can speculate about the cause of this success—was it because the organization was created to meet defined needs in nursing accreditation, or because of its value-based orientation, or because of its strong commitment to inclusivity? Was it the unique mix of dedicated Commissioners, volunteers, and staff? Whatever the reasons, significant support for CCNE's work has been a constant from the earliest days of the organization. This recognition from professional nursing organizations, employers of professional nurses, governmental agencies, and regulators, as well as other accrediting groups has resulted in CCNE's ability to implement actions rapidly and accomplish goals that have generated accreditation excellence.

Implementation of Accrediting Procedures

In 1997, CCNE began accrediting baccalaureate and graduate programs in nursing by conducting reviews of programs that applied for CCNE preliminary approval. This review by the four members of the CCNE Preliminary Review Panel resulted in the approval of 317 of 322 applications (Board, 1998a). This large, rapid response demonstrated nursing programs' commitment to participate in the new accrediting process.

Preliminary approval was not a prerequisite for accreditation, nor was it a status of accreditation by CCNE. Programs with preliminary-approval status were expected to make progress toward accreditation by CCNE; however, preliminary approval did not automatically ensure eventual accreditation. If a preliminary approved program were granted accreditation by CCNE, then the accreditation status replaced the preliminary approval for that program. In June 2003, there were still 128 nursing programs located in 82 institutions with preliminary approval status by CCNE. The last programs to hold preliminary approval status were awarded accreditation in October 2006 (Board, 2006). This extended time frame for preliminary approval was based on the length of time of a program's previous accreditation.

Members of the 2003 CCNE Board of Commissioners (first row) Susan Woods, Lynn Babington, Jill Derstine, Renee Holleran, Charlotte Beason (second row) Mary Margaret Mooney, Susan Fontana, Caroline Stellmann, Donald Mattison (third row) Anne Wojner, Marsha Lewis, Harriet Feldman, and E. Jane Martin.

Autonomy

Since 1998, CCNE has been an autonomous arm of AACN and is autonomous in all aspects of its accreditation activities (AACN, 1998a; CCNE & AACN, 2002). Autonomy is a requirement of the U.S. Department of Education (USDE) and is

necessary to demonstrate that there is a separation between the parent organization and the accrediting agency. This independence ensures that there is no undue influence by another organization related to accrediting activities. CCNE manages its own finances and establishes and reviews its own standards, bylaws, operating policies, and procedures. CCNE selects and trains its members, officers, committee members, evaluators, and consultants. Although, CCNE shares its premises and administrative personnel with AACN, costs are allocated between the two organizations and are based on actual expenditures or a percentage of salary.

As a nationally recognized agency, CCNE's goal is to foster continuing improvement in baccalaureate and graduate nursing programs, and thereby, in professional practice. The 13-member elected Board, which governs CCNE, represents the agency's community of interest: three faculty representatives, three chief nurse administrators of nursing programs, three professional nurses, two professional consumers, and two public consumers (CCNE, 2000a). The chair of the Board appoints and the Board confirms members of all committees except the Nominating Committee, which is elected by CCNE-affiliated programs.

Achievements of the Accreditation Review Committee

The Accreditation Review Committee (ARC) is a standing committee of CCNE and serves as the primary review body for programs seeking initial or continuing accreditation by CCNE. Work was initially completed by two panels, with frequent reporting within the whole committee during plenary sessions to ensure internal consistency and consensus of recommendations. Inter-rater reliability is checked at intervals by having both panels complete independent reviews of the same program. As noted earlier, the ARC requested an expansion to three panels to encompass the greater workload with the initiation of DNP accreditation. The achievements of the ARC mirror the values of CCNE. In particular, the committee fosters ongoing quality improvement by making procedural recommendations to the Board. For example, the committee created, used, and evaluated a form to rate the quality of team reports. These evaluations are given to on-site evaluation team members in the spirit of support for ongoing improvement. In addition, the committee has consistently suggested items to be included in evaluator training and made the initial recommendation for specific training for team leaders.

Achievements of the Report Review Committee

The mission of CCNE is advanced by its Report Review Committee (RRC), a standing committee of the Board charged with monitoring the performance of accredited programs. Once accredited, programs are required to report to CCNE halfway through the accreditation period to demonstrate that they are sustaining program quality. Evaluating these reports is the primary charge of the RRC. The RRC also reviews other reports, such as Special Reports prepared at CCNE direction to address areas of concern. The RRC began its first reviews of interim reports, called Continuous Improvement Progress Reports (CIPRs), in 2001. As increasing numbers of nursing programs achieved accreditation with CCNE, the volume of CIPRs increased dramatically. By 2007, the RRC had grown from its original seven members to eleven members, and by 2008, the RRC had examined more than 500 reports. Seeking to improve the accuracy and efficiency of its own process, the RRC developed a template for programs in 2006 to assist in focusing on the most essential evidence of program quality.

Members of the 2004 CCNE Report Review Committee (left to right) Nancy Sypert, Martha Lavender, and Donald Mattison.

The CIPR encourages introspection and honest appraisal by programs of their educational practices and outcomes and helps ensure that programs maintain a focus on the accreditation standards beyond the initial period of application for accreditation. As Jane Voglewede, chair of the RRC in 2008, observed, "Accreditation is not an isolated event. It is a process. The RRC takes the baton from the ARC and the Board and helps programs make a conscious effort to stay strong and move forward" (personal communication, August 20, 2008).

United States Department of Education Recognition

In March 2000, Secretary of Education Richard Riley communicated his decision to recognize CCNE for a 2-year term as a nationally recognized accrediting agency for baccalaureate and graduate-level nursing education. This term was the maximum that could be granted to an agency seeking initial recognition.

This milestone decision did not occur without attention to quality by CCNE, challenges to CCNE's scope of accreditation, assertions that a new accreditation body within nursing education was unnecessary or discriminatory, or meticulous review by the USDE, whose staff attended both Board and ARC meetings and observed on-site evaluations.

In the summer of 2002, Secretary of Education Rod Paige officially granted continued recognition of CCNE as a national agency for the accreditation of baccalaureate and graduate degree nursing education programs. Of 11 agencies reviewed by USDE, CCNE was the only one reviewed for continued recognition that received no citations or stipulations; recognition was continued for the maximum period of 5 years. The Secretary's action reinforced the significant reform in health professions accreditation initiated by CCNE. Creation of CCNE charted a new course, with a new model, that took assessment of nursing education to a uniquely new standard (CCNE, 2002a).

Council for Higher Education Accreditation Recognition

CCNE has been awarded recognition by the Council for Higher Education Accreditation (CHEA) for a maximum period of 10 years. Founded in 1996, CHEA offers formal, non-governmental recognition of higher education accrediting bodies. Membership in CHEA is considered an indication of accreditation quality. In a November 2001 review before CHEA's Committee on Recognition, during the course of the public comment period, CCNE was again challenged for its limited accreditation scope. However, the committee concluded its discussions by recommending CCNE's recognition and on January 21, 2002, the CHEA Board of Directors accepted that recommendation; CCNE was recognized with no citations or stipulations (J. Eaton, personal communication, January 21, 2002). CHEA President Judith Eaton offered these perspectives,

> As a new accrediting organization created in 1996, CCNE has had a rare and valuable challenge: the freedom to apply the best of current thinking about the role of self-regulation through accreditation to baccalaureate and master's nursing education. CCNE has responded to this challenge, with standards and practices that reflect careful and creative attention to accreditation and its service to higher education, students and the public. (personal communication June 23, 2005)

Evaluator Training

All of CCNE's on-site evaluation teams consist of both educators and practicing nurses who are selected according to their academic, administrative, and practice expertise in light of the type and specialty orientation of the program being reviewed. Ensuring a comprehensive review, teams validate the findings presented in the nursing program's self-study document, assess compliance with CCNE's standards, and gain insight into the program's self-improvement efforts (CCNE, 2003a).

Consistent with its values and commitment to continuous quality improvement, CCNE conducts training programs to ensure that on-site evaluators are fully knowledgeable of CCNE's policies and practices. Material is presented in a manner that fosters collegial relationships and highlights the method by which CCNE holds its own internal processes accountable to the same values and standards for continued quality improvement. Consistent with quality improvement, much of the training content is based on suggestions or modifications that come from evaluator feedback and comments from the ARC or RRC, as well as actions taken by the Board (CCNE, 2003a).

Evaluator training is a selective process. CCNE has received several thousand nominations for individuals to serve as volunteer evaluators, and has trained more than 800 educators and practicing nurses for this purpose. The value of this training has been captured in the evaluations of participants and in the survey comments of evaluators following completion of their on-site work. The program was described as "inclusive and informative" by a participant representing practice at the most recent training (CCNE, 2008d, p. 2). As noted earlier, retraining of evaluators occurs whenever issues are noted or on a regular basis when the standards document is revised.

Practicing Nurse On-site Evaluators

Since CCNE's inception in 1998, practicing nurses have been considered members of the CCNE community of interest and they, along with public consumers, employers, faculty, and deans, are represented on the Board and appointed committees. Although CCNE documented that numerous evaluators who represented academe were also practicing nurses, those who practiced as their primary professional role were not members of the first on-site evaluation teams.

CCNE's inclusion of nurses whose primary professional role is practice on evaluation teams was prompted by the Secretary of Education's *Criteria for Recognition of Accrediting Agencies*. The USDE requires an agency to have both educators and practitioners on its evaluation, policy, and decision-making bodies if it accredits programs or single-purpose institutions that prepare students for a specific profession (USDE, 2004). When the agency communicated this requirement to CCNE, the organization moved decisively to comply with the Secretary's *Criteria*, directing that all on-site evaluation teams contain at least one practicing nurse, defined as a nurse who "regularly engages, as his or her primary professional role, in the provision of nursing care to individuals, families, groups, or communities" (CCNE, 2001b, p. 8). Practicing nurses who serve as on-site evaluators are master's or doctorally prepared and have, "knowledge about nursing in general and depth of knowledge in at least one area of nursing practice" (p. 8).

The first group of practicing nurses participated in evaluator training activities in April 2000. Because evaluation teams were already in place for the spring 2000 review cycle, practicing nurses were observers on the already constituted teams. Since fall 2000, practicing nurses have been appointed to all CCNE on-site evaluation teams.

Practicing nurse on-site evaluators reflect a wide range of roles including staff nurses, nurse managers, nurse executives, nurse practitioners, clinical nurse specialists, and quality management nurses. Anecdotal comments from post-evaluation surveys, training evaluations, and other informal surveys indicate that practicing nurses, team leaders, and nursing programs hosting CCNE evaluation teams find the inclusion of practicing nurses on evaluation teams to be an asset (Beason, 2005). As expressed by one on-site evaluator, an accreditation visit is "a wonderful opportunity to bring together people in practice and academia so that we continue to value the role that each plays in supporting the nursing profession" (CCNE, 2008c, p. 22).

CCNE trainer Betty Johnson presenting at the annual workshop on writing self-studies.

Team Leader Training

As on-site evaluations continued, Board members, staff and committees regularly tracked issues and comments that could strengthen the review process. One such set of observations centered on the need for additional team leaders, team leader skill development, and the need to provide training for highly qualified on-site evaluators to move into team leader roles. These discussions of the importance of maintaining a highly skilled and diverse roster of team leaders for on-site evaluations led to CCNE's first invitational Team Leader Training Program in October 2002. Seventy-one evaluators attended the training program, which was held in conjunction with AACN's fall meeting. Content included structuring on-site evaluation schedules for an effective outcome, making team assignments, interacting with the host program before and during an on-site evaluation, and writing the evaluation report.

Constituent Forums and Workshops

CCNE has conducted a number of forums in connection with AACN conferences to provide current information and updates on processes and procedures. Early in CCNE's life, these forums provided the opportunity to answer questions about the newly implemented accreditation process, constituent expectations, fee-structures, and application procedures. In addition, participants could learn about progress toward USDE recognition and the recognition process. These forums were an important way to obtain feedback from members of the community of interest that could help in shaping the organization. Moreover, CCNE also used these forums as well as printed announcements to solicit volunteers for committees and evaluator training.

Based on input from constituents, evaluators, and ARC members, CCNE staff also implemented annual workshops on writing self-studies. Limited to programs that would submit a self-study during an upcoming review cycle, the workshops were an immediate and fully subscribed success, even though they were not mandated by CCNE. Board members, experienced team leaders, and staff served as instructors and covered topics ranging from clarification of the CCNE standards and evidence that might document meeting the standards to the mechanics of hosting an on-site evaluation. Surveys of workshop attendees over the years consistently indicated the activity is helpful and meaningful, while ARC and Board members noted a positive change in the clarity and content of self-studies. Like the forums, the workshops provided excellent feedback for improving CCNE activities and procedures. New client-focused processes for arranging and paying for on-site evaluations, submission of electronic self-studies, and the requirement of a single annual data form shared by both AACN and CCNE are examples of modifications resulting from constituent feedback.

Support and Recognition

Both the Steering Committee and Board recognized the need to support and recognize members of the community of interest as critical to CCNE's success. As CCNE was being implemented, the Steering Committee, AACN, and, later, CCNE, were in contact with academic, professional, and regulatory entities that were vested in the education and credentialing of nurses. Through nationwide press releases, regional hearings, national mailings, and individual briefings, efforts were made to describe

the formation of the new CCNE accrediting entity, emphasizing its intent to "bring uniformity and a more streamlined and coordinated approach to accrediting baccalaureate and graduate nursing programs" (AACN, 1997a). These communications answered concerns and questions that arose, and also solicited support for CCNE activities.

The Federal Nursing Services represented one sector with a key investment in the accreditation of nursing programs. All branches of the uniformed nursing services, as well as the Department of Veterans Affairs (VA) and U.S. Public Health Service, require graduation from an accredited nursing program for employment. In addition, scholarships, Reserve Officers' Training Corps (ROTC) programs, VA employee tuition assistance, and VA funded student programs were contingent on nursing programs' accreditation status. CCNE Board chair Linda Amos and/or AACN Executive Director Geraldine Bednash met with each of the Federal Nursing Chiefs and their staffs to detail the goals of the Steering Committee and the emerging CCNE organization, as well as the process by which the organization would attain recognition by the USDE. Each of the federal services agreed to accept CCNE accreditation when the organization became recognized by USDE and to change any restrictive language appearing in their regulations (J. Engel, personal communication, November 14, 1997; C. Mazzella, personal communication, December 24, 1997). In addition, VA officials agreed to fund programs with preliminary review or accredited by CCNE and their students enrolled in programs while the organization was in the process of attaining USDE recognition (F. Kennedy, personal communication, May 15, 2001).

Enthusiastic support for CCNE was also communicated in unsolicited letters received from deans and directors of baccalaureate and graduate nursing programs that had been reviewed by CCNE on-site evaluation teams. The letters described the teams as professional, knowledgeable and well organized. All indicated that their reviews had been positive experiences (CCNE, n.d.). Moreover, the support of individual state boards of nursing was notably demonstrated as several boards moved to conduct joint on-site evaluations with CCNE, accept CCNE self-studies in partial or complete fulfillment of state documentation requirements, or otherwise consider programs' CCNE accreditation status in the state approval process.

Acceptance by Nursing Programs and CCNE's Community of Interest

By June 2003, approximately 63% of baccalaureate degree nursing programs and 77% of master's degree nursing programs in the United States had affiliated with CCNE. The Board had accredited 485 baccalaureate and master's degree nursing programs located at 306 institutions. Another 128 nursing programs at 82 institutions held preliminary approval status and were scheduled for accreditation review by CCNE. In addition, 76 nursing programs at 49 institutions held new applicant status. Widespread acceptance of CCNE continues. By June 2008, the percentage of baccalaureate and master's degree programs affiliating with CCNE had increased to 75% and 83%, respectively. This included 837 accredited baccalaureate and master's degree nursing programs located at 511 institutions, and an additional 53 nursing programs at 42 institutions holding new applicant status (J. Butlin, personal communication, September 3, 2008).

CCNE's acknowledged expertise and leadership in quality-based accreditation also is evident by the increasing requests for Board member and staff member participation in policy and professional groups. When the American Nurses Credentialing Center (ANCC) and the Commission on Accreditation for nurse anesthesia moved to create a quality-focused review committee as the mid-level step in their accreditation of continuing nursing education, both organizations included a representative of CCNE because of the success of its review process. Similarly, when the Institute of Medicine examined the use of accreditation standards to promote diversity in health professions education, CCNE's views were sought.

CCNE staff members have actively participated in the higher education, nursing, and accreditation communities. As examples, Jennifer Butlin represented specialized accreditors at the Accreditation Roundtable of the Secretary of Education's Commission on the Future of Higher Education and presented at a National Advisory Council on Nurse Education and Practice meeting of the Department of Health and Human Services Health Resources and Services Administration. She also presented on issues and trends in higher education accreditation at the national conferences of the University Continuing Education Association and the Hispanic Association of Colleges and Universities. Margaret Jackman participated in a multi-year Greater Expectations Project on Accreditation and Assessment and presented at workshops of the Association of American Colleges and Universities and the Association of General and Liberal Studies to promote integration of the liberal studies in professional programs.

With respect to nursing and the health professions, Jennifer Butlin contributed to a study commissioned by the W.K. Kellogg Foundation's Sullivan Alliance on Diversity in the Health Professions and also has assumed leadership roles in the Alliance for Nursing Accreditation. Periodically, she has presented at meetings of the AACN, ANCC, the Association of Academic Health Centers, the National Council of State Boards of Nursing, and the National Organization of Nurse Practitioner Faculties.

In the accreditation and recognition arenas, staff members regularly attend meetings of the USDE National Advisory Committee on Institutional Quality and Integrity, which advises the Secretary of Education on issues pertaining to the recognition of accrediting agencies. Jennifer Butlin has chaired the External Recognition Issues Committee of the Association of Specialized and Professional Accreditors (ASPA), and has presented at meetings of ASPA and CHEA.

Finally, in the international arena, both Jennifer Butlin and Margaret Jackman have showcased CCNE's accreditation program to officials from quality assurance organizations and ministries of education and health in other countries interested in establishing accreditation or other assessment mechanisms. In addition, Jennifer Butlin has presented at conferences in Canada, Chile, South Korea, and Singapore. Margaret Jackman has presented at the International Accreditation Conference of the Pan American Health Organization in Canada and at the XVII Congreso Nacional de Enfermeria (National Nurses Congress) in Columbia.

This widespread recognition by accrediting and other organizations demonstrates that CCNE has emerged as a national influence in shaping both health care and education policy. With its involvement in public forums and collaborations with other organizations CCNE models its commitment to quality education and social responsibility.

Association of Specialized and Professional Accreditors Membership

CCNE was accepted as a member of ASPA in 1999. ASPA promotes a Code of Good Practice for Accrediting Bodies, which CCNE adopted in 1998 (Board, 1998b). ASPA is the only voice that solely represents specialized accreditors and works with both government agencies and higher education officials to promote excellence in accreditation practices and education (ASPA, n.d.). CCNE has participated in ASPA in several ways. ASPA Executive Director Cynthia Davenport commented:

> …I have had the pleasure of watching a new organization be designed, developed and grow to become a fully functioning and well-respected member of the accreditation community. CCNE is to be commended for this achievement. (personal communication, June 29, 2005)

Alliance for APRN Credentialing

As a founding member of the Alliance for Nursing Accreditation (now the Alliance for APRN Credentialing) in November 1997, CCNE has worked closely with other regulatory and credentialing bodies to promote and improve collegiate and specialized accreditation for nursing, bring better efficiencies to the accreditation process, and address issues of mutual concern. Under the leadership

of AACN, the impetus for creating the Alliance came from member concerns that the accreditation of multiple specialties was costly and duplicative. As a special benefit, the Alliance allows the development of common processes, common data sets, and commonly accepted standards and norms. An alliance model is also consistent with the values of CCNE and the goals of CHEA (Alliance, 1997). Based on a decision to focus on the credentialing of advanced practice nurses, this group changed its name in 2006 to the Alliance for APRN Credentialing (Alliance, 2006).

Since the Alliance's beginning, members have successfully addressed mutual concerns resulting in CCNE joint accreditation reviews with state boards of nursing and the American Association of Nurse Anesthetists/Council on Accreditation of Nurse Anesthesia Education Programs. Through a formal agreement with AACN, CCNE can access selected data elements from AACN's well-established annual survey for routine monitoring of program compliance with the CCNE standards. Further, Alliance members have written and CCNE has endorsed a common Statement on Distance Education Policies that reiterated the belief that distance learning programs should be held accountable to the same standards as traditional programs (Appendix I).

CCNE worked closely with the Consortium for Quality Nurse Practitioner Education, which evolved from the Alliance and engaged in extensive discussions regarding implementation of the *Criteria for Evaluation of Nursing Practitioner Programs*, developed by the National Task Force on Quality Nurse Practitioner Education in 1997 (later revised in 2002 and 2008). The Consortium was comprised of representatives of nurse practitioner certification and education organizations. The group released the White Paper of the Consortium for Quality Nurse Practitioner Education in September 2000, which formally recommended that CCNE and the National League for Nursing Accreditation Commission (NLNAC) integrate evaluation of specific nurse practitioner educational programs into their respective accreditation processes. To determine the extent to which this integration was being accomplished, representatives of the Consortium were invited to observe on-site evaluations conducted by CCNE and NLNAC in spring 2001. Through its collaborations with the Consortium, CCNE provided assurances that all evaluation teams assigned to review master's programs with nurse practitioner tracks included at least one nurse practitioner. In 2002, the CCNE Board approved the inclusion of the task force criteria into the revised 2003 CCNE Standards, which were implemented in January 2005. The recently revised task force criteria (NTF, 2008) were included as a requirement in the revised 2008 CCNE standards (CCNE, 2008h, p. 6).

Alliance meetings offer a forum for updates, frank discussions, and mutual problem solving. Meetings have focused on issues surrounding USDE recognition policies, domestic and international credentialing, registered nurse licensure, and clinical nurse specialist education. The group also has discussed efforts by the NCSBN to develop uniform criteria for recognizing APRNs and interstate practice authority for APRNs (CCNE, 2003a; Alliance, 2000, 2002, 2003). Recently, at the urging of members of the Alliance, CCNE agreed to initiate discussion of a process for pre-approval of new advanced practice programs at the master's and doctoral (DNP) level. At its April 4, 2008 meeting, the Executive Committee of the CCNE Board held opening dialogues with representatives of several certifying bodies for advanced practice nursing to discuss the pre-approval process (Executive Committee, 2008b).

Achievements of Volunteers

Peer review is the hallmark of voluntary accreditation (Butlin, 2005). From CCNE's inception, volunteers have played pivotal roles in the organization and continue to be critical to its success. Without the countless unpaid hours of volunteer work from nursing faculty and practicing nurses and the support of their employers, accreditation would not be possible.

One noteworthy supporter of CCNE volunteers was the Department of Veterans Affairs (VA) Veterans Health Administration, an organization that provided key support to CCNE's recruitment

of practicing nurses as on-site evaluators. To help with CCNE's efforts, the VA broadcast information about CCNE activities and the need for practicing nurse volunteers to its over 160 facilities nationwide. In addition, these communications noted that both CCNE and VA medical centers would experience positive gains from nurses participating in accreditation activities and encouraged nurse executives to support CCNE's work by granting administrative leave to nurses taking part in the process. As a result, an early influx of well-qualified VA nurses added considerable numbers to CCNE's practicing nurse evaluator pool.

Faculty and practitioners have been eager, excited, and willing to participate in all CCNE processes. These professionals give their time and talent to serve on CCNE committees, perform reviews, conduct on-site evaluations, write reports, and respond to critique of their materials. In addition, they have participated in evaluator training, team leader training, and retraining. These volunteers graciously provide leadership, feedback, and professional investment in making CCNE work as a premier accrediting agency. CCNE is grateful to its cadre of skilled and motivated volunteers and to those who have supported them in their participation in CCNE activities. This history of 10 years of accreditation excellence is in many ways their story.

Ongoing Achievements

By implementing a values-based, quality-focused accreditation process CCNE's achievements have had a profound effect on the education of professional nurses across the United States. As CCNE-affiliated programs move toward international teaching sites, this effect will be felt worldwide. The achievements of CCNE's first 10 years are notable because they are a direct result of support and buy-in from groups with an investment in accredited nursing programs and the graduates they prepare. They also are the result of committed volunteers and the actions of an accomplished professional staff.

Yet CCNE cannot rest on these accomplishments. Indeed, scientific, technological, social, and economic forces will continue to influence professional nursing. For example, the rapid development of DNP programs necessitated a rapid response from CCNE to amend the CCNE Standards to include DNP program approval. CCNE demonstrated its responsiveness and nimbleness in completing the standards revision and implementing DNP program review for fall 2008.

Thus, CCNE has shown its ability to be relevant to a dynamic profession. In the years to come, the challenge to remain a strong proponent of nursing accreditation excellence will lead to even greater achievements.

Chapter 6

Influencing Nursing's Future

Suzanne R. Van Ort, Susan L. Woods, and Mary Jo Clark

Editorial Note: When this chapter originally was written, it was after CCNE's first 5 years of operation. At that time, the authors envisioned what might occur for CCNE in the future. Much of that future vision has already come to pass and a new future awaits the organization. In order to give readers a sense of the changes that have occurred, this chapter has been divided into two sections. In the first section, "The View at 5 Years," what was written in the original document was retained; the second section, entitled, "The View at 10 Years," describes the authors' view of CCNE's future at the time of this writing.

The View at 5 Years

During the first 5 years after its establishment, CCNE addressed multiple issues that will have an impact on the profession of nursing. As the leading advocate for baccalaureate and graduate nursing education, AACN for many years envisioned and responded to changes in health care delivery and in nursing education. As the autonomous arm of AACN, CCNE is in the forefront as an accreditation agency that responds to change.

This chapter explores issues addressed by CCNE as they relate to professional futures. First, however, the recent changes in health care delivery and in nursing education that prompted CCNE action must be put into context.

Changing Health Care Delivery

In the United States, the health care delivery system is constantly undergoing change in response to social, political, and global forces. The complexity of care; costs of care; demand for new services and treatments; availability of new, expanding technologies; rapidly growing, diverse population of clients seeking health care services; disparities in health outcomes; and consumers' expectations, all challenge the structure and effectiveness of the current health system. Within this environment, ever-changing demands are placed on its professionals, the programs that educate them, and the agencies that accredit these educational programs.

One workforce issue that continues to have an impact on accreditation is the nursing shortage that is expected to worsen as baby boomers age and the need for health care grows. By the year 2020, the United States is expected to experience a 20% shortage in the number of nurses (400,000) required (Buerhaus, Staiger, & Auerbach, 2000). Compounding the shortage of nurses is a growing shortage of faculty in schools of nursing with baccalaureate and graduate programs. Over the past several years, the faculty deficit has reached critical proportions as current faculty are rapidly advancing toward retirement and the pool of replacement faculty is decreasing. As is the case for overall nursing workforce, the mean age of faculty has increased in less than a decade from 49.7 years in 1993 to 53.3 years in 2002 for doctoral faculty and from 46 years to 48.8 years for master's faculty (AACN, 2003b).

A potential impact for CCNE is the future availability of sufficient numbers of on-site CCNE evaluators and team leaders. An insufficient pool of volunteer peer reviewers would jeopardize the integrity of the accreditation process that has come to be known as the premier quality review in American postsecondary education. Moreover, specialized accreditation agencies would fail to meet the standards set forth by the U.S. Department of Education (USDE), which require both educators and practitioners on evaluation teams (Butlin, 2005). Thus, these combined shortages challenge not only nursing and its educational systems, but also accreditation services and ultimately the health of the nation.

Another critical issue was addressed in 2004 by the Sullivan Commission. The Commission's report acknowledged that health professions do not resemble, in terms of diversity, the populations they serve. The blue-ribbon panel suggested that failure to reverse the trend could place at least one third of U.S. citizens at risk for health problems (Sullivan Commission, 2004). According to the Commission, African-Americans, Hispanic Americans, and American Indians make up more than 25% of the U.S. population, but only 9% of the nation's nurses (Sullivan Commission, p. 2). The panel's recommendations emphasized:

- increasing diversity and ensuring cultural competence at all levels of the health care workforce;
- increasing recognition of underrepresented minority health professionals in cultural competence programs;
- increasing funding for research on racial disparities;
- setting health system goals for having multilingual staff;
- increasing the number of multilingual students in educational programs; and
- promoting training in diversity and cultural competence among health professions students, faculty and providers. (Sullivan Commission, p. 5)

One key recommendation is that accrediting bodies include diversity and cultural competence as requirements for accreditation. In its first 5 years, CCNE identified diversity as a component of its standards. During the second Standards Committee deliberations, the commitment to diversity was reaffirmed, especially as the amended standards required, for the first time, that programs demonstrate use of the AACN *Essentials*, which specifically address diversity. In addition, CCNE Board chair Charlotte Beason testified before the Sullivan Commission on CCNE's efforts and commitment related to diversity (Board, 2003a).

All health care professionals are being asked to promote health care that is safe, effective, client-centered, timely, efficient, and equitable (Institute of Medicine [IOM], 2001). At the same time, new models of collaboration among educators, clinicians, and students are being proposed. Educators are being asked to prepare students to deliver patient-centered care as members of an interdisciplinary team, using evidence-based practice, quality improvement approaches, and informatics (IOM, 2003). Industry is focusing on transforming the workplace to foster meaningful work that centers on patients. As a result, new partnerships are emerging between health care systems and education to prepare new nurses and to test education and practice models that are client-centered, generate quality outcomes, and are cost-effective. As these new partnerships and new models evolve, the public looks to CCNE accreditation to ensure quality.

Changing Higher Education

Colleges and universities in the United States underwent important changes in the 1980s and 1990s that reflected, among other issues, a growing need for increasing higher education's availability and accessibility to multiple constituents. Many of the changes realized were increases in the number of programs, as well as different types of programs such as accelerated programs and those offered by consortia. In addition, educational programs made greater use of distance delivery systems or revised curricula to offer flexible learning for working adults in the workplace and in off-campus sites.

By the late 1990s, for-profit institutions that offered degrees claimed an increasing percentage of student enrollment in higher education. Many of these programs were distance education or weekend offerings. Their use of technologies and their private status enabled them to compete with existing nonprofit public institutions by offering students highly specific options while, at the same time, making a profit (Winston, 1999). These institutions serve large numbers of students worldwide, primarily working adults, with a schedule that meets their needs and locations such as office spaces rather than traditional campuses. Moreover, for-profit institutions can readily respond to changes in the marketplace by altering their curricula to meet demand. Though many

of these for-profit institutions are accredited and committed to meeting accreditation standards, the long-term effect of their competitive place in higher education has yet to be determined.

In addition, higher education also moved from a primary focus on the process of teaching to a focus on learning outcomes. Assessment of the outcomes of teaching and learning necessitated not only a revision of curricula, but also a new openness among faculty to creating experiences that facilitated students' achievement of expected learning outcomes.

Finally, within higher education, there has been a commitment to the inclusion of a liberal arts education in all professional disciplines (AACN, 2004c). This commitment has a direct impact not only on nursing education itself, but on the processes to accredit it. Incorporation of liberal education concepts is an important feature of the AACN *Essentials*, and recognizing the importance of this foundation guided CCNE to include these concepts in its standards document to measure a program's quality and effectiveness.

Changing Nursing Education

Two nationally recognized reports also provided foundational information to support changes in professional nursing education. The first seminal work by the Center for the Health Professions at the University of California, San Francisco (O'Neil & Coffman, 1998), addressed the changing roles, responsibilities, and employment patterns of registered nurses for the future. Seven strategies were suggested:

> Create an integrated continuum for nursing practice; create a continuum of education that supports the practice continuum; focus the profession on two core competencies; strengthen the professional commitment to research; reduce the number of nurses educated in associate degree and diploma programs; create strategic partnerships for nursing; and invest in enhancing leadership. (O'Neil & Coffman, 1998, pp. 217-223)

Of particular relevance to the CCNE standards were the emphases on two core competencies (population-based approaches to health and incorporation of psychosocial-behavioral perspectives into the delivery of care), as well as the commitment to research and leadership development (O'Neil & Coffman, 1998).

In addition, publication in 1997 of AACN's *A Vision of Baccalaureate and Graduate Nursing Education: The Next Decade* (AACN, 1997b) provided guidelines for CCNE's accreditation process. For example, the AACN *Vision* statement identified the need for programs to educate nurses to provide high-quality, cost-effective, accessible, and accountable care focused on the whole person across the lifespan. CCNE incorporated the AACN *Vision*, including its emphasis on globalization of health care and the practice of nursing in multiple settings, into the accreditation process and standards.

AACN responded to changes in the nursing profession by collaborating with the organization that represents university hospitals. In 2003, AACN and the University HealthSystem Consortium (UHC) published a Joint Task Force report on *Building Capacity Through University Hospital and University School of Nursing Partnerships*. The task force identified short- and long-term solutions to increasing capacity in the nursing workforce through the implementation of a partnership model. Among the short-term solutions were creating new programs and accelerating career progression; sharing faculty and increasing access to clinical experiences; and collaborating in clinical experiences. Long-term solutions included creating career ladder programs to support baccalaureate nursing education and creating consortia for leadership in nursing practice, education, and research (AACN, 2003a).

Both sets of solutions have implications for CCNE in evaluating the quality and effectiveness of these new partnerships. Will the CCNE standards need to be revised or interpreted differently in partnership situations? How will participants provide evidence in the self-studies and on-site evaluations that reflect the partnership model? How will the consortium model be reflected in program reviews? Many of these questions have been answered as CCNE has evolved, but as new arrangements develop, CCNE will need to re-examine its processes and expected outcomes to ensure program quality and program effectiveness.

Nursing programs also have responded to changing needs by increasing the numbers of students enrolled, offering new types of programs, and by delivering programs via distance education and other innovative means. For example, although distance education came into use in higher education in the 1980s, its popularity in nursing education expanded only in recent years.

The number of distance education programs for nurses grew significantly in the 1990s, particularly nurse practitioner programs offered online. Online programs are now common in other graduate nursing specialties as well as at the doctoral level. As one response, the first CCNE Standards Committee recommended, and the Board approved, that nursing programs accredited by CCNE have their distance delivery systems evaluated using the same standards as traditional on-site programs. The CCNE Board also reaffirmed this position when the CCNE standards were revised and amended in 2003. Distance education outcomes will need to continue to be assessed by CCNE to assure the public that they continue to meet expectations for program quality and effectiveness.

Nursing educators also have developed accelerated (fast-track) programs as one route to the baccalaureate degree. The generic or basic baccalaureate program is repackaged to offer qualified students a 12-to-16 month curriculum for the degree. These programs are particularly appealing to students who hold a previous non-nursing degree and bring knowledge from that degree to the nursing program. Although the majority of accelerated programs in nursing offer the baccalaureate degree, some master's degree programs are also offered in an accelerated format (AACN, 2002).

Some graduate schools have begun to offer Master's Entry Programs in Nursing (MEPN) or Graduate Entry Programs in Nursing (GEPN). These graduate programs offer an accelerated pre-licensure component prior to traditional graduate programs. Some schools offer these students both the baccalaureate degree and graduate degree, while others offer only the graduate degree at the completion of the MEPN/GEPN curriculum.

Moreover, new graduate programs are preparing to provide leadership opportunities in health care environments across all settings. In particular, the clinical nurse leader (CNL) role was designed to prepare leaders to assume accountability for health care outcomes for a specific group of clients based on the application of research-based information in designing, implementing, and evaluating patient care plans (AACN, 2004b). The CNL is a provider and manager at the point of care to individuals and groups and coordinates, delegates, and supervises the care provided by the health care team, including licensed nurses, technicians, and other health professionals (AACN, 2004b, 2004f). As this new role evolves, accreditation of CNL programs must be addressed by CCNE to ensure that they meet the expectations of the CCNE standards.

At the doctoral level, AACN has recognized the DNP as the highest level of preparation for clinical nursing practice in the future (AACN, 2004a). In 2004, AACN members voted to move the level of preparation necessary for advanced nursing practice roles from the master's degree to the doctoral level by 2015 (AACN, 2004d, 2004e). The CCNE Board in October 2004 determined that accreditation of these new doctoral programs is consistent with CCNE's mission and scope of operations and noted that standards for the practice doctorate would need to be developed. The practice doctorate issue is further discussed in the final section of this chapter.

Among the health care professions, the emergence of interdisciplinary education is also influencing accreditation decision making. Lynda Davidson, second chair of the CCNE Board, acknowledged that there will be an increased interdisciplinary focus throughout health professions education (personal communication, October 23, 2004). Although interdisciplinary education has been present in higher education for many years, only recently has nursing education embraced a more interdisciplinary scope. Nursing programs have been challenged by the IOM recommendations (IOM, 2003) that suggested five core competencies: the ability to deliver patient-centered care; work as a member of an interdisciplinary team; engage in evidence-based practice; apply quality improvement approaches; and use information

technology. Of relevance to CCNE, the IOM report recommends that accrediting agencies ensure that students and professionals in the workforce develop and maintain proficiency in these five core areas (Long, 2003). Long linked the IOM's recommendations with the AACN *Essentials* and called on nursing programs to respond to the IOM competencies in preparing nurses for the future. Incumbent upon CCNE will be re-examining its standards and expectations as these, and potentially other, competencies are incorporated into nursing education. CCNE evaluators and team leaders will then need to be retrained to address any changes.

Envisioning Future Directions

CCNE continues to face a range of issues that have been considered during the initial 5 years, but have not yet been resolved completely. In an interview conducted as part of the History Project, Linda Amos, first chair of the CCNE Board, stated, "Nursing is on the brink of major change due to health care issues of access and quality of care that will require continued self-assessment and changes in education and the accreditation process" (personal communication, October 23, 2004). CCNE will need to be alert to these changes and respond with adjustments in the accreditation process, as appropriate. Carole Anderson, former AACN President, offered one caution, "CCNE will need to balance its activities in responding to pressure from different directions—to be careful in not trying to do too much—it will need to stay in touch with AACN" (personal communication, February 9, 2005). Thus the Board will need to consider its scope and community of interest in being proactive and responsive to changes in the profession.

One issue raised repeatedly during the first 5 years was accreditation of international programs. The Board and its appointed Task Force on International Programs considered requests by programs in foreign countries to accredit their programs. Different issues arise for foreign institutions offering their own nursing programs as their curricula may not be comparable to U.S.-based educational programs. Moreover, if the primary language is other than English, communicating with and evaluating the program may be challenging. Application of the CCNE standards poses a challenge if the curricula being reviewed have different expected outcomes. The characteristics of faculty also may be unique to a specific country and its own constituencies. Regardless of the type of international program, many issues arise in considering accreditation of international programs. These issues will need to be addressed by CCNE as more international and global emphases affect nursing education. For the present, in response to the recommendations of the task force, the CCNE Board decided that CCNE will not accredit international programs at this time (Board, 2003a).

In spring 2003, the CCNE Board agreed to develop an accreditation process for post-baccalaureate nurse residency programs. These programs seek CCNE accreditation to ensure quality in their residency training programs and to meet the federal requirements set forth by the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) to qualify for pass-through dollars to defray some of the expense of educating nurses. Discussion with UHC and AACN is continuing as the accreditation process is developed. In response to the community of interest, the CCNE Board appointed a Task Force on Accreditation of Post-Baccalaureate Nurse Residency programs (Board, 2003a) to develop the standards.

A third issue remaining for CCNE's future is examination of its own values, in accordance with the organization's commitment to continuing quality improvement. As the mission and scope of CCNE evolve, the values on which the organization is based must be reviewed. Critical questions are raised: Do the CCNE values need to be revised? Are there important values not included at present? Do the CCNE values effectively serve both CCNE and the community of interest?

Another issue for the future is the development of new regulatory models, particularly for advanced practice nursing. At present, each state addresses the issue of advanced practice in different ways, limiting the mobility of qualified advanced practice nurses from state to state and impairing the ability of the general public to benefit from the skills and expertise of this group of providers. Movement is underway to develop a model for the regulation of advanced practice nursing across the nation, and CCNE is actively

involved in this effort. Whether and how a unified approach to advanced practice is achieved remains to be seen.

Geraldine Bednash, Executive Director of AACN, in addressing future directions for CCNE, commented that "the [CCNE] Board will need to have a readiness for change," and that a challenge to CCNE will be "to have a finger on the pulse" of changes in nursing that affect accreditation. She advised CCNE, as well, not to become "fixed," but to be "nimble" in thinking about change (personal communication, February 9, 2005). Thus, CCNE's willingness to change will be essential in coming years.

The first three chairs of the CCNE Board of Commissioners (left to right) Linda Amos, Lynda Davidson, and Charlotte Beason, during history project interview, October 2004.

Commenting on future directions for CCNE, Charlotte Beason, third chair of the CCNE Board stated, "Nursing is on the threshold of exciting times. Practice changes will necessitate changes in education processes and accreditation. Nursing's (and CCNE's) community of interest will change and grow and their needs will change" (personal communication, October 23, 2004). Moreover, one respondent to the CCNE History Project Survey stated, "CCNE has the people, direction, [and] focus essential for promoting continuous improvement in nursing education to prepare graduates with the skills needed to meet the ever-changing environment graduates will encounter" (CCNE, 2004c, p. 4).

The View at 10 Years

As indicated in earlier chapters, much of what was viewed as elements of CCNE's future at 5 years has already come to pass, while some issues, such as accreditation of international programs, remain to be addressed. DNP accreditation and accreditation of nurse residency programs are already here, but new issues have arisen that will occupy CCNE for the near future. Some of those issues are the development of a pre-approval process for new advanced practice nursing programs, accreditation of post-graduate advanced practice nursing certificate programs, and the roll out of the proposed regulatory model for advanced practice. Other issues to be addressed include continuing accreditation of advanced practice nursing programs at the master's level, incorporation of AACN's revised *The Essentials of Baccalaureate Education for Professional Nursing Practice* and other professional standards and guidelines into the CCNE standards, and the question of whether or not CCNE will review DNP programs that have a sole focus on the preparation of nurse educators. Each of these issues will be briefly addressed here.

Pre-Approval of Advanced Practice Nursing Programs

Given the proliferation of advanced practice nursing programs throughout the country, there has been growing concern about the quality of advanced practice nursing education. Accredited programs are carefully scrutinized to determine that they meet identified educational standards. New programs in nurse midwifery and nurse anesthesia undergo a pre-approval process conducted by the specialized accreditors for such programs prior to enrolling students. However, no such process currently exists for newly developed nurse practitioner (NP) or clinical nurse specialist (CNS) programs. Members of the Alliance for APRN Credentialing and other professional organizations have been asking for some sort of comparable pre-approval process for NP and CNS programs. In response to this request from its community of interest, CCNE has committed to the development of a pre-approval process for new programs in both of these roles.

During an April 4, 2008 conference call, the Executive Committee of the CCNE Board initiated dialogue with representatives from the National Association of Clinical Nurse Specialists (NACNS) and the National Organization of Nurse Practitioner Faculties (NONPF) to get their initial input regarding pre-approval. Issues discussed were the format for the process (paper review vs. on-site evaluation), timing in relation to program implementation, the need for standards and procedures, and the role of the other professional organizations in the process. CCNE made it clear that it believes and has always supported that a paper review is sufficient to ensure that the necessary resources are in place to mount a quality NP or CNS program (Executive Committee, 2008b). Specific areas for review that are being considered include the curriculum, faculty, and clinical experiences. Additional questions to be resolved include the sanctions to be applied, if any, for failure to seek pre-approval prior to implementing a new NP or CNS program and the qualifications of reviewers.

CCNE invited NACNS and NONPF to identify current CCNE evaluators who are members of their organizations who could possibly serve on a task force to develop pre-approval criteria. These individuals would have the required knowledge of the CCNE accreditation standards as well as the perspectives of the professional organizations to bring to the table. Tasks for the future with respect to pre-approval of APRN programs include the development of pre-approval criteria, the pre-approval process, training of reviewers, and development of a fee structure. At its April 2008 meeting, the CCNE Board initiated activity with a vote to establish a task force to develop a pre-approval process. Depending on the process developed, implementation of pre-approval activities may necessitate a reorganization of CCNE's committee structure with the addition of a pre-approval review committee similar to the ARC, RRC, and the new Residency Accreditation Committee (RAC) (Board, 2008b).

Accreditation of Post-Graduate APRN Certificate Programs

Another burgeoning area of professional concern is the proliferation of post-graduate certificate programs for APRN practice. In the past, CCNE has accredited only programs leading to a specific academic degree and has not reviewed post-graduate certificate programs. At the request of the Alliance and other nursing professional organizations, however, the Executive Committee of the Board agreed to explore the potential for CCNE to expand its scope of operation to include post-graduate certificate programs. In order to do so, the organization will need to determine the applicability of the current education accreditation standards to certificate programs. It is possible CCNE might only accredit post-graduate certificate programs that are offered in institutions that have the same specialties in a master's degree program. This approach, however, does not address the issue of quality in certificate programs in institutions that do not also have accredited degree programs in the area of specialty. Another decision that will need to be made is whether or not post-graduate certificate programs would be included in the pre-approval process for new NP and CNS programs described above.

The Regulatory Model of APRN Practice

CCNE has been actively involved in activities by the professional organizations, certifying bodies, accrediting bodies, and state boards of nursing to create a national model for regulation of APRN practice that would promote quality standards for APRN practice throughout the country and facilitate movement of APRNs from one state to another. In 2008, a draft statement regarding the Regulatory Model of APRN Practice was disseminated to various constituencies for comment (National Council of State Boards of Nursing [NCSBN], 2008). The model calls for uniform second licensure requirements for APRNs in all states. Under the model, APRNs would be licensed in one of four role areas (Certified Nurse Practitioner [CNP], Clinical Nurse Specialist [CNS], Certified Nurse Midwife [CNM], or Certified Registered Nurse Anesthetist [CRNA]) with a focus on direct care to members of one or more of six designated populations (family/individual across the lifespan, adult-gerontology,

pediatrics, neonatal, women's health/gender-related, or psych/mental health). Preparation for specialty practice within a population focus (e.g. pediatric oncology or adult-geriatric palliative care) could occur in addition to the preparation for the role and population focus, but would not be regulated by licensure, and would instead be regulated through certification by specialty nursing organizations.

APRN licensure would be in addition to RN licensure and would be predicated on graduate preparation for the role. The model specifies four areas of intraprofessional responsibility for APRN practice: licensing, accreditation, certification, and education. CCNE as an accrediting body would address the responsibilities of accreditation and, within that capacity, would ensure that educational institutions meet their responsibilities. Suggested responsibilities for accrediting agencies include pre-approval of APRN education programs prior to student enrollment and accreditation of post-graduate certificate programs for APRN preparation (NCSBN, 2008), both of which are currently being considered by CCNE. In July 2008, the AACN Board endorsed the proposed regulatory model (AACN, 2008a). Because implementation of much of the model will require changes in state legislation and regulation, if adopted, it will only be implemented incrementally, and the exact implications for advanced practice and education remain to be seen.

Future Accreditation of Advanced Practice Master's Programs

Another question that has been posed for CCNE in the near future is the status of continuing accreditation for master's degree programs that have an advanced practice focus. Based on AACN's *The Essentials of Doctoral Education for Advanced Nursing Practice* (2006), master's level education for advanced nursing practice is expected to be replaced by doctoral level preparation by 2015—a target date that has been suggested by AACN. CCNE has been asked repeatedly if it will continue to accredit master's programs with an advanced practice focus. CCNE's position has been that it accredits degree programs, not particular tracks within a degree and that, for the foreseeable future, the organization will continue to accredit advanced practice programs at the master's level (CCNE, 2008g).

One of the issues is the continued use of AACN's *The Essentials of Master's Education for Advanced Practice Nursing* (1996c) as a curricular foundation for master's programs in nursing. This is an aging document and is not likely to be revised by AACN in light of the proposed movement to APRN preparation at the doctoral level by 2015. The question then arises as to what standards and guidelines could appropriately be used by master's programs with an APRN focus, an issue that CCNE will need to resolve at some point in time.

Use of Professional Standards and Guidelines

The use of appropriate professional standards and guidelines as a foundation for nursing education programs has two other aspects in addition to that discussed above in relation to master's level APRN education. The first aspect is the increasing pressure on CCNE to require incorporation of certain specific sets of standards and guidelines by its accredited programs. For example, there is an expectation that the AACN white paper on CNL education will be used as the foundation for master's level clinical leader programs. It is anticipated that AACN will draft an *Essentials* document for these programs to replace *The Essentials of Master's Education for Advanced Practice Nursing* (AACN, 1996c). Will CCNE then require the incorporation of this document for accreditation of CNL programs? Likewise, there has been pressure to require use of the NACNS standards for CNS education. To this point, CCNE has resisted such pressure due to the lack of agreement on the applicability of these standards and guidelines to the gamut of CNS programs. Will this change if and when CNS practice falls within the APRN regulatory model as proposed? Similar questions might also be raised about standards for other areas of specialization.

The second issue is a related one and deals with the adoption of revised sets of standards and guidelines. In the April 2008 revision of CCNE's *Standards for Accreditation of Baccalaureate and Graduate Degree Nursing Programs*, the Board accepted the recommendation of the Standards Committee that incorporation of the newly revised *Criteria for Evaluation of Nurse Practitioner Programs* (NTF, 2008)

be required of all nurse practitioner programs. A decision about whether to replace the required *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 1998b) with the proposed revision of that document, could not be made in April 2008 because the AACN Board was not scheduled to review the document until July 2008. Thus, the AACN membership will consider the revised document at the AACN Fall Semiannual Meeting in October 2008. Due to this timeline, CCNE determined that the most logical process would be for the CCNE Standards Committee and Board to consider the final document and make a determination about its inclusion in the CCNE standards following approval by AACN (Standards Committee, 2008). This process of review and reconsideration is required whenever foundational documents incorporated into the standards are revised.

Education-focused DNP Programs

Another issue that has future ramifications for CCNE accreditation and the development of the profession is that of DNP programs that have a primary educational focus rather than a focus on advanced practice. Even now, in 2008, DNP programs are being initiated that are designed to prepare nurse educators without an advanced practice focus, and the question of eligibility for CCNE accreditation is being raised. At its April 2008 meeting, the Board passed a resolution that CCNE would draft a position statement to the effect that the intent of the DNP program is to prepare nurses with advanced expertise in clinical practice and that programs focused solely on an educational role do not meet that intent. For that reason, CCNE has put forth a statement that DNP programs with a strictly educational focus do not comply with the requirement to incorporate *The Essentials of Doctoral Education for Advanced Nursing Practice* (AACN, 2006) and will not be eligible for CCNE accreditation (CCNE, 2008a). This position does not mean that advanced practice programs that also prepare graduates to function as educators are not eligible for accreditation, since preparation for education roles over and above the DNP curriculum is recommended in *The Essentials of Doctoral Education for Advanced Nursing Practice* (Board, 2008b). Whether this position will change in the future remains to be seen.

Other challenges for CCNE in the future lie not so much in events that may occur, but in the need for the organization to maintain its commitment to quality nursing education. Mary Margaret Mooney, former Board chair, described this challenge as one of balancing rigor with flexibility and "remaining faithful to our mission and sensitive to our constituencies" (personal communication, July 16, 2008). Another former Board chair, Jill Derstine, noted that CCNE's autonomous relationship with AACN means that the organization is "always on the cusp of issues" and will need to maintain a proactive stance regarding new developments in the nursing profession (personal communication, July 16, 2008).

As indicated in this view of the future at CCNE's 10th year, the issues confronting CCNE have changed dramatically from those envisioned at the 5-year mark. CCNE's history, however, has demonstrated the organization's ability to address future issues in a timely manner for the good of the profession and the health of the world's population. As noted by Harriet R. Feldman, current chair of the Board,

> Ten years is not a long time. The great maturity of this organization after only 10 years is laudable…. CCNE is very responsive to the public,… both inside and outside the organization…. For any organization to be as responsive as this has to be very unusual (personal communication, July 16, 2008).

As CCNE evolves, the quality of the organization's response to its constituencies and their issues is expected to continue. The issues addressed in the first 10 years will become the milestones of CCNE's history. The first 10 years have built a strong foundation for achievement of excellence in accreditation now and in the future.

Harriet R. Feldman, 2008 CCNE Board chair.

References

Accreditation Review Committee. (1999, August 16-18). *Meeting minutes*. Washington, DC: Commission on Collegiate Nursing Education.

Accreditation Review Committee. (2000a, January 31-February 2). *Meeting minutes*. Washington, DC: Commission on Collegiate Nursing Education.

Accreditation Review Committee. (2000b, July 27-29). *Meeting minutes*. Washington, DC: Commission on Collegiate Nursing Education.

Accreditation Review Committee. (2001, August 9-11). *Meeting minutes*. Washington, DC: Commission on Collegiate Nursing Education.

Accreditation Review Committee. (2008, July 24-26). *Meeting minutes*. Washington, DC: Commission on Collegiate Nursing Education.

Alliance for APRN Credentialing. (2006, March). *Meeting minutes*. Washington, DC: Author.

Alliance for APRN Credentialing. (2008a, March). *Formalizing the Alliance for APRN Credentialing*. Washington, DC: Author.

Alliance for APRN Credentialing. (2008b, March). *Meeting minutes*. Washington, DC: Author.

Alliance for Nursing Accreditation. (1997, November 14). *Meeting minutes*. Washington, DC: Author.

Alliance for Nursing Accreditation. (2000, October). *Meeting minutes*. Washington, DC: Author.

Alliance for Nursing Accreditation. (2002, March). *Meeting minutes*. Washington, DC: Author.

Alliance for Nursing Accreditation. (2003, March). *Meeting minutes*. Washington, DC: Author.

Alliance for Nursing Accreditation. (2005, October). *Meeting minutes*. Washington, DC: Author.

American Association of Colleges of Nursing. (1995, November-December). Task force on accreditation established. *Syllabus*, 21, 6.

American Association of Colleges of Nursing. (1996a, November-December). AACN members overwhelmingly endorse action to establish alliance to accredit nursing higher education. *Syllabus,* 22, 6.

American Association of Colleges of Nursing. (1996b). *Accreditation survey*. Washington, DC: Author.

American Association of Colleges of Nursing. (1996c). *The essentials of master's education for advanced practice nursing*. Washington, DC: Author.

American Association of Colleges of Nursing. (1997a, January-February). AACN appoints steering committee to guide new accreditation effort. *Syllabus*, 23, 1.

American Association of Colleges of Nursing. (1997b). *A vision of baccalaureate and graduate nursing education: The next decade*. Washington, DC: Author.

American Association of Colleges of Nursing. (1997c, March). *Business meeting minutes*. Washington, DC: Author.

American Association of Colleges of Nursing. (1997d, May-June). CCNE moving forward. *Syllabus,* 23, 3.

American Association of Colleges of Nursing. (1998a, November-December). Commission on Collegiate Nursing Education moves forward with accreditation activities. *Syllabus, 24, 6.*

American Association of Colleges of Nursing. (1998b). *The essentials of baccalaureate education for professional nursing practice*. Washington, DC: Author.

American Association of Colleges of Nursing. (2002). *Issue bulletin: Accelerated programs: The fast-track to careers in nursing*. Washington, DC: Author.

American Association of Colleges of Nursing. (2003a). *Building capacity through university hospital and university school of nursing partnerships*. A joint task force report of the University Health System Consortium (UHC) and American Association of Colleges of Nursing (AACN). Washington, DC: Author.

American Association of Colleges of Nursing. (2003b). *Faculty shortages in baccalaureate and graduate nursing programs: Scope of the problem and strategies for expanding the supply.* Retrieved August 22, 2004 from http://www.aacn.nche.edu/Publications/White Papers/Faculty Shortages.htm

American Association of Colleges of Nursing. (2004a). *AACN adopts a new vision for the future of nursing education and practice: Position on the practice doctorate approved by AACN member schools.* Retrieved August 21, 2008 from http://www.aacn.nche.edu/Media/NewsReleases/DNPRelease.htm

American Association of Colleges of Nursing. (2004b). *Clinical nurse leader: Frequently asked questions.* Washington, DC: Author.

American Association of Colleges of Nursing. (2004c). *Fact sheet: The impact of education on nursing practice.* Washington, DC: Author.

American Association of Colleges of Nursing. (2004d). *Frequently asked questions: Position statement on the practice doctorate in nursing.* Washington, DC: Author.

American Association of Colleges of Nursing. (2004e). *Position statement on the practice doctorate in nursing.* Washington, DC: Author.

American Association of Colleges of Nursing. (2004f). *Working paper on the role of the clinical nurse leader.* Retrieved August 21, 2008 from http://www.aacn.nche.edu/Publications/WhitePapers/CNL6-04.DOC

American Association of Colleges of Nursing. (2006). *The essentials of doctoral education for advanced nursing practice.* Washington, DC: Author.

American Association of Colleges of Nursing. (2008a). *AACN endorses APRN consensus model*. Retrieved September 30, 2008 from http://www.aacn.nche.edu/Media/NewsWatch/2008/Aug.html#3

American Association of Colleges of Nursing. (2008b). *DNP program list*. Retrieved July 31, 2008 from http://www.aacn.nche.edu/DNP/DNPProgramList.htm

Association of Specialized and Professional Accreditors. (n.d.). *Specialized & professional accreditation.* Retrieved July 26, 2008 from http://www.aspa-usa.org/maintop.html

Association of Specialized and Professional Accreditors. (1995). *Code of good practice for accrediting bodies.* Retrieved August 21, 2008 from http://www.aspa-usa.org

Association of Specialized and Professional Accreditors. (2002). *Accreditation in the United States.* Retrieved November 23, 2004 from http://www.aspa-usa.org

Association of Specialized and Professional Accreditors. (2008). *Specialized and professional accreditation.* Retrieved August 4, 2008 from http://www.aspa-usa.org

Beason, C. F. (2005). A new role in accreditation activities offers expanded horizons for registered nurses. *Journal of Professional Nursing, 21,* 191-196.

Board of Commissioners. (1998a, February 6-8). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

Board of Commissioners. (1998b, July 31-August 1). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

Board of Commissioners. (1999a, April 11-12). *Meeting minutes*. Washington, DC: Commission on Collegiate Nursing Education.

Board of Commissioners. (1999b, September 23-25). *Meeting minutes*. Washington, DC: Commission on Collegiate Nursing Education.

Board of Commissioners. (2000a, March 2-3). *Meeting minutes*. Washington, DC: Commission on Collegiate Nursing Education.

Board of Commissioners. (2000b, September 21-22). *Meeting minutes*. Washington, DC: Commission on Collegiate Nursing Education.

Board of Commissioners. (2001, September 27-29). *Meeting minutes*. Washington, DC: Commission on Collegiate Nursing Education.

Board of Commissioners. (2002a, April 18-20). *Meeting minutes*. Washington, DC: Commission on Collegiate Nursing Education.

Board of Commissioners. (2002b, September 26-28). *Meeting minutes*. Washington, DC: Commission on Collegiate Nursing Education.

Board of Commissioners. (2003a, April 30-May 2). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

Board of Commissioners. (2003b, October 2-4). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

Board of Commissioners. (2004, October 7-9). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

Board of Commissioners. (2006, October 26-28). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

Board of Commissioners. (2007a, April 9). *Email regarding Standards Committee appointments.* Washington, DC: Commission on Collegiate Nursing Education.

Board of Commissioners. (2007b, April 19-21). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

Board of Commissioners. (2007c, October 11-13). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

Board of Commissioners. (2008a, February 16). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

Board of Commissioners. (2008b, April 14-16). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

Buerhaus, P., Staiger, D. O, & Auerbach, D.I. (2000). Implications of an aging registered nurse workforce. *Journal of the American Medical Association, 283*, 2948-2954.

Butlin, J. (2005). *Nurses' reasons for participation as evaluators in specialized accreditation.* Unpublished doctoral dissertation. The George Washington University.

Canadian Association of Schools of Nursing & Commission on Collegiate Nursing Education. (2004). *Mutual recognition agreement on accreditation.* Retrieved August 4, 2008 from http://www.aacn.nche.edu/Accreditation

Commission on Collegiate Nursing Education. (n.d.). *Letters from program deans and directors.* Washington, DC: Author.

Commission on Collegiate Nursing Education. (1997). *Regional hearing agendas and participant lists.* Washington, DC: Author.

Commission on Collegiate Nursing Education. (1998a). *Procedures for accreditation of baccalaureate and graduate nursing education programs.* Washington, DC: Author.

Commission on Collegiate Nursing Education. (1998b). *Standards for accreditation of baccalaureate and graduate nursing programs.* Washington, DC: Author.

Commission on Collegiate Nursing Education. (1998c). *Summary evaluation of CCNE's accreditation process.* Washington, DC: Author.

Commission on Collegiate Nursing Education. (1999a). *Internal operating manual of rules and procedures.* Washington, DC: Author.

Commission on Collegiate Nursing Education. (1999b). *Response to Department of Education staff analysis.* Washington, DC: Author.

Commission on Collegiate Nursing Education. (2000a). *Bylaws of the Commission on Collegiate Nursing Education.* Washington, DC: Author.

Commission on Collegiate Nursing Education. (2000b). *Workshop on writing self-studies.* Washington, DC: Author.

Commission on Collegiate Nursing Education. (2001a). *Annual report*. Washington, DC: Author.

Commission on Collegiate Nursing Education. (2001b). *Procedures for accreditation of baccalaureate and graduate nursing education programs.* Washington, DC: Author.

Commission on Collegiate Nursing Education. (2002a). *Annual report.* Washington, DC: Author.

Commission on Collegiate Nursing Education. (2002b). *Team leader training: Evaluation summary.* Washington, DC: Author.

Commission on Collegiate Nursing Education. (2003a). *Annual report.* Washington, DC: Author.

Commission on Collegiate Nursing Education. (2003b, October 16). *CCNE amends accreditation standards* (press release). Retrieved November 22, 2003 from http://www.aacn.nche.edu/Accreditation/PressReleaseStandards03.htm

Commission on Collegiate Nursing Education. (2003c). *Evaluator training: Evaluation summary.* Washington, DC: Author.

Commission on Collegiate Nursing Education. (2003d). *Post-visit assessments.* Washington, DC: Author.

Commission on Collegiate Nursing Education. (2003e). *Standards for accreditation of baccalaureate and graduate nursing programs*. Washington, DC: Author.

Commission on Collegiate Nursing Education. (2004a). *History project survey, Part 1*. Washington, DC: Author.

Commission on Collegiate Nursing Education. (2004b). *History project survey, Part 2*. Washington, DC: Author.

Commission on Collegiate Nursing Education. (2004c). *History project survey, Part 3*. Washington, DC: Author.

Commission on Collegiate Nursing Education. (2007, Fall). *Post-visit assessment by program officials.* Washington, DC: Author.

Commission on Collegiate Nursing Education. (2008a). *CCNE decision regarding the DNP degree title.* Retrieved August 22, 2008 from http://www.aacn.nche.edu/accreditation/DNPaccred.htm

Commission on Collegiate Nursing Education. (2008b). Call for evaluator nominations for nurse residency program accreditation. Retrieved June 10, 2008 from http:www.aacn.nche.edu/accreditation/nrpeval.htm

Commission on Collegiate Nursing Education. (2008c, Spring). *Comments from assessment by on-site evaluators.* Washington, DC: Author.

Commission on Collegiate Nursing Education. (2008d, June 27-28). *Comments from evaluator training.* Washington, DC: Author.

Commission on Collegiate Nursing Education. (2008e, March 28). *Comments from self-study workshop.* Washington, DC: Author.

Commission on Collegiate Nursing Education. (2008f). *Comments on CCNE's proposed standards for accreditation of baccalaureate and graduate programs*. Washington, DC: Author.

Commission on Collegiate Nursing Education. (2008g). Frequently asked questions: DNP programs & CCNE accreditation. Retrieved September 1, 2008 from http://www.aacn.nche.edu/Accreditation/dnp/FAQ.htm

Commission on Collegiate Nursing Education. (2008h). *Standards for accreditation of baccalaureate and graduate nursing programs*. Washington, DC: Author.

Commission on Collegiate Nursing Education & American Association of Colleges of Nursing. (2002). *Memorandum of agreement between the American Association of Colleges of Nursing and the Commission on Collegiate Nursing Education*. Washington, DC: Authors.

Council for Higher Education Accreditation. (2006). *Accreditation serving the public interest*. Retrieved July 26, 2008 from http://www.chea.org

Council for Higher Education Accreditation. (2007). *Recognized accrediting organizations.* Retrieved July 26, 2008 from http://www.chea.org

Davenport, C. A. (2000, August). *Recognition of chronology*. Retrieved November 23, 2004 from http://www.aspa-usa.org

Dill, W. R. (1998). Specialized accreditation: An idea whose time has come? Or gone? *Change*, *30*(4), 18-25.

Eaton, J. S. (2006). *An overview of U.S. accreditation.* Retrieved July 26, 2008 from http://www.chea.org

Executive Committee. (2008a, January 30). *Meeting minutes*. Washington, DC, Commission on Collegiate Nursing Education.

Executive Committee. (2008b, April 4). *Meeting minutes*. Washington, DC, Commission on Collegiate Nursing Education.

Fenwick, D. E. (2001, October 29). *Site visitor observation and report*. Washington, DC: Council for Higher Education Accreditation.

Flexner, A. (1910). *Medical education in the United States and Canada.* A Report to the Carnegie Foundation for the Advancement of Teaching. Washington, DC: Science and Health Publications (Reprinted from the original edition).

Hultman, K. (2002). *Balancing individual and organizational change: Walking the tightrope to success.* San Francisco: John Wiley & Sons.

Institute of Medicine. (2001). *Crossing the quality chasm.* Washington, DC: The National Academies Press.

Institute of Medicine. (2003). *Health professions education: A bridge to quality.* Washington, DC: The National Academies Press.

Kalisch, P. A., & Kalisch, B. J. (1978). *The advance of American nursing.* Boston: Little, Brown.

Long, K. A. (2003). The Institute of Medicine Report: Health professions education: A bridge to quality [Policy Highlight]. *Policy & nursing practice. 4*, 259-262.

National Council of State Boards of Nursing. (2008). *Consensus model for APRN regulation: Licensure, accreditation, certification, and education*. Retrieved August 1, 2008 from https://www.ncsbn.org/7_23_08_consensue_APRN_final.pdf

National League for Nursing Accreditation Commission. (2008a). *Accreditation manual.* Retrieved August 4, 2008 from http://www.nlnac.org/manuals/NLNACmanual2008.pdf

National League for Nursing Accrediting Commission. (2008b). *NLNAC assuring quality for the future of nursing education.* Retrieved August 4, 2008 from http://www.nlnac.org

National Task Force on Quality Nurse Practitioner Education. (2002). *Criteria for evaluation of nurse practitioner programs.* Washington, DC: Author.

National Task Force on Quality Nurse Practitioner Education. (2008). *Criteria for evaluation of nurse practitioner programs.* Washington, DC: Author.

Preliminary Review Panel. (1998, February). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

O'Neil, E. & Coffman, J. (Eds). (1998). *Strategies for the future of nursing.* San Francisco: Jossey-Bass.

Report Review Committee. (2001, February 14). *Meeting minutes*. Washington, DC: Commission on Collegiate Nursing Education.

Roberts, M. M. (1954). *American nursing: History and interpretation.* New York: Macmillan.

Standards Committee. (1997, May 12). *Meeting minutes*. Washington, DC: Commission on Collegiate Nursing Education.

Standards Committee. (2002a, June 18). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

Standards Committee. (2002b, September 17). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

Standards Committee. (2002c, October 26-27). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

Standards Committee. (2002d, November 26). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

Standards Committee. (2002e, December 4). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

Standards Committee. (2003a, February 19). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

Standards Committee. (2003b, March 23). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

Standards Committee. (2003c, July 8). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

Standards Committee. (2008). *Report to the Board of Commissioners*. Washington, DC: Commission on Collegiate Nursing Education.

Steering Committee. (1997a, February). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

Steering Committee. (1997b, April). *Meeting minutes*. Washington, DC: American Association of Colleges of Nursing.

Steering Committee. (1997c, October). *Meeting minutes.* Washington, DC: American Association of Colleges of Nursing.

Sullivan Commission on Diversity in the Healthcare Workforce. (2004). *Missing persons: Minorities in the healthcare professions.* [Executive Summary]. Durham, NC: Duke University School of Medicine.

Task Force on Doctoral Accreditation. (2000, August). *Meeting minutes.* Washington, DC: Commission on Collegiate Nursing Education.

U. S. Department of Education. (1999, December 7). *National Advisory Committee on Institutional Quality and Integrity testimony.* Washington, DC: Author.

U. S. Department of Education. (2001, December 11). *National Advisory Committee on Institutional Quality and Integrity testimony*. Washington, DC: Author.

U. S. Department of Education. (2004). *Secretary's criteria for recognition of accrediting agencies. 602.15(a)4.* Retrieved October 20, 2004 from http://www.ed.gov/admins/finaid/accred/accreditation_pg12.html#Recognition%20Criteria

Winston, G. C. (1999). For-profit higher education: Godzilla or Chicken Little? *Change. 31* (1), 12-19.

Appendices

Appendix A

AACN Task Force on Accreditation

Linda K. Amos, Chair
Dean and Professor, College of Nursing
University of Utah

Brenda S. Cherry
Dean, College of Nursing
University of Massachusetts Boston

Thelma L. Cleveland
Dean
Intercollegiate Center for Nursing Education

Sue T. Hegyvary
Dean, School of Nursing
University of Washington

Sandra Jamison
Chair, Department of Nursing
Messiah College

Sandra Rogers
Dean, College of Nursing
Brigham Young University

Joyce K. Shoemaker
Dean, College of Nursing
Medical College of Ohio

Toni J. Sullivan
Dean, School of Nursing
University of Missouri-Columbia

Appendix B

AACN Steering Committee

Linda K. Amos, Chair
Dean and Professor, College of Nursing
University of Utah

Jean E. Bartels
Chair, Division of Nursing
Alverno College

Lynda J. Davidson
Assistant Professor and Assistant Dean, School of Nursing
University of Pittsburgh

Gary L. Filerman
Associate Director
Pew Health Professions Commission

Barbara Russell Kelley
Pediatric Nurse Practitioner, Massachusetts General Hospital
Chelsea Health Center

Robert V. Piemonte
Former Executive Director
National Student Nurses Association

Douglas L. Wood
President
American Association of Colleges of Osteopathic Medicine

Appendix C

Alliance for APRN Credentialing

Accreditation Commission for Midwifery Education

American Academy of Nurse Practitioners Certification Program

American Association of Colleges of Nursing

American Association of Critical-Care Nurses Certification Corporation

American College of Nurse-Midwives

American Midwifery Certification Board

American Nurses Credentialing Center

Association of Faculties of Pediatric Nurse Practitioners

Commission on Collegiate Nursing Education

Council on Accreditation of Nurse Anesthesia Educational Programs

National Association of Clinical Nurse Specialists

National Association of Nurse Practitioners in Women's Health, Council on Accreditation

The National Certification Corporation for the Obstetric Gynecologic and Neonatal Nursing Specialties

National Council of State Boards of Nursing

National Organization of Nurse Practitioner Faculties

Pediatric Nursing Certification Board

Appendix D

CCNE Preliminary Review Panel

Betty M. Johnson, Chair
Chair, Department of Nursing
Clinch Valley College of the University of Virginia

Mary S. Collins
Dean and Professor, Decker School of Nursing
SUNY Binghamton University

Susan L. Woods
Associate Dean for Academic Programs, School of Nursing
University of Washington

Ana Maria Valadez
Director Undergraduate Program, School of Nursing
Texas Tech University Health Sciences Center

Appendix E

CCNE Board of Commissioners (1998-2008)

Representatives of Chief Nurse Administrators

Linda K. Amos
Dean and Professor, College of Nursing
University of Utah
1998-2000 (Chair 1998-2000)

Carole A. Anderson
Dean and Professor, College of Nursing
The Ohio State University
2000-2001

Richardean Benjamin
Chair and Professor, School of Nursing
Old Dominion University
2007-

Brenda S. Cherry
Dean, College of Nursing
University of Massachusetts Boston
1998-2002 (Treasurer 1998-2001)

Jill B. Derstine
Chair and Professor, Department of Nursing
Temple University
2002-2007 (Secretary 2004-2005, Chair 2006-2007)

Harriet R. Feldman
Dean and Professor, Lienhard School of Nursing
Pace University
2003- (Secretary 2006, Vice Chair 2007, Chair 2008)

E. Jane Martin
Dean, School of Nursing
West Virginia University
2003-2006 (Vice Chair 2006)

Mary Margaret Mooney
Chair and Professor, Department of Nursing
Clarke College
2001-2002 (Treasurer 2002)

Jeanne M. Novotny
Dean and Professor, School of Nursing
Fairfield University
2008-

Suzanne R. Van Ort
Dean and Professor, College of Nursing
The University of Arizona
1998-2000

Faculty Representatives

Richardean Benjamin
Chair and Professor, School of Nursing
Old Dominion University
2004-2006

Donna L. Boland
Associate Professor and Associate Dean for Undergraduate Programs
School of Nursing
Indiana University
1998-2003

Cynthia Flynn Capers
Professor and Coordinator of Academic Leadership Initiatives, College of Nursing
The University of Akron
2007-

Mary Jo Clark
Professor, Hahn School of Nursing and Health Science
University of San Diego
2006- (Vice Chair 2008)

Lynda J. Davidson
Assistant Professor and Assistant Dean, School of Nursing
University of Pittsburgh
1998-2002 (Vice Chair 1998-2000, Chair 2001-2002)

Carol A. Ledbetter
Associate Dean and Professor, School of Nursing
Oregon Health & Science University
2007-

Marsha Lewis
Associate Professor and Director of Graduate Studies, School of Nursing
University of Minnesota
2003-2005

Mary Margaret Mooney
Professor, Department of Nursing
North Dakota State University
2003-2006 (Treasurer 2003, Chair 2004-2005)

Susan L. Woods
Associate Dean for Academic Programs, School of Nursing
University of Washington
1998-2003 (Secretary 1998-2000, Vice Chair 2003)

Appendix E (continued)

Practicing Nurse Representatives

Anne Wojner Alexandrov
Professor, NET SMART Project Director
and Attending Nurse
University of Alabama at Birmingham
Comprehensive Stroke Center
2003-2008

Constance Taylor Curran
Community Health Nurse
Bayside Community Center
2007-2008

Patricia Eisenberg
Clinical Nurse Specialist
Community Health Network
2004-2006

Susan A. Fontana
Family Nurse Practitioner
Alexian Brothers Medical Center
1998-2004

Renee Holleran
Chief Flight Nurse and Emergency
Clinical Nurse Specialist
University of Cincinnati Hospital
1998-2003 (Secretary 2003)

Barbara R. Kelley
Pediatric Nurse Practitioner,
Massachusetts General Hospital
Chelsea Health Center
1998-2001 (Secretary 2001-2002)

William Michael Scott
Director, School of Nursing Clinics
Duke University
2005- (Secretary 2007, Treasurer 2008)

Professional Consumer Representatives

Lynn Babington
Director of Clinical Programs
Health Services Partnership of Dorchester
2002-2005 (Vice Chair 2004-2005)

Charlotte F. Beason
Program Director, Nursing Strategic
Healthcare Group
US Department of Veterans Affairs
1998-2003 (Vice Chair 2001-2002, Chair 2003)

Charlotte C. Dison
Vice President and Chief of Nursing Services
Baptist Hospital of Miami
1998-1999

Mary Ann McGinley
Senior Vice President for Patient Services
and Chief Nursing Officer
Thomas Jefferson University Hospital
2004- (Treasurer 2006-2007, Secretary 2008)

Thomas Smith
Senior Vice President, Patient Care Services
and Chief Nursing Officer
Cambridge Health Alliance
2006-2008

Nancy R. Sypert
Director of Medical-Surgical Services
Shands at Alachua General Hospital
2000-2001

Public Consumer Representatives

Gary L. Filerman
Consultant
1998-1999

Donald R. Mattison
Senior Advisor, National Institutes
of Child Health and Human Development
National Institutes of Health
2000-2006 (Treasurer 2004-2005)

S. Regina Smith
President
Service Center for Non-Profits
2007

Caroline B. Stellmann
President
Stellmann Associates
2000-2005

Jane Voglewede
Associate General Counsel
MeritCare Health System
2006-

Douglas L. Wood
President
American Association of Colleges
of Osteopathic Medicine
1998-1999

Appendix F

CCNE Standing Committees (1998-2008)

Accreditation Review Committee

Lynn Babington
Associate Professor, School of Nursing
Northeastern University
2003- (Co-chair 2004-2005)

Charlotte F. Beason
Program Director, Nursing Strategic Healthcare Group
US Department of Veterans Affairs
1999-2003 (Co-chair 1999-2003)

Donna L. Boland
Associate Professor and Associate Dean for Undergraduate Programs
School of Nursing, Indiana University
1999-2002

Mary Louise Brown
Chair and Professor, School of Nursing
Milwaukee School of Engineering
2004

Patricia A. Burns
Dean and Professor, College of Nursing
University of South Florida
2002-2007

Mary Jo Clark
Professor, Hahn School of Nursing and Health Science
University of San Diego
1999-2003, 2006- (Co-chair 2006-)

Mary S. Collins
Dean and Professor, Decker School of Nursing
SUNY Binghamton University
1999-2004

Nadine Coudret
Dean, College of Nursing and Health Professions
University of Southern Indiana
2008-

Lynda J. Davidson
Assistant Professor and Assistant Dean, School of Nursing
University of Pittsburgh
2000

Charlotte C. Dison
Vice President and Chief of Nursing Services
Baptist Hospital of Miami
1999-2001

Sandra R. Edwardson
Dean and Professor, School of Nursing
University of Minnesota
1999-2002

Patricia Eisenberg
Clinical Nurse Specialist
Community Health Network
2005-2006

Harriet R. Feldman
Dean and Professor, Lienhard School of Nursing
Pace University
2007- (Co-chair 2007-)

Timothy M. Gaspar
Dean, College of Nursing and Health Sciences
Winona State University
1999-2003

Renee Holleran
Chief Flight Nurse and Emergency Clinical Nurse Specialist
University of Cincinnati Hospital
1999-2003

Carolina G. Huerta
Chair and Professor, Nursing Department
University of Texas-Pan American
2003-

Betty M. Johnson
Chair, Department of Nursing
Clinch Valley College of the University of Virginia
1999-2001

Barbara R. Kelley
Pediatric Nurse Practitioner,
Massachusetts General Hospital
Chelsea Health Center
1999-2002

Elizabeth Connelly Kudzma
Professor, Division of Nursing
Curry College
2005-

Appendix F (continued)

Marsha Lewis
Associate Professor and Associate Dean for Education, Nell Hodgson Woodruff School of Nursing
Emory University
2004-

E. Jane Martin
Dean, School of Nursing
West Virginia University
2003- (Co-chair 2004-2006)

Julie L. Millenbruch
Associate Professor, Division of Nursing
Alverno College
1999-2002

Dianne Cooney Miner
Dean, Wegmans School of Nursing
St. John Fisher College
2005-

Mary Margaret Mooney
Chair and Professor, Department of Nursing
North Dakota State University
2001-2007

Linda K. Niedringhaus
Director, Deicke Center for Nursing Education
Elmhurst College
2002-2007

Jeanne M. Novotny
Dean and Professor, School of Nursing
Fairfield University
2008-

William Michael Scott
Director, School of Nursing Clinics
Duke University
2007-

Roy Ann Sherrod
Professor
Capstone College of Nursing
The University of Alabama
2003-

Anita Hupy Siccardi
MSN Coordinator, School of Nursing
University of Indianapolis
2004-

Heidi Taylor
Dean and Associate Professor, College of Nursing and Health Sciences
West Texas A&M University
2004-

Mary P. Watkins
Chair and Professor, Department of Nursing
Delaware State University
1999-2003

Jimmie Williams
Chief Nursing Officer
Columbus Regional Healthcare System
2004

Susan L. Woods
Associate Dean for Academic Programs, School of Nursing
University of Washington
1999-2004 (Co-chair 1999-2003)

Report Review Committee

Anne Wojner Alexandrov
Professor, NET SMART Project Director and Attending Nurse
University of Alabama at Birmingham Comprehensive Stroke Center
2005-

Richardean Benjamin
Chair and Professor, School of Nursing
Old Dominion University
2002-2007

Mecca S. Cranley
Dean and Professor, School of Nursing
SUNY University at Buffalo
1999-2002

Jill B. Derstine
Chair and Professor, Department of Nursing
Temple University
2003-2008 (Chair 2004-2007)

Charlie Jones Dickson
Professor, School of Nursing
The University of Alabama at Birmingham
1999-2001

Peggy Ellis
Clinical Professor, School of Nursing
Saint Louis University
2005-

Appendix F (continued)

Harriet R. Feldman
Dean and Professor, Lienhard School of Nursing
Pace University
2006

Gary L. Filerman
Consultant
1999

Susan A. Fontana
Family Nurse Practitioner
Alexian Brothers Medical Center
1999-2004 (Chair 2000-2003)

Mary Jane S. Hanson
Professor and Director Graduate Program,
Department of Nursing
University of Scranton
2007-

Eleanor V. Howell
Dean, School of Nursing
Creighton University
2007-

Cynthia Huff
Assistant Chair Graduate Studies, Division
of Nursing and Behavioral Health
Carson-Newman College
2004-2006

Barbara R. Kelley
Associate Professor/Director,
Graduate Programs, School of Nursing
Northeastern University
2004-

Martha Griffith Lavender
Dean and Professor, College of Nursing
and Health Sciences
Jacksonville State University
2003-2008

Carol A. Ledbetter
Associate Dean and Professor,
School of Nursing
Oregon Health & Science University
2005-

Donald R. Mattison
Senior Advisor, National Institutes
of Child Health and Human Development
National Institutes of Health
2000-2006

William J. McBreen
Director Master's Program in Nursing,
College of Nursing and Health Sciences
Winona State University
2008-

A. Gretchen McNeely
Associate Dean, College of Nursing
Montana State University-Bozeman
1999-2002

Norann Planchock
Dean and Professor, College of Nursing
Northwestern State University of Louisiana
2007-

Elizabeth Ritt
Professor, College of Nursing
and Health Professions
Lewis University
2003-2004

Mary Jane Schank
Professor, College of Nursing
Marquette University
1999-2002

Nancy R. Sypert
Director of Medical-Surgical Services
Shands at Alachua General Hospital
2000-2006

Suzanne R. Van Ort
Dean and Professor, College of Nursing
The University of Arizona
1999 (Chair 1999)

Jane C. Voglewede
Associate General Counsel
MeritCare Health System
2006- (Chair 2008)

Steven R. Weiner
Senior Director of Patient Access
New York University Medical Center
2003

Budget Committee

Theresa Perfetta Cappello
Dean, School of Health Professions
Marymount University
2003-2004

Appendix F (continued)

Brenda S. Cherry
Dean, College of Nursing
University of Massachusetts Boston
1998-2001 (Chair 1998-2001)

Nadine Coudret
Dean, College of Nursing and
Health Professions
University of Southern Indiana
2002-2003

Nancy O. DeBasio
Dean and President
Research College of Nursing
2005-2006

Dorothy M. Detlor
Dean, College of Nursing
Washington State University
2004-2005

Susan H. Fetsch
Dean and Professor, School of Nursing
Avila University
2007-2008

Alexia Green
Dean, School of Nursing
Texas Tech University Health Sciences Center
2008-

Carolyn S. Gunning
Dean, College of Nursing
Texas Woman's University
2000-2001

Donald R. Mattison
Senior Advisor, National Institutes
of Child Health and Human Development
National Institutes of Health
2004-2005 (Chair 2004-2005)

Mary Ann McGinley
Senior Vice President for Patient Services
and Chief Nursing Officer
Thomas Jefferson University Hospital
2006-2007 (Chair 2006-2007)

Mary Margaret Mooney
Chair and Professor, Department of Nursing
North Dakota State University
2002-2003 (Chair 2002-2003)

Elizabeth Nichols
Dean and Professor, College of Nursing
Montana State University-Bozeman
2006-2007

Grace A. Peterson
Chairperson, Division of Nursing
Concordia University Wisconsin
2000-2002

William Michael Scott
Director, School of Nursing Clinics
Duke University
2008- (Chair 2008-)

Douglas L. Wood
President
American Association of Colleges
of Osteopathic Medicine
1998-1999

Nominating Committee

Kristine Alster
Interim Dean, College of Nursing and Health Sciences
University of Massachusetts Boston
2003

Karen Balakas
Associate Professor, Department of Nursing
Jewish Hospital College of Nursing and Allied Health
2003-2004 (Chair 2004)

Jean E. Bartels
Chair and Professor, School of Nursing
Georgia Southern University
2008

Eleanor F. Bond
Associate Professor, School of Nursing
University of Washington
2000

Linda P. Brown
Professor and Associate Dean and Director
of Undergraduate Studies
School of Nursing
University of Pennsylvania
1999

Patricia A. Burns
Dean and Professor, College of Nursing
University of South Florida
2008

Appendix F (continued)

Sara L. Campbell
Interim Dean and Professor,
Mennonite College of Nursing,
Illinois State University
2007-2008 (Chair 2008)

Janyce G. Dyer
Professor and Associate Dean for Graduate
Programs, School of Nursing
Barry University
2002-2003 (Chair 2003)

Laura Cox Dzurec
Associate Dean and Associate Professor,
School of Nursing
Oregon Health Sciences University
1999

Catherine Earl
Assistant Professor, Kirkhof School of Nursing
Grand Valley State University
2004

Cheryl Easley
Dean, College of Nursing
and Allied Health Sciences
Saginaw Valley State University
1998

Sandra L. Ferketich
Dean and Professor, College of Nursing-
Health Sciences Center
University of New Mexico
2002

Marilyn E. Flood
Associate Dean of Academic Programs,
School of Nursing
University of California, San Francisco
1998

Laurel Garzon
Graduate Program Director, School of Nursing
Old Dominion University
2006-2007 (Chair 2007)

Davina J. Gosnell
Dean and Professor, College of Nursing
Kent State University
2002

Ann M. Gothler
Chair and Professor, Division of Nursing
The Sage Colleges
2001-2002 (Chair 2002)

Dean Gross
Assistant Professor, Department of Nursing
North Dakota State University
2004

Alicia Huckstadt
Associate Professor and Director
Graduate Program, School of Nursing
Wichita State University
2001

Susan R. Jacob
Executive Associate Dean and Professor,
College of Nursing
University of Tennessee Health Science Center
2006

Barbara A. Johnston
Associate Dean for Graduate Programs,
School of Nursing
Texas Tech University Health Sciences Center
2000-2001 (Chair 2001)

Susan M. Kennerly
Associate Dean for Academic Affairs,
College of Nursing
University of Cincinnati Medical Center
2001

Norma Kiser-Larson
Assistant Director, Department of Nursing
North Dakota State University
2006

Catherine J. Knuteson
Associate Professor, Division of Nursing
Alverno College
1999

Patricia Kraft
Dean, Division of Nursing
Carson-Newman College
2005-2006 (Chair 2006)

Michael J. Kremer
Associate Professor, College of Nursing
Rush University Medical Center
2004-2005 (Chair 2005)

Kathleen Krichbaum
Associate Professor and Division Head,
School of Nursing
University of Minnesota
2006

Appendix F (continued)

Christine Latham
Professor, Department of Nursing
California State University, Fullerton
2005

K. Alberta McCaleb
Associate Professor and Chair
Undergraduate Studies, School of Nursing
University of Alabama at Birmingham
2005

A. Gretchen McNeely
Associate Dean, College of Nursing
Montana State University-Bozeman
2007

Karen Devereaux Melillo
Chair and Professor, Department of Nursing
University of Massachusetts Lowell
2008

Kenneth P. Miller
Associate Dean and Professor, College
of Nursing-Health Sciences Center
University of New Mexico
2000

Arlene J. Montgomery
Endowed University Professor and
Associate Director, Nursing Center
Hampton University
2003

Sandra Adams Motzer
Assistant Professor, Department
of Biobehavorial Nursing/Health Systems
University of Washington
2003

Anne Griswold Peirce
Dean and Professor, School of Nursing
University of Mississippi Medical Center
1999-2000 (Chair 2000)

SuEllen Pinkerton
Vice President for Patient Services, Shands Hospital
University of Florida
1998

Sally Rankin
Director of FNP Program, Department
of Family Health Care Nursing
University of California, San Francisco
1998-1999 (Chair 1999)

Mary Jo Regan-Kubinsky
Dean, Division of Nursing and Health Professions
Indiana University South Bend
2005

Arlene A. Sargent
Associate Dean for Program Development
and Undergraduate Studies
Samuel Merrit/Saint Mary's Intercollegiate
Nursing Program
2000

Joyce K. Shoemaker
Dean, School of Nursing
Medical College of Ohio
1998 (Chair 1998)

Terri Simpson
Associate Professor, School of Nursing
University of Washington
2002

Marjorie Smith
Professor, College of Nursing and Health Sciences
Winona State University
1998

Kathleen M. Thies
Associate Professor, Director Graduate
Entry Pathway, Graduate School of Nursing
University of Massachusetts Worcester
2007

Teresa L. Cervantez Thompson
Dean and Professor, College of Nursing
and Health
Madonna University
2008

L. Joyce Washington
Associate Professor, School of Nursing
Barry University
2001

M. Dee Williams
Executive Associate Dean, College of Nursing
University of Florida
2004

Angela F. Wood
Chair for Undergraduate Studies, Division
of Nursing and Behavioral Health
Carson-Newman College
2007

Appendix G

CCNE Standards Committees

Standards Committee 1997

Lynda J. Davidson, Chair
Assistant Professor and Assistant Dean, School of Nursing
University of Pittsburgh

Maria Amayah
Coordinator of Women's Health Care Programs College of Nursing and Health Sciences
University of Texas at El Paso

Elaine Hagenbuch
Professor, School of Nursing
Troy State University

Sandra Jamison
Chair, Department of Nursing
Messiah College

Robert Kirkwood
Retired Executive Director
Middle States Commission on Higher Education

JoEllen Koerner
Vice President, Patient Services
Sioux Valley Hospital

Suzanne R. Van Ort
Dean and Professor, College of Nursing
The University of Arizona

Standards Committee 2002

Carole A. Anderson, Chair
Dean and Professor, College of Nursing
The Ohio State University

Donna L. Boland
Associate Professor and Associate Dean for Undergraduate Programs, School of Nursing
Indiana University

Mary Jo Clark
Associate Dean and Professor, Hahn School of Nursing and Health Science
University of San Diego

Mecca S. Cranley
Dean and Professor, School of Nursing
SUNY University at Buffalo

Pamela Dell Dennison
Clinician 4, Heart Center
University of Virginia Health System

Karin Polifko-Harris
Vice President of System Development and Research
NCH Healthcare System

Joyce Pulcini
Associate Professor, School of Nursing
Boston College

Caroline B. Stellmann
President
Stellmann Associates

Suzanne R. Van Ort
Dean and Professor, College of Nursing
The University of Arizona

Standards Committee 2007

Mary Margaret Mooney, Chair
Professor, Department of Nursing
North Dakota State University

Anne Wojner Alexandrov
Professor, NET SMART Project Director, Attending Nurse
University of Alabama at Birmingham Comprehensive Stroke Center

Mary Jo Clark
Professor, Hahn School of Nursing and Health Science
University of San Diego

Patricia Clinton
Director of Master's and DNP Programs, College of Nursing
The University of Iowa

Lynda J. Davidson
Dean, School of Nursing and Health Sciences
Robert Morris University

Elizabeth Fuselier Ellis
Chief of Advanced Practice
Memorial Hermann Hospital-Texas Medical Center

Appendix G (continued)

Barbara R. Kelley
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Appendix H

ASPA Member Code of Good Practice

An accrediting organization holding membership in the Association of Specialized and Professional Accreditors (ASPA):

1. Pursues its mission, goals, and objectives, and conducts its operations in a trustworthy manner.
   - Focuses primarily on educational quality, not narrow interests, or political action, or educational fashions.
   - Demonstrates respect for the complex interrelationships involved in the pursuit of excellence by individual institutions or programs.
   - Exhibits a system of checks and balances in its standards development and accreditation procedures.
   - Maintains functional and operational autonomy.
   - Avoids relationships and practices that would provoke questions about its overall objectivity and integrity.
   - Analyzes criticism carefully and responds appropriately by explaining its policies and actions and/or making changes.
2. Maximizes service, productivity, and effectiveness in the accreditation relationship.
   - Recognizes that teaching and learning, not accredited status, are the primary purposes of institutions and programs.
   - Respects the expertise and aspirations for high achievement already present and functioning in institutions and programs.
   - Uses its understanding of the teaching and learning focus and the presence of local expertise and aspirations as a basis for serving effectively at individual institutions and programs.
   - Keeps the accreditation process as efficient and cost-effective as possible by minimizing the use of visits and reports, and by eliminating, wherever possible, duplication of effort between accreditation and other review processes.
   - Works cooperatively with other accrediting bodies to avoid conflicting standards, and to minimize duplication of effort in the preparation of accreditation materials and the conduct of on-site visits.
   - Provides the institution or programs with a thoughtful diagnostic analysis that assists the institution or program in finding its own approaches and solutions, and that makes a clear distinction between what is required for accreditation and what is recommended for improvement of the institution or program.
3. Respects and protects institutional autonomy.
   - Works with issues of institutional autonomy in light of the commitment to mutual accountability implied by participation in accreditation, while at the same time, respecting the diversity of effective institutional and programmatic approaches to common goals, issues, challenges, and opportunities.
   - Applies its standards and procedures with profound respect for the rights and responsibilities of institutions and programs to identify, designate, and control (a) their respective missions, goals, and objectives; (b) educational and philosophical principles and methodologies used to pursue functions implicit in their various missions, goals, and objectives; (c) specific choices and approaches to content; (d) agendas and areas of study pursued through scholarship, research, and policy developments; (e) specific personnel choices, staffing configurations, administrative structures, and other operational decisions; and (f) content, methodologies, and timing of tests, evaluations, and assessments.
   - With respect to professional schools and programs, recognizes the ultimate authority of each academic community for its own educational policies while maintaining fundamental standards and fostering consideration of evolving needs and conditions in the profession and the communities it serves.
4. Maintains a broad perspective as the basis for wise decision making.
   - Gathers and analyzes information and ideas from multiple sources and viewpoints concerning issues important to institutions, programs, professions, publics,

governments, and others concerned with the content, scope, and effectiveness of its work.

- Uses the results of these analyses in formulating policies and procedures that promote substantive, effective teaching and learning, that protect the autonomy of institutions and programs, and that encourage trust and cooperation within and among various components of the larger higher education community.

5. Focuses accreditation reviews on the development of knowledge and competence.
   - Concentrates on results in light of specific institutional and programmatic missions, goals, objectives, and contexts.
   - Deals comprehensively with relationships and interdependencies among purposes, aspirations, curricula, operations, resources, and results.
   - Considers techniques, methods, and resources primarily in light of results achieved and functions fulfilled rather than the reverse.
   - Has standards and review procedures that provide room for experimentation, encourage responsible innovation, and promote thoughtful evolution.
6. Exhibits integrity and professionalism in the conduct of its operations.
   - Creates and documents its scope of authority, policies, and procedures to ensure governance and decision making under a framework of "laws not persons."
   - Exercises professional judgment in the context of its published standards and procedures.
   - Demonstrates continuing care with policies, procedures, and operations regarding due process, conflict of interest, confidentiality, and consistent application of standards.
   - Presents its materials and conducts its business with accuracy, skill, and sophistication sufficient to produce credibility for its role as an evaluator of educational quality.
   - Is quick to admit errors in any part of the evaluation process, and equally quick to rectify such errors.
   - Maintains sufficient financial, personnel, and other resources to carry out its operations effectively.
   - Provides accurate, clear, and timely information to the higher education community, to the professions, and to the public concerning standards and procedures for accreditation, and the status of accredited institutions and programs.
   - Corrects inaccurate information about itself or its actions.
7. Has mechanisms to ensure that expertise and experience in the application of its standards, procedures, and values are present in members of its visiting teams, commissions, and staff.
   - Maintains a thorough and effective orientation, training, and professional development program for all accreditation personnel.
   - Works with institutions and programs to ensure that site teams represent a collection of expertise and experience appropriate for each specific review.
   - Conducts evaluations of personnel that involve responses from institutions and programs that have experienced the accreditation process.
   - Conducts evaluations of criteria and procedures that include responses from reviewers and those reviewed.

Adopted by the ASPA Membership:
March 21, 1995

Appendix I

Alliance for Nursing Accreditation Statement on Distance Education Policies

The growth of distance education courses and programs for the delivery of nursing education has increased and is expected to continue to increase. Recognizing this growth and the need to ensure the public that nursing education programs maintain a high standard of quality, the Alliance for Nursing Accreditation endorses the following standard:

All nursing education programs delivered solely or in part through distance learning technologies must meet the same academic program and learning support standards and accreditation criteria as programs provided in face-to-face formats, including the following:

- Student outcomes are consistent with the stated mission, goals, and objectives of the program; and
- The institution assumes the responsibility for establishing a means to assess student outcomes. This assessment includes overall program outcomes, in addition to specific course outcomes, and a process for using the results for continuous program improvement.

Mechanisms for ongoing faculty development and involvement in the area of distance education and the use of technology in teaching-learning processes are established. Appropriate technical support for faculty and students is provided.

When utilizing distance learning methods, a program provides learning opportunities that facilitate development of students' clinical competence and professional role socialization and establishes mechanisms to measure these student outcomes.

When utilizing distance learning methods, a program provides or makes available resources for the students' successful attainment of all program objectives.

Each accreditation and program review entity incorporates the review of distance-education programs as a component of site visitor/evaluator training.

Appendix J

CCNE Task Force on Post-Baccalaureate Nurse Residency Program Accreditation

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