
ARTICLES

Why Competencies in Graduate Health Management and Policy Education?

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ABSTRACT

During the past decade there has been a growing interest in learning and competency-based systems in various areas of education, training, and professional development. As a result, a number of competency initiatives have been undertaken across the health professions, including medicine, nursing, and pharmacy. Concurrent with these activities have been the resounding calls for: 1) both curricular content and process review in health administration and related training programs, 2) rethinking and reform of current educational practices, and 3) evidence-based, outcomes-focused education in health management and policy education.

In spite of governmental mandates and accrediting body specification for educational improvement, the debate about the use of competency models, competencies themselves, and competency-based education (CBE) still continues in a number of post-secondary educational settings—both within and outside of the professions. Specifically, faculties in health management and policy educational programs, including undergraduate and graduate education across the US, have questioned the need for the evolving competencies, competency models, and outcomes-based educational processes and assessment methods currently being developed and or adopted within the profession.

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Outlined in this paper are four of the current inflection points related to the competency/outcomes-based movement in the professions during the past decade: 1) The Changing Workforce and Workplace, 2) Reform in the Educational Continuum, 3) Evolving Accreditation Requirements, and 4) Continuous Quality Improvement (CQI) in Health Management and Policy Education.

...there are a series of reports about professional Schools—that professional schools have failed to teach the skills of the 21st century, that they have failed to keep up with the change in the labor market, that they have failed to prepare people for jobs, they are too academic, and they are too research-oriented. You can see this in law schools, nursing schools, medical schools, and you see it in education schools. ...these are the complaints from the external community—the employer community, those representing workers...these problems look the same place after place and you see the similarities between these complaints.

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INTRODUCTION

After several decades of exploring and importing pedagogical theory and best practices, a number of health professions during the early 1990's developed educational and professional development competency models and initiated the deployment of outcomes or competency-based education to: 1) provide greater specification regarding the expected standards for the profession, 2) enhance the quality of their educational programs, and, ultimately, 3) to better prepare their graduates for their roles upon graduation (Calhoun, Davidson, Sinioris, Vincent, & Griffith 2002). Early adopters for educational reform in the health professions included medicine, nursing, dentistry, and pharmacy. Starting with government funding in the early 1970's, these professions enlisted the assistance of professional educators in developing and enhancing educational programming in their respective disciplines; engaged in national demonstration activities and networking to enhance their curricula; joined consortia for sharing educational resources and best practices; and invested in offices of education for their schools and programs (McGuire, Foley, Gor, & Richards 1983; Hitchcock 2002).

Concurrent with these activities were the resounding calls for: 1) both curricular content and process review in health administration and related training programs (Pew Health Professions Commission 1993; Dalston

& Bishop 1995; Bishop, Ferran, & Bishop 2001), 2) rethinking and reform of current educational practices (Boufford 1999), and 3) evidence-based, outcomes-focused education in health management and policy education (Griffith 1998; Calhoun, et al. 2002). Hence, during the past decade there has been a growing interest in learning and competency-based systems in various areas of education, training, and professional development, especially in higher education (Calhoun, Vincent, Baker, Butler, & Sinioris 2004). As a result, a number of competency initiatives have been undertaken across the health professions, including healthcare management. These initiatives have been outlined previously by both Garman and Johnson (2006) and Calhoun et al. (2002), with significant detail regarding related terminology and the structure of competencies versus learning objectives being addressed by Calhoun et al. (2002). Nevertheless, the debate about the use of competency models, competencies themselves, and competency-based education (CBE) still continues in post-secondary educational settings today—both within and outside of the professions. Specifically, faculties in health management and policy educational programs—including undergraduate and graduate education—across the US have continued to question the need for the evolving competencies, competency models, and the outcomes-based educational processes and assessment methods currently being developed and or adopted within their profession, as well as by their accrediting bodies (Kovner 2007; Studer 2007).

A great deal of variability still exists today in relation to the terms associated with competency-based modeling and measurement. The terms are often used in many different ways or interchangeably. Competency-based education and testing (CBET) in itself has a number of other frequently used synonyms, such as “outcome-based education” (OBE), “criterion-based outcomes” (CBO), “criterion-referenced education” (CRE), “standards-based instruction” (SBI), “evidence-based education” (EBE), etc. Equally confusing to many educators is the differentiation between a competency and a learning objective—the latter most often being viewed as the incremental learning experiences at the course and experiential levels that lead to the development of the competencies (Calhoun, Ramiah, Weist, & Shortell 2008).

Due to the lack of a common lexicon, confusion also arises among educational development groups, even in identifying “what it is” that they are striving to achieve through the deployment of competency-based educational principles and approaches (Calhoun et al. 2002). As Marcolin, Campeau, Munro and Huff (2000) report, the proliferation of approaches on the concept of competency has hindered the creation of a cumulative

body of knowledge for educational enhancement. Westera (2001) points out that there are two distinct denotations of competencies in education. From a *theoretical* perspective, competence is perceived as a cognitive structure that facilitates specific behaviors. From an *operational* approach, competencies are seen to cover both a broad range of higher-order skills—including knowledge, skills, attitudes, meta-cognition, and behaviors that represent the ability to cope with complex and unpredictable situations—and strategic thinking and behaviors that presuppose conscious and intentional decision-making.

Many associate competence (Goldstein 1995; Klein 1996) with expert behavior. For instance, the Healthcare Financial Management Association (HFMA) competency definition focuses on “outstanding performance” and “top performers” (Clarke 2002). Similarly, the National Center for Healthcare Leadership (NCHL) defines competency as those attributes that distinguish “outstanding” from “typical” performance (Calhoun 2004). In contrast, Dreyfus and Dreyfus (1986), treat competence as a stage preceding advanced stages of proficiency and expertise. Hence, in this model the range of proficiency varies across different groups, as well as across the different career stages. In the general human resources literature, the construct is most often operationalized as the minimal level of performance to successfully complete a task.

Beyond terminology, another major argument in the CBET debate is based on the premise that there is no proof that competency-based teaching and learning strategies will impact: 1) the quality of the education that students receive; 2) student capabilities upon graduation from their programs; or 3) the industries in which they will be employed (Kovner 2007). Therefore in lieu of such evidence for change, “continue as we have for decades” or “do nothing differently” strategies are inferred as viable options—or the pathway of least resistance—in spite of no widely known or accepted body of research supporting that prior strategies and educational approaches have, as well, either been effective or of relevance during the past few decades. In fact, current non-outcome-based educational methodologies continue to be called into question by both professional educators and employers in the health professions (Grubb 1995; Manno 1995; Judy & D’Amico 1998; Institute of Medicine 2003; Karoly & Panis 2004; Gandossy, Tucker, & Verna 2006).

The debates and suggestions regarding alternative approaches to CBET continue despite the repeated and informed calls for educational reform, outcomes-based education, and behaviorally-focused curricula across the professions not only by leaders within their own professions, but as well by

those involved with the three seminal Institute of Medicine (IOM) Reports (IOM 1999; IOM 2001; IOM 2003). The most recent IOM Report, *Health Professions Education: A Bridge to Quality* (2003); forcefully lays out the need for improved educational programming based on specified behavioral outcomes to improve healthcare services and outcomes in the US. As stated in the preface, *A Bridge to Quality* makes the case that reform of health professions education is critical to enhancing the health of the United States and that inter-professional core competencies are essential for this reform.

Faculty across the professions also continue to struggle with both the reasons for changes in current educational methodologies as well as the “how to’s” for getting started; the first obstacle often being how to address faculty questions and doubts regarding the “why’s” for the inevitable transformation taking place across the entire spectrum of education today. As is widely recognized and supported by the Association of University Programs in Health Administration (AUPHA 2004), most faculties in the professions continue to have discipline-specific teaching credentials, with few having formal degrees or training backgrounds in the field of education. Therefore they establish their courses and teaching methods based on the way they learned and with which they are most comfortable, versus using well-vetted educational best practices and newer technologies (van der Vleuten 2000; Tannenbaum 1994); the predominant method most frequently being the lecture format focused on the transfer of knowledge (Wass 2001; IOM 2003; Calhoun & Wainio 2007). In contrast, employers continue to call for graduates who can enter the workforce better prepared to quickly contribute to the efficiency and productivity of the organization (Judy & D’Amico 1998; Gandossy et al. 2006). Therefore the preference is not only for highly knowledgeable graduates, but also those with well-developed behavioral and technical skills (Karloly & Panis 2004; Warden 2001). As a result, students entering graduate programs today are increasingly expecting to gain the essential knowledge for their future roles in the professions, as well as the skills sets viewed as essential for success in their career progression.

Outlined in this paper are four of the current inflection points for the competency/outcomes-based movement in the professions during the past decade: 1) The Changing Workforce and Workplace, 2) Reform in the Educational Continuum, 3) Evolving Accreditation Requirements, and 4) Continuous Quality Improvement (CQI) in Health Management and Policy Education.

THE CHANGING WORKPLACE AND WORKFORCE:

The many contributing forces that have led to the continual shaping and re-

shaping of the workforces and workplaces both within the US and globally have been well-laid out for the 21st century in many recent sources (Judy & D'Amico 1998; Karoly & Panis 2004; Gandossy, et al. 2006; ASTD 2006). Given the mounting challenges in the industry, the nature of work and skill requirements are rapidly changing for those in the health professions particularly. The notion that positions as a static set of roles and responsibilities has clearly given way to the description of positions in more general terms, allowing for greater flexibility and adaptation to changing organizational needs (Garman & Johnson 2006).

Key to optimal performance for both individuals and organizations in the accelerating pace of change in the health care industry today are critical behavioral and technical skill sets built on a foundational knowledge base. As noted by Karoly and Panis (2004), knowledge alone is no longer a major differentiator in terms of performance in today's workplace; an essential characteristic for future workforces will be their skill sets and the level of proficiency in each. Knowledge is a baseline expectation that is assumed across graduates with specific degrees or from certain professional programs. In the future, behaviorally-based and measurable skills that are transferable across a wide array of health care management and policy positions will be preferred, used for final employment selection, and more highly compensated.

Examples of some of the universal skills for optimal job performance or leadership repeatedly addressed in the contemporary management literature include: collaboration (Wess 2005), process improvement (Matla 2003), relationship and team building (Clements 2007), and talent development (Ulrich 2004). In addition, the emotional intelligence competencies as outlined by Goleman (2000) and the "soft skills" in management are increasingly being referenced as essential for optimal success in the field (Dvorak 2007).

Critical to student or worker development of competency is an understanding of the specific behaviors that encompasses a specific skill—i.e. how is proficiency in *process improvement* exemplified, measured, and subsequently acquired and in which learning environments and by which method is such optimal. This is the context in which outcomes-based education will need to be framed for the decades ahead, as both future student and employer buyers will be expecting such and making final decisions based on the proven outcomes among the many educational provider options (Karoly & Panis 2004). Healthcare will continue to change and require a highly skilled workforce that readily adapts for lifelong learning. A prerequisite for ensuring such will be the identification and specification of skill sets—or

competencies—that accommodate these transformation processes (Judy & D’Amico 1998; Karoly & Panis 2004; Gandossy et al. 2006).

REFORM IN THE EDUCATIONAL CONTINUUM

The lengthy thirty-to-forty year debate regarding the pros and cons of competency or outcomes-based education (Table 1) has been somewhat quelled during the past decade by both professional educators and practitioners in pedagogy, as well as in the fields of education and professional development, including the health professions (Garman & Johnson 2006; Calhoun et al. 2002). Additional experience with the principles of outcomes-based education and the deployment of related educational practices has led to both the increasing calls for and the use of these CBET across the entire educational continuum. In 2005, the US Secretary of Education, Margaret Spellings, formed the Commission on the Future of Higher Education: 1) to ensure that the nation’s students across all educational settings are being equipped with the skills for success in the 21st century, and 2) to develop a comprehensive strategy for postsecondary education that would better serve America and address the economic and workforce needs for our nation’s future (DOE 2006b).

With the emphasis on the compliance requirements for the congressionally-mandated and federally-funded US Department of Education (DOE) “No Child Left Behind” program to strengthen K-12 education, there are few elementary school curricula in the U.S. not based on clearly outlined and communicated educational specifications. These outcomes are expected to be achieved during each grade level, as well as throughout the entire curriculum. Both students and parents in these programs are continually and fully informed regarding what a student should both “know” and be capable of “doing”—both behaviorally and technically: 1) at each specific grade level, 2) by the time of the year in the educational process, and 3) in relation to level of proficiency. Detailed performance measurement and reporting systems are used to specify all educational outcomes throughout the progression of the learning process. In these reports the specific skills required in each content area are outlined behaviorally and in measurable terms. No actions are stated in relation to general “knowing”, “understanding”, or “appreciating”, but rather in relation to what the student can be directly observed doing as evidence of their achievement from the concerned educational process and other related learning activities.

In addition to the clearly articulated outcomes for all involved stakeholders—students, parents, teachers, administrators, policy makers, and educational funding agents—all teachers, regardless of their areas of

Table I: Competency-based Education - Key Trends, Issues, Benefits and Barriers Addressed in the Accreditation Literature

Trends

- Challenges of 21st century health practice
- Ongoing changes in practice environments
- Increased emphasis on accountability in higher education
- Proliferation of competency-based education mandates
- Incorporation of competencies in accreditation criteria
- Development of voluntary profession-based credentialing

Benefits

- Specification of essential knowledge, skills and other attributes for performance
- Clarification of goals, targets, and gaps for improvement
- Alignment of educational process and practice needs
- Curriculum balance and continuity
- Common goal-setting opportunities – faculty and students
- Basis for continual quality improvement in teaching and evaluation
- Enhanced learning outcomes
- Potential for higher levels of mastery
- Facilitation of learner-mentor dialogue
- Opportunities for more relevant real-world, work-like assessment
- Goal-oriented career planning
- Portfolio development based on strengths and accomplishments
- Identification of weakness for development
- Enhanced inter-profession communication and planning

Issues and Barriers

- Confusing and inconsistent terminology
 - Faculty consensus/acceptance
 - Innate resistance to change
 - Methodological deployment complexities
 - Lack of faculty understanding regarding pedagogical best practices
 - Costs and time requirements
 - Questionable assessment mechanisms and defensibility
 - Limited faculty knowledge and facility with alternative assessment methods (beyond written examinations and papers)
 - New development investments versus adoption of others' practices
-

specialization, are regularly provided continuing in-service education and professional development opportunities. These activities are strongly recommended and reinforced, even required, to enhance their teaching, learning, and assessment methods and to optimize both competency-based educational processes and outcomes for each student.

Although the Spelling Commission and the related deployment processes have met with controversy, the widely recognized principles of the “No Child Left Behind” legislation are being expanded across all grades throughout exemplar school districts and others nationally. With continued congressional support for strengthening K-12 education and aligning high school standards with college expectations, schools will be held accountable for both educational quality and results (DOE 2006b). The impact of such indicates there may be increased expectations from both parents and students in relation to what can be achieved from the educational activities and processes engaged in across the varying educational settings. Of equal importance is that these will be the students in the decades ahead—most likely with intense parental involvement—applying to and graduating from the country’s post-secondary education colleges and universities, and ultimately perhaps entering the health professions.

Similar skill-focused educational and professional development approaches are also now widely used throughout many employment arenas both within and outside of health care (Intagliata, Ulrich, & Smallwood 2000). Core competency employee expectations are increasingly being specified by many Fortune 500 companies, as well as by large healthcare delivery systems—Catholic Health Association, Providence Health System, Bon Secours, Catholic Health Initiatives, Christus Health, Wheaton Franciscan Services, Trinity Health and Ascension Health (O’Toole, Rocklage, Ballard, & Pingleton 2007; Giganti 2002). Competencies and competency models are identified and widely communicated throughout these organizations. Employee development and performance assessment methods and programs are also set up based upon the competencies specified for both specific roles and continued organizational improvement and progress.

Given the changing work landscape—as well as the congressionally-sanctioned initiatives, the increasing need for a more highly skilled workforce, and the growing emphasis and significant investments in “foundational workforce skills” and “career readiness” certification in over 40 states today (DOE 2006a)—the identification and specification of standards for educational outcomes will most likely continue to be emphasized across the entire spectrum of education, training, and professional development in the decades ahead (American Society for Training and Development 2006).

EVOLVING ACCREDITATION REQUIREMENTS

Central to the IOM’s vision for health professions education is the integration of a core set of competencies—one that is shared across the professions—into the health professions oversight spectrum (IOM 2003). In an effort to increase

transparency and accountability in post-secondary education specifically, Secretary Spelling convened members of the related accrediting communities in 2006 to move toward measures that place more emphasis on learning and less on inputs in the nation's institutions of higher education. In support of the proposals from this group, funding has been committed by the Department of Education to colleges, universities, and states that collect and publicly report student learning outcomes (DOE 2006c).

Spurred by the recognition that with changing healthcare industry technology and work organizations, professional schools, like other industries, are also being called upon to do more to equip their graduates with more sophisticated and higher level skills, not just knowledge alone (Karoly & Panis 2004; Judy & D'Amico 1998; Grubb 1995). These concerns have set in motion a growing demand for clearer, higher, and measurable educational outcomes, as well as increased industry input into the development of the standards for such (Grubb 2004; Lankard 1995). This push for both increased standards and accountability in education has also been intensified by other national educational policy initiatives over the past decade.

In the early 1990's, the US Departments of Education and Labor supported 22 projects to create skill standards for a wide variety of occupations and industries. The National Skills Standards Board (NSSB), authorized in 1994 by the Goals 2000: Educated American Act, built on these projects and the efforts of other industrial and occupational groups that have established skill standards. The purpose of this Act was to stimulate the development of a voluntary national system of skill standards by creating a framework of career clusters within which skills standards can be developed (DOE 1999). In support of this goal, the NSSB (which became the National Skill Standards Board Institute (NSSBI) in 2003) continues to support partnerships of business, trade associations, education, community organizations, and other stakeholders in the development of educational skill standards. It also endorses skill-based outcomes systems developed by industry-labor-education partnerships.

Similar changes in accreditation standards have also taken place across the core health professions of dentistry, medicine, nursing, and pharmacy. A review of the accreditation standards for these professions over the past five to seven years clearly reveals a change of emphasis from knowledge-oriented content areas and disciplines to competencies, skills sets, and performance outcomes, with nearly all addressing the need for competency-based curricular specification in some form. An array of the rationales provided in the resource materials for the four health professions accrediting bodies which have to date either developed specific competencies or advocated for the

Table 2: Accreditation Rationales for Specification of Educational Competencies and Standards

Curriculum Development
- Establish vision for CQI
- Specify foundational knowledge, skills, attitudes & behaviors
- Guide planning
- Frame goals
- Formalize processes
- Specify instructional events and methods
- Establish teaching/learning expectations and outcomes
- Adjust levels/domains of learning
- Increase relevancy and applicability
- Facilitate coordination & coherency: <ul style="list-style-type: none"> - sequencing - content integration - methods of pedagogy - processes for evaluation
- Align institution/program missions and goals with practice needs
- Determine essential resources
Evaluation
- Assess course/program effectiveness
- Guide assessment of student performance and achievement
- Determine adequacy of resources
- Track progress
- Determine comparability of educational experiences
- Align evaluation methods with expected learning outcomes
- Identify equivalency of evaluation methods
- Increase accountability
- Monitor content
- Measure workload
- Benchmark with other courses/programs/institutions
Student Selection and Counseling
- Identify criteria
- Align class/program size with resources
- Establish norms
- Standardize policies and procedures
- Facilitates career planning and experiential portfolio development
Other
- Guide affiliations
- Direct professional development and continuing education
- Facilitate faculty development
- Meet demand and challenges of 21 st century employment

use of CBE are listed in Table 2. These oversight groups include the American Board of Dental Public Health (1998), Commission on Accreditation of Healthcare Management Education (2007), Council of Education for Public Health (2005), and Liaison Committee on Medical Education (2006).

In concert with the changes in accreditation standards in other health professions, the Commission on Accreditation for Health Management Education (CAHME) also recently changed their standards to require the: 1) adoption of competencies as the basis for guiding an accredited program's curricular planning, and 2) linking of course content and learnings to the specified competencies. Starting in 2008, any program seeking CAHME accreditation will have to provide the competency model that drives curriculum design and planning, teaching, learning, and educational assessment in the program—the preference being for one that is evidence-based and validated in relation to proven performance in the field. In addition, a justification for the selected model will also have to include an overview of the alignment of the model with both the program's mission and the types of jobs their students enter upon completion of the program.

CONTINUOUS QUALITY IMPROVEMENT (CQI) IN HEALTH MANAGEMENT AND POLICY EDUCATION

In order to ensure responsiveness to the changing forces in the workplace, education at large, and accreditation, the educational process in health management and policy education will need to be either enhanced or significantly changed—going beyond, heretofore, only the calls for transformation (Boufford 1999; Griffith 2000; Warden 2001). Future students across the health professions will expect greater specificity in the learning outcomes—beyond traditional general knowledge, understanding, and appreciation of the healthcare industry learning objectives—in order to meet evolving employer expectations (Karoly & Panis 2004). Advanced students entering these programs, especially those with prior experience in the field, will also seek out and/or pay for those programs and institutions which can document the critical skills sets they will gain during their educational experiences to optimize their employment opportunities (Judy 1998). As well, the students of the decades ahead will be drawn to those educational experiences which utilize both learning and teaching methods aligned with their contemporary learning styles (Karoly & Panis 2004).

In her 1999 Andrew Pattullo Lecture, Jo Ivey Boufford stated that the process of educational design at the professional school level will have to incorporate a combination of the core knowledge and skills needed in our field, influenced by the need for a timely response to the challenges graduates

will face. Such requires knowledge of both the demands of employers and feedback from alumni and students. It will therefore be the responsibility of the concerned educators and practitioners to look ahead for developing trends and paradigms for action that will allow both students and faculty—in their own intellectual inquiry—to push the envelope further and to proactively shape the field of management. We can no longer just respond to the environment around us. Faculty in health sector management and policy face a double challenge in teaching—not just “what” or “how to,” but also “what for” (Boufford 1999).

Although teaching facility and expertise is often assumed with college and university faculty appointments, it is widely recognized by both students and faculty themselves that significant variability exists. If the educational transformations being called for in health professions education are to be realized, concerned faculties will first have to gain consensus that—as in all of healthcare—continual quality improvement in their curricular activities, including both content and process, will need to be embraced, encouraged, invested in, and supported. The competing demands of teaching, research, and service often preclude a balanced emphasis on each. Nevertheless, education is the core mission in the nation’s colleges and universities and as in the pursuit of all new knowledge and innovation, recognized best practices and developing science across disciplines should be considered.

The evolving art and science of the discipline of education will also need to be: 1) reviewed for increased faculty awareness and understanding, and 2) analyzed for relevance and applicability within the context of health management and policy education. As noted by Garman and Johnson (2006), leaders in education should be particularly open to cutting-edge approaches and should foster a climate of creativity and a sense of safety in trying new things. A philosophy of altruistic pedagogical enhancement and the inclusion of best practices in education will need to be a part of ongoing faculty development sessions. Such will also need to be incorporated into learning and assessment activities in line with the work environments and challenges that the students will be immediately facing upon graduation. Lecturing and passive knowledge transfer, which has repeatedly been shown to be less effective in terms of longer-term retention and performance outcomes (IOM 2003; Wass 2001; van der Vleuten 2000; Tannenbaum 1994), will not survive as a single dominant learning methodology in the decades ahead. Both medical and nursing education have adopted methodologies in which students will need to: 1) engage in

reflective observation and evaluation—being able to assess their own skill levels as well as that of their peers based on specific criteria, 2) experience real-world, case-based simulations and problem-solving, and 3) participate in teams with their colleagues in the other professions. When utilized, these methods cannot be adequately understood, deployed or optimized without clarity regarding the specific outcomes to be realized.

DISCUSSION

The four forces addressed above indicate that educational transformation is currently taking place across all levels and types of institutions of education in the U.S. and will gain even more momentum in the decade ahead. Clearly, as with all socio-economic inflection points, these trends will have to be monitored and carefully considered if optimal educational planning and development are to be realized across all of graduate education. Educators in health management and policy education need to be prepared for students who may be coming with increasing expectations regarding not only the knowledge base, but also the specific skills they will have to have for optimizing their employment opportunities upon graduation.

Due to increased pressures in the health industry for optimal performance, as measured by the IOM (1999) six aims—safety, effectiveness, patient-centered, timely, efficient, and equitable care—employers too will be seeking graduates with both the knowledge and skills to be highly performing members of the management team either at the start of their employment or within a few months of their orientation to the organization. Gone are the days when the first year or two upon entry to a profession can be allocated to teaching the skills needed for the professional to perform effectively (Karloly & Panis 2004). Those with advanced skill sets and portfolios of experiences reflecting real-world exposure and achievements will be highly sought after and the first employed (Gandossy, et al. 2006).

The bridge to quality as addressed in the third IOM report cannot be crossed without attending to the core competencies essential for inter-profession collaboration and the improvement of the health of this nation. As recently called for by the ASTD Public Policy Board (2006), identification of competencies is one of the early requisite steps to a comprehensive action plan to take charge of the skills gap within the United States. Whether called personal development standards, essential capabilities, competencies, expected outcomes, or goals, current trends indicate that greater definition and specification of desired and measurable skills in all aspects of healthcare will be expected and respectively called for in the decade ahead (Hitchcock 2002). Once performance expectations are well defined and related assess-

ment processes are clearly specified, both program and student development plans can be outlined—creating clearer pathways to strategies for change management and enhanced educational practices. Having access to such will then hopefully improve higher education's performance and the ability to measure that performance in line with the "bridge to quality" across the health professions, regardless of the degree-granting program.

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