Embedding Interprofessional Accreditation Standards: A National Research Collaboration

Literature Synthesis 2008-2012

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Introduction

“An effective accreditation system exists when a program or organization in higher education can demonstrate through a variety of examples that it is meeting the outset purpose of a program” (Kennedy et al., 2011, p.5).

Accreditation is a major force influencing the educational experiences and curricula in health professional schools. In recent years, attention has turned to interprofessional education as an integral component of accreditation. In 2008 Dr. Vernon Curran completed a comprehensive environmental scan related to accreditation that has been used as a starting point for this literature synthesis. In Curran’s conclusion, accreditation is summarized as i) the gatekeeper for quality, ii) the incentive for improvement and iii) the process that links the agencies and individuals responsible for educational growth and change (Curran V., 2008).

The body of literature over the past 4 years reveals increasing attention to accreditation trends than in the past. Although some of the literature examines the outcomes of accreditation, there is a dearth of information relevant to accreditation language or processes that facilitate embedding IPE in health professional education. It is noteworthy that few papers on learning and education in health care reference accreditation.

The following literature review will be used as a basis for discussions that will take place at a CIHR funded workshop designed to move an accreditation research agenda forward in Canada.

Aims of the Review

The aim of this review is to explore the literature on accreditation trends in the education and training of health care providers and other related professions in order to:

a) describe general trends and new themes in accreditation;
b) identify outcomes, local and global, of IPE accreditation standards on the five domains defined in AIPHE 1 and 2 (resources, organizational commitment, faculty, students, academic program);
c) describe educational outcomes achieved through accreditation (reaction, knowledge, skills, attitudes, behavior etc.) particularly those that are measureable and signaled by accreditation;
d) describe how accreditation has facilitated embedding interprofessional education into curricula,

e) discuss how much “generic language” vs. “program specific language” is recommended for accreditation standards; and

f) inform the AIPHE 2012 Workshop and paper that will discuss next steps needed to embed and strengthen IPE standards in health professional education.

**Method**

A variety of keywords and databases were used to ensure that relevant literature was identified. The methods included a systematic search and analysis of Canadian and international peer-reviewed and grey literature and specific policy and meeting reports from 2008 through to May 2012.

The framework to classify the work was based on the Environmental Scan Report: Interprofessional Education and Accreditation Processes in Pre-Licensure Health Professional Education (Curran, V. 2008) to provide a comparative basis for the findings.

Selection criteria were broad by necessity. All papers describing accreditation and accreditation trends in health related fields were included. Papers were excluded if they were beyond the review period, or lacked relevance to the aims of the synthesis. Exceptions were made for older literature if it had not been included in the Curran review.

Twenty-three papers were reviewed for critical, comparative and descriptive content on accreditation for health care and health care related professions and health care education worldwide. Two were deemed irrelevant.

**Keywords:** interdisciplinary accreditation, accreditation trends, pharmacy accreditation, interprofessional accreditation, medical education accreditation.

**Search Strategy:**

Web of Science: sorting by number of times cited, then following related articles.

Google Scholar: Under advanced search, search keywords in title only “allintitle: ____”.

Pub Med: MeSH indexed terms of combining accreditation and interdisciplinary studies yielded the best results. Accreditation with subheadings ‘trends’ into search builder was also appropriate.
Findings and Discussion

Trends

Based on the review of the literature, several broad themes were identified. The following section highlights the overall trends and illustrates these through quotes and summaries from specific literature sources.

Impact of globalization:

“Global movements of people, pathogens, technologies, financing, information and knowledge underlie international transfer of health risks and opportunities” (Frenk et al., 2010, p. 8). This trend is gaining global attention from developing and growing economies and educational environments. In Canada, where the import of skilled labor is substantial, attention to implications of this trend is important. Accreditation plays a key role in the transferability of health care workers by ensuring equitable knowledge and it can begin to proactively address the resulting issues of global movement both in education and practice.

- “We are increasingly interdependent in terms of key health resources, especially skilled workers” (Frenk et al., 2010, p.8).
- Growth of for-profit proprietary schools challenges accreditation and certification processes that are unevenly practiced worldwide (Frenk et al., 2010).
- “All countries should move to align accreditation, licensing and certification with health goals through engaging relevant stakeholders in setting objectives, criteria, assessment and tracking of accreditation processes”(Frenk et al., 2010, p. 58).
- Global cooperation should be promoted by relevant bodies including WHO UNESCO (Frenk et al., 2010).
- “Globally and even nationally there is little uniformity with respect to qualification and competency of degree holders” (Frenk et al., 2010, p. 23).
- In Halliwell’s paper on veterinary schools, the Euro-wide system of accreditation with sectorial directives is intended to allow a worker with a recognized diploma, free movement through EU. Unfortunately there is an unwillingness to enforce and member states decide for themselves (Halliwell et al., 2004).
- WHO and World Federation for Medical Education are attentive to the need for cross-border education and training and the idea of setting global standards. This is not new in the last decade (Kennedy et al., 2011).
- “Easier mobility and global accreditation standards for medical trainees would assist in addressing the growing challenges that are arising in healthcare. In the
past decade numerous initiatives have been developed worldwide to create consistency of quality assurance standards in higher education…RCPSC and CFPC has recent history of merging standards” (Kennedy et al., 2011, p. 6).

- The evolution of higher education accreditation: 1970’s institutions were regulated by government rules; 1980’s quality assurance policies became the focus; 1990’s free movement of people and open access lead to decentralized European agencies; 1999 Bologna Declaration changed everything. European ministers developed common terminology and guidelines to allow freedom of movement. Voluntary and private accreditation was more successful than government policies at this time (Schwarz et al., 2005).
- Accreditation was adopted in different areas for different reasons. Eastern Europe – state controlled accreditation to address social and political changes; in Germany to address inefficiencies; in UK self-organization was the driver (Schwarz et al., 2005).

**Stakeholder involvement:**

A trend towards broader inclusion of stakeholders such as patients, students and others is often cited as a means to get ‘buy in’ and to improve outcomes. Committed stakeholders bring a wide circle of influence to the task. Phillips in particular reported positive outcomes through a dedicated communication strategy with stakeholders who in turn demonstrated more engagement, stronger commitment and more ownership during revision of pharmacy accreditation standards (Phillips et al., 2012). These trends suggest that participation of external influencers brings better outcomes to the accreditation process.

- “Support from senior leadership and champions is critical” (Bainbridge et al., 2011, p. 7).
- “All countries should move to align accreditation, licensing and certification with health goals through engaging relevant stakeholders in setting objectives, criteria, assessment and tracking of accreditation processes (Frenk et al., 2010, p. 58).
- IOM wants to engage “presidents, deans, department chairs, residency directors in the process of aligning competencies and curriculum to more socially accountable accreditation criteria” (Frenk et al., 2010, p. 32).
- Recommends adding civic leaders and patients (Phillips et al., 2012).

**Influence of accreditation:**

It has been hypothesized that interprofessional criteria must be embedded into accreditation standards as a means to ensure that IPE becomes part of health
education programs. The expectation is that this will lead to collaborative health care and ultimately safer and more effective, efficient patient care. “Accreditation committees have developed and approved explicit standards...that encourage residency programs to...teach competencies” (Bainbridge et al., 2011, p. 7). By including interprofessional language into accreditation, it is believed that IPE will be fostered in a growing number of health care education programs.

- “An area where IPE is particularly gaining traction is through the national accreditation of health education programs” (Bainbridge et al., 2011, p. 6).
- In a comparison of the accreditation standards between eight health education profession programs and academic programs there are...opportunities for IPE that can help address barriers (Brandt et al., 2009).
- Frenk promotes interprofessional and trans-professional education that breaks down professional silos while enhancing collaborative and non-hierarchical relationships in effective teams (Frenk et al., 2010).
- “Many organizations, institutions, and philanthropists now endorse interprofessional education in the preparation of health professionals. In the US, these groups include the Accreditation Council for Graduate Medical Education” (Goldberg et al., 2012, p. 99).
- “An area where IPE is particularly gaining traction is through the national accreditation of health education programs” (Bainbridge et al., 2011, p. 6).
- “Accreditation committees...have developed and approved explicit conjoint standards that encourage residency programs to explicitly teach...competencies” (Bainbridge et al., 2011, p. 7).
- Goldberg calls for coordination of “credentialing, licensing and accreditation bodies to join in advocacy for IPE to ensure that students have the necessary foundation in geriatrics and teamwork” (Goldberg et al., 2012, p. 99).
- “Although the accrediting standards of most professions reviewed contained content about interdisciplinary teams, few of these were outcomes-based competency expectations” (Wong, B., 2011, p. 5).

The voluntary nature of accreditation:

Voluntary participation in accreditation may result in greater outcomes over the more common system of top down accreditation typically delivered through government agencies or professional associations. When health education organizations are motivated to adopt standards to publically demonstrate quality, the outcomes can be markedly improved. In Europe, the impetus to improve quality through accreditation was the result of favorable press in a weekly magazine (Schwarz et al., 2005). Enforced accreditation can be effective but the success of emerging voluntary accreditation systems bear observation.

- Many programs undertake accreditation voluntarily (Bainbridge et al., 2011).
• “In most countries, government performs [accreditation] and has ultimate authority. Many nations it is done by professional councils or associations. Private medical schools are less likely than publically funded ones to undergo accreditation procedures (Frenk et al., 2010, p. 29).
• Legally binding accreditation has not been effective (Halliwell et al., 2004).
• The evolution of higher education accreditation...1999 Bologna Declaration changed everything. European ministers developed common terminology and guidelines to allow freedom of movement. Voluntary and private accreditation was more successful than government policies at this time (Schwarz et al., 2005).

Outcomes of accreditation:

The effort to standardize programs through accreditation can lead to a force fit of an educational framework designed in a different context (Frenk et al., 2010). In the diverse application of interprofessional education, variables may make a respected framework less effective and the implementation of accreditation standards more challenging. Institutional structure, program champions, hidden curriculum and local settings are just a few examples of the variations that can influence accreditation outcomes. Even though local education standards are driven by the desire to fit into accreditation and education frameworks designed elsewhere, the result can be a poor fit.

• “As with undergraduate education, the hidden curriculum plays a powerful role in either reinforcing or undermining inter and intraprofessional relationships” (Bainbridge et al., 2011, p. 1).
• Program standards are harmonizing but educational curricula are not (Halliwell et al., 2004).
• Problems have arisen with the result of standards matching “the least common denominator since [European] authority’s main interest was free movement of professionals and goods.” As a result...institutions devised their own accreditation (Halliwell et al., 2004, p. 108).
• Some dental hygiene programs are accredited but divergence in education systems is a bigger issue (Luciak-Donsberger et al., 2003).
• “Mimicking’ or borrowing of evaluation and accreditation schemes took place on a large scale”. These copied accreditation schemes can be an easy win but are sometimes “window dressing”, where appearances belied a poorly adopted accreditation system (Schwarz et al., 2005, p. 36).

The call to evaluate the outcomes of accreditation is important to policy makers and academic programs but there is a reluctance to draw conclusions. The dearth of evaluations or metrics for accreditation outcomes is a reason and it is particularly evident for IPE. Several papers criticized the evaluation of accreditation outcomes but
few offer sound measures or suggestions to those attempting the task. The hesitancy to accept or extrapolate successes and challenges with accreditation programs is a major challenge.

- The Brandt paper is a comparison of the accreditation standards between eight American health education professions. There are insights into areas of commonality, points for collaboration and opportunities for IPE that can help address barriers (Brandt B., 2009).
- Accreditation assessment criteria are few and metrics are seldom used (Frenk et al., 2010).
- The Maman-Dogma paper observed that the accreditation process is highly competitive but did not draw conclusions on its effects (Maman-Dogma et al., 2011).
- Professional accreditation organizations mandate for their own professions and as a result, assessment of outcomes is difficult (Thistlethwaite J., 2012).
- The Ellis paper out of the US discusses how to report on progress with the accreditation process within nursing education. Data was collected for agreed upon goals by students, faculty, staff, employers and community. Data collected are pass rates, certification rates, graduation rates and employment rates (Ellis et al., 2012).

*Embedding IPE into Accreditation Standards and Curricula:*

Health care systems and academic programs are being challenged to embed IPE into structures and processes and accreditation is viewed as an effective incentive. But it comes with pitfalls. To implement change into a system noted for silos, entrenched thinking and budget cuts is a tall order. A few examples of the challenges facing IPE accreditation are lack of funding for accreditation and its evaluation, resistance to compliance and the potential for overly rigid standards all of which can impede implementation. Most papers reviewed do not address IPE or how to successfully embed it in academic programs and instead only declare that it should be done. With these challenges accreditation is an effective but imperfect tool to promote adoption and integration of IPE.

- Instructional innovations “should be systems based to improve the performance...by adapting core professional competencies to specific contexts while drawing on global knowledge...[and] promote interprofessional and trans-professional education that breaks down professional silos while enhancing collaborative and non-hierarchical relationships in effective teams” (Frenk et al., 2010, p. 2-3).
- Evan’s paper cites the lack of opportunities for collaborative learning and practice and calls for interprofessional curricula to be formally developed but neglects to address how they have addressed the challenge. “Formalized interprofessional
education is posited as an effective strategy to improve interactions among oral health professionals leading to improved patient care” (Evans et al., 2010, p. 227).

- “[Within team-based learning] team roles of individual health professionals have floundered amid the divided faculty and curricula of the different professions, the rigid tribalism that afflicts them, hyper-specialization of some professionals, and overly rigid accreditation standards that restrict opportunities for collaboration” (Frenk et al., 2010, p. 39).
- Efforts to embed IPE have led to inclusion of objectives emphasizing teamwork and professional interactions and it is speculated that this will generate new opportunities for IP programs and their evaluation (Thistlethwaite J., 2012).

**Accreditation Language:**

The suggestion that generic accreditation language may yield better outcomes than program specific language is a question that is virtually missing in the literature reviewed. This may simply be omission or it may present as a challenge that is too overwhelming on first consideration. Of the twenty three papers reviewed only one meaningfully discusses uniformity of language. The absence of literature that explores the use and effectiveness of generic language in accreditation tells us that there may be untapped opportunities to improve our current accreditation processes.

- Goldberg discusses collaborative competencies as applied to gerontology programs: “generic professional competencies” could overlay the notion of generic accreditation language” (Goldberg et al., 2012, p. 100).
- The Frenk paper proposes 3 generations of reform and calls for a systems-based competency driven education system locally and globally but does not address accreditation specifically (Frenk et al., 2010).

**Key Messages**

From the review of the literature and the emergent themes, there are several key messages which may help to guide the workshop discussions.

a) General trends and new themes for accreditation

- Professional mobility, global accreditation standards and the movement to align accreditation are discussed frequently and with thoughtful consideration (Kennedy et al., 2011; Frenk et al., 2010; Halliwell, 2004; Schwarz et al., 2004).
- The role and importance of stakeholders is evident in the literature (Frenk et al., 2010; Schwarz et al., 2004; Bainbridge et al., 2011).
• Absence of external or public input to the accreditation process is often considered (Kennedy et al., 2011; Phillips et al., 2010).

• Interprofessional criteria or related ideas are somewhat evident in accreditation standards (Frenk et al., 2010; Goldberg et al., 2012).

• There is a new and tentative discussion around the success of voluntary accreditation processes (Frenk et al., 2010; Winchester et al., 2008; Ellis et al., 2012; Schwarz et al., 2005).

• The literature expresses commitment to core competencies within accreditation and certification processes (Wong et al., 2011; U of Min, 2009; Goldberg et al., 2012; Bainbridge et al., 2011).

b) Outcomes from IPE education standards (local and global) (Note: non-IPE subject matter is included)

• Local education standards are driven by the desire to fit into accreditation frameworks that were designed elsewhere. This often results in a poor fit (Frenk et al., 2010; Schwartz et al., 2005).

• Movement of health workers as a result of global accreditation may result in loss of talent from poorer countries and has resulted in one-way movement as a result of immigration barriers (Frenk et al., 2010; Halliwell et al., 2004).

• There is reluctance to draw conclusions on the outcomes of accreditation (Maman-Dogma et al., 2011; Thistlethwaite et al., 2012).

• Engaging stakeholders has a positive outcome as a result of their influence on the accreditation process (Phillips et al., 2010).

c) Educational outcomes (knowledge, skills, attitudes etc.) (Note: non-IPE subject matter is included)

• A program’s effectiveness and its student outcomes are measured through key elements and examples (Ellis et al. 2012; Phillips et al., 2010; Winchester et al., 2008).

• Accreditation criteria and assessments are few and metrics are seldom used (Frenk et al., 2010).

• Accreditation, both voluntary and mandatory, has resulted in impressive results (Halliwell et al., 2004; Kennedy et al., 2011; Schwartz et al., 2005).
d) Embedding IPE

- Hidden curriculum plays a role in the development of interprofessional relationships suggesting accreditation may not be the best tool to measure and influence relationships (Bainbridge et al., 2011).
- IPE is gaining traction through accreditation (Bainbridge et al., 2011).
- Overly rigid accreditation standards can restrict opportunities for collaboration (Frenk et al., 2010).
- Most papers reviewed do not consider IPE and do not address embedding for any specific objectives.

e) Accreditation language

- Generic professional competencies can overlay the notion of generic accreditation language (Goldberg et al., 2012).
- There is little uniformity globally or nationally with respect to competencies (Frenk et al., 2010). Frenk does not address accreditation language specifically.

Conclusion

The road to embed IPE into our health care education programs is fraught with twists, bumps and hazards. The use of accreditation as a means to increase the pace of IPE adoption has been explored tentatively and there is room to test and evaluate the outcomes. We are charged to change and adapt our education systems to proactively equip our health care workers to deliver complicated, interprofessional and safe patient care. The trends that offer the best grip on this bumpy surface include response and attention to global standards, commitment to interprofessional content and core competencies, inclusion of external stakeholders and voluntary accreditation. IPE has been embedded successfully in many programs and contexts. Our journey is well underway.

Evaluating IPE accreditation outcomes from local, global and educational perspectives is an enduring challenge that even with anecdotal success is not well investigated in the literature. Reluctance to draw conclusions is evident but there are good examples of systems and outcomes to explore. In particular, engaging stakeholders has shown
excellent outcomes and several papers compare and contrast accreditation systems. There are measurable successes and examples to follow for evaluating accreditation outcomes.

Finally, the literature has shown tentative insights on how IPE has been embedded and how generic accreditation language may strengthen IPE standards. Diverse institutional systems and contexts mean that investigation and development should be approached step-wise with careful consideration. Accreditation has demonstrated positive influences and it is with great anticipation that this literature synthesis is presented as means to inform the next steps on the road to comprehensive interprofessional education and ultimately interprofessional collaboration and care.

References


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