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Accreditation Standards and Health Professions Education Programs' Development of Providers Prepared to Care for Older Adults: A Content Analysis

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Abstract

Purpose: Accreditation of health professions education (HPE) programs is rigorous, comprehensive, and essential to the quality assurance and continuous enhancement of instruction and training required of future providers. The purpose of this study was to complete an assessment of accreditation standards for allopathic medicine (medical doctor and physician assistant), pharmacy, physical therapy, and psychology in the United States to consider how these published standards guide didactic and clinical training in older adult / geriatric content. **Methods:** This exploratory study used content analysis to analyze concepts related to geriatric content across five HPE accreditation documents. A coding scheme was developed including a codebook of terminology related to the education of students prepared to provide healthcare to older adults and coding spreadsheets to systematically consider the criteria within the data sources. **Findings:** Less than 2% of criteria explicitly addressed geriatric content. Implicit references, while increased across all five accreditation documents, could be subject to program interpretation. **Conclusions:** Accreditation standards may lack the specificity, quality, and/or quantity to support the preparation of future providers for person-centered healthcare for older adults. If professional programs rely on existing accreditation standards to set the bar for preparing healthcare providers for practice, it might also correlate with producing practitioners who are underprepared to address the needs and preferences of older adults.

Keywords: Geriatrics; Clinical competence; Curriculum; Health professions education

Introduction

Background

Accreditation of health professions education (HPE) programs is rigorous, comprehensive, and essential to the quality assurance and continuous enhancement of instruction and training of future providers [1]. Accreditation commissions define the broad standards and more granular criteria required for didactic and clinical education and evaluate HPE programs to ensure compliance. In general, accreditation commissions' standards and criteria address areas such as programs' missions, goals, and outcomes; self-assessment and improvement planning; institutional and program integrity; faculty qualifications; student recruitment and admissions; curriculum plans; curricular content; student outcomes; and sufficient resources [2-6]. HPE programs are required to complete an extensive self-study, submit to a comprehensive site visit, and respond to follow-up queries to receive initial accreditation and/or demonstrate continued compliance.

In the United States of America (USA), concerns about a limited or under-prepared healthcare workforce to address the needs of an aging population have been voiced for decades [7-15]. Challenges include the volume of older adult patients, made more complex when the older person's care includes co-morbidities with multiple medications, therapies, and providers [16]. Additionally, fewer providers specialize in the care of older adults than other specialty areas, which means that healthcare practitioners with only baseline preparation in geriatrics provide the predominance of older adult healthcare [17]. Preparation across professions varies substantially. Deficits in geriatric-focused didactic instruction, whether via stand-alone courses or threaded through HPE curricula, have been reported in physical therapy, medicine, and pharmacy education literature. [9,17-19].

Significance and Purpose

Given that the vast majority of older adult healthcare is provided by generalists or providers with specialties other than geriatrics, it is necessary to better understand how students are prepared to address the complex healthcare needs of older adults. HPE programs are at liberty to add more didactic and/or clinical training than what is required by their accrediting bodies, but given the focus on demonstrating quality assurance for each accreditation standard and already crowded and complex curricula, HPE programs often use these standards as the guideposts for what is included in each curriculum with a

focus on quality assurance versus continuous quality improvement [1].

The purpose of this study was to complete a thorough assessment of accreditation standards via content analysis for allopathic medicine (doctor of medicine and physician assistant), pharmacy, physical therapy, and psychology and consider how these published standards guide didactic and clinical training in older adult content by considering these two research questions: 1). What is the percent allocation of criteria referencing older adult content? 2) Are references to older adult content similar?

Methods

Ethics statement: Institutional Review Board approval was received for this study (H191315_01). This study was the initial step in a larger project on the development, implementation, and evaluation of a geriatric-focused curriculum for entry-level healthcare professionals.

Study Design: This exploratory study used the research tool of content analysis to analyze concepts related to older adult content across five HPE programs' published accreditation documents. This methodology considers interpreting and understanding meanings and has been used in studies related to contemporary HPE [20-22].

Research Team: The research team consisted of four clinician-educators, including a pharmacist, a physician assistant, and two physical therapists. Each has extensive academic experience with accreditation processes, teaching experience within their respective professions, and practice experience with older adults.

Data Sources: Texts chosen for analysis included current accreditation documents for five HPE programs (Medical Doctors, Physician Assistants, Physical Therapists, Pharmacists, and Psychologists) [2-6].

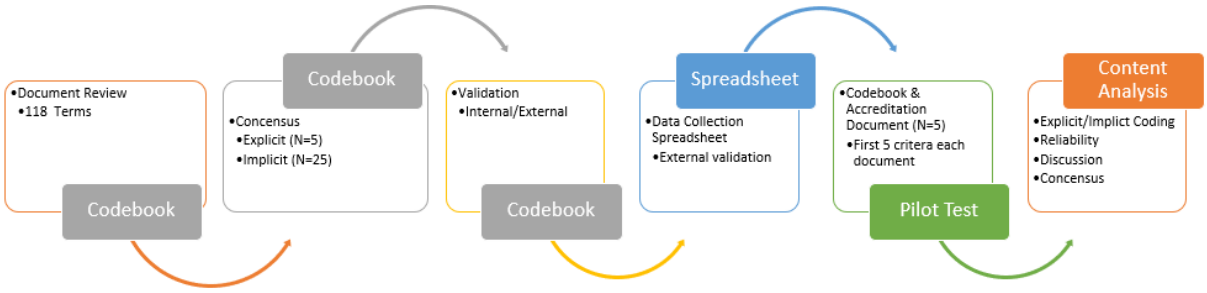

Figure 1: Visual representation of the methodology.

Coding Scheme: Using an a priori design, the researchers developed a coding scheme in order to have a systematic way to consider the criteria within the data sources [20-22]. As demonstrated in Figure 1, the research team first developed a codebook of terms related to geriatric/older adult healthcare from a review of principal documents of core competency language and key terminology used in professional literature and training programs specific to older adults. [18, 23-27]. Validity of the codebook was strengthened through consensus. The codebook began with 118 terms. Terms were included if 75% of the team approved the selection. The team lead served as the tie-breaker if the decision was split. The research team agreed that diagnosis-specific terms such as osteoporosis or glaucoma and terms specific to geriatric syndromes such as falls or polypharmacy would be removed from the codebook as no accreditation documents require education in specific medical conditions. The research team then engaged in further debate about grouping terms with similar intent to ensure words and phrases were consistently categorized. Once consensus was reached on the final 30 terms/term groupings, the team proceeded to assign them to explicit or implicit categories. Explicit older adult terms/term groupings (n=5) directly referenced age; the remaining 25 terms/term groupings were identified as implicitly referencing concepts necessary for didactic or clinical education for the provision of healthcare for older adults. Term groupings were consolidated under a single descriptive term for reporting purposes (Table 1). The research team approved the explicit and implicit terminology of the codebook. Validity of the codebook was further strengthened by an independent review by community-based practitioners in the fields of medicine, pharmacy, physical therapy, and gerontology who were external to the research team.

Explicit (n=5)	
Consolidated Term	**Term/Term Groupings**
Ageism	Ageism
Geriatric Specialist	Geriatrics, Geriatrician, Geriatric Clinical Specialist
Older Adult	Geriatric, Older Adult, Elderly, Late Life
Aging	Age, Aging
Lifespan	Life cycle, Lifespan
Implicit (n=25)	
Learning Environment	Learning Environment, Clinical Experiences
Behavioral Health	Mental, Behavioral Health, Psychological
Function	Function, Functional, Mobility, Functional Decline, Functional Dependence

Health Promotion	Health Promotion, Wellness
Ethics	Advocate, Professional Values, Professional Behaviors, Professional Conduct
Safety	Safety, Adverse, Adherence, Compliance
Care Coordination	Coordination Across the Care Spectrum, Care Plan, Care Transitions, Care Settings
End of Life	Death, Dying, End of Life, Advanced Directives/care plan, Power of Attorney, POLST, Grief, Palliative Care, Hospice
Quality of Life	Quality of Life, Autonomy
Interdisciplinary Teams	Interdisciplinary Team Care, Multidisciplinary, Interprofessional, Referral, Consultation
Caregiving	Caregiver Burden, Family, Support
Disability	Disability, Disablement Models
Payment	Reimbursement, Payer Models, Healthcare Systems and Benefits
Population Health	Population Health, Health Disparities, Social Determinants of Health
Contemporary Practice	Contemporary Practice, Prepared to Practice, Professional Roles and Responsibilities, Standards of Practice
Abuse	Abuse, Vulnerable
Evidence-based	Evidence-based, Evidence-Informed, Scientific Method, Clinical/Translational Research
Curriculum	Sequential, Complexity, Foundational, Fundamental Knowledge, Broad Exposure, Service-Learning, Community-based, Screen, Assess, Treat, Competency
Qualified Preceptors	Qualified Preceptors, Qualified Clinical Instructors
Program	Aims, Mission, Resources, Outcomes
Communication	Interprofessional Skills, Communication, Lifelong Learning, Critical Thinking, Critical Reasoning
Faculty	Qualified Faculty, Role Models, Adjunct Faculty, Sufficient Number of Faculty
Workforce	Workforce Needs

Table 1: Codebook explicit/implicit terms (N=30).

CAPTE		Physical Therapy	Geriatric Content				
# Criteria Considered	Standard #	CRITERIA	No (0)/ Implicit (I)/ Explicit (E)	Sequential Implicit	Implicit Codebook	Sequential Explicit	Explicit Codebook
	Standard 1	The program meets graduate achievement measures and program outcomes related to its mission and goals.					
1	1A	The mission[1] of the program is written and compatible with the mission of the institution, with the unit(s) in which the program resides, and with contemporary preparation[2] of physical therapists.	I	1	17		
2	1B	The program has documented goals[1] that are based on its mission, that reflect contemporary physical therapy education, research and practice, and that lead to expected program outcomes.	I	2	17		
3	1C	The program meets required student achievement measures[1] and its mission and goals as demonstrated by actual program outcomes.	I	3	17		
4	1C1	Graduation rates[1] are at least 80% averaged over two years. If the program admits more than one cohort per year, the two year graduation rate for each cohort must be at least 80%. When two years of data are not available, the one-year graduation rate must be sufficient to allow the program to meet the expectation for a two-year graduation rate of at least 80%.	0				
5	1C2	Ultimate licensure pass rates[1] are at least 85%, averaged over two years. If the program admits more than one cohort per year, the ultimate two-year licensure pass rate for each cohort must be at least 85%. When two years of data are not available, the one-year ultimate rate must be sufficient to allow the	0				

Figure 2. Example of coding spreadsheet.

Next, the research team created spreadsheets for criteria assessment (Figure 2). An external expert, known to the team of researchers secondary to their role as director of assessment for the larger grant from which this study emerged, reviewed the spreadsheet template and made recommendations for the tabulation of data. Individual spreadsheets included each Commissions' accreditation standards and criteria and served as the platform for data collection. The spreadsheet columns 1) sequentially numbered the criteria, 2) identified the standard/criteria reference, 3) provided the criterion narrative, 4) identified if the criterion explicitly, implicitly, or did not address older adult content, 5) sequentially numbered the implicit references, 6) identified the implicit criterion's codebook term, 7) sequentially numbered the explicit criteria, and 8) identified the explicit criterion's codebook term. For consistency in calculating the total number of criteria for each document, neither accreditation standard headings/ subheadings, nor introductory stems used to introduce a corresponding list of criteria, were counted. The spreadsheets were vetted for completeness and accuracy by a graduate

research assistant assigned to the study before the research team began their reviews. The team pilot-tested the coding scheme methodology, assessing the first five criteria of each accreditation document. After pilot testing, the research team approved the coding methodology.

Content Analysis: Research team members used the codebook to individually code each criterion in the accreditation spreadsheets as to its reference to geriatric content (E=explicit, I=implicit, or 0=not at all). In order to ensure intercoder reliability, the team member from each profession led the content analysis review of their own profession's accreditation criteria. This allowed for clarification of intent and profession-specific nuances. A medical doctor with specialization as a geriatrician and an academic clinical psychologist were available to provide additional insight for criterion clarification for the professions of medicine and psychology [21]. Discussion for each criterion commenced until consensus was reached on the rating of each criterion for older adult content.

Findings

Conceptually, the five accreditation documents were similar in that each addressed the program's mission, goals, and outcomes; self-assessment and improvement planning; institutional and program integrity; faculty qualifications; student recruitment and admissions; curriculum plans; curricular content; student outcomes; and sufficient current and projected resources. The results are presented for each research question.

1) What is the percent allocation of criteria referencing older adult content? : A total of 782 accreditation criteria were assessed via content analysis across the five professions. When considered cumulatively, 14 of the 782 criteria (1.8%) included an explicit term (Table 2). Three of the 5 explicit codebook terms were represented in the accreditation documents. The most prevalent was lifespan (9 of 14), followed by aging with the 5 remaining explicit references. The use of the term "elderly" was included in one criterion that also referenced lifespan. Each data source included at least 2 criteria that explicitly included curricular attention to older adults. The percent of criteria with explicit reference to older adult content ranged from 1% (APA; Psychology) to 3% (CAPTE; Physical Therapy).

Implicit references showed greater variability across the data sources. Implicit references ranged from 23% to 47% and were found in 272 of 782 criteria (34%). As with the explicit references, APA and CAPTE had the least and most implicit criteria identified, respectively. Ten of the 25 implicit headings were identified in all 5 data sources and cumulatively accounted for 80.2% of all implicit references (see bolded terms in Table 4). "Program" accounted for 19.8% of the total implicit references, "Curriculum" 12.9%, "Contemporary Practice" 11%, "Qualified Faculty" 9.6%, "Learning Environment" 7.4%.; "Ethics" 6.6%; "Communication" 5.9%, "Interdisciplinary Team" 5.9%; "Cultural Competence" 3.7%, and "Evidence-based" 3.3%. Examples of criteria with explicit (lifespan and age) and implicit (interprofessional) codebook references are presented in Table 3 [2-6].

2) Are references to older adult content similar in intent? : While each data source included explicit references to "aging" or "lifespan," the assurance that didactic and clinical training encompasses adequate instruction for older adult content is wanting. As noted, the physician assistant criteria B2.06 (Table 2) further expanded the definition of "life span" to categorical references of "infants, children, adolescents, adults, and the elderly," thus allocating attention to specific age groups which might be at risk for less attention. The 10 implicit terms identified in all five accreditation documents included essential elements for the academic and clinical preparation of future providers. Without parallel consideration of programs' curricula, it is not possible to draw meaningful inferences about how these criteria are guiding or informing the older adult/geriatric didactic and clinical education of HPE students.

Commission (Profession)	Total Criteria	Explicit Criteria	% Explicit	Implicit Criteria	% Implicit
LCME (Medicine)	115	2	1.7%	33	2.0%
ARC-PA (Physician Assistant)	197	3	1.5%	77	39.6%
ACPE (Pharmacy)	136	3	2.2%	52	38.2%
CAPTE (Physical Therapy)	135	4	3%	64	47.4%
APA (Psychology)	199	2	1%	46	23.1%
TOTAL	782	14	1.8%	272	34%

Table 2: Total Explicit and implicit references to older adult content in accreditation criteria.

Commission (Profession)	Explicit	Implicit
LCME (Medicine)	Standard 7.2: The faculty of a medical school ensure that the medical curriculum includes content and clinical experiences related to each organ system; each phase of the **human life cycle**; continuity of care; and preventive, acute, chronic, rehabilitative, and end-of-life	Standard 7.9: **Interprofessional Collaborative** Skills. The faculty of a medical school ensures that the core curriculum of the medical education program prepares medical students to function collaboratively on **health care teams** that include health professionals form other disciplines as they provide coordinated services to patients. These curricular experiences include practitioners and/or students from the other health professions.

ARC-PA (Physician Assistant)	Standard B2.06: The program curriculum must include instruction in the provision of clinical medical care across the **life span** including prenatal, infant, children, adolescents, adults, and **elderly**.	Standard B1.08: The curriculum must include instruction to prepare students to work collaboratively in **interprofessional** patient centered **teams**.
ACPE (Pharmacy)	Standard 12.4: The Pre-APPE curriculum provides foundational knowledge and skills that allow for care across **the patient's lifespan.**	Standard KE11.2: **Interprofessional** team education – To advance collaboration and quality of patient care, the didactic and experiential curricula include opportunities for students to learn about, from, and with other members of the **interprofessional healthcare team**…
CAPTE (Physical Therapy)	Standard 6E: The curriculum includes organized sequences of learning experiences that prepare students to provide physical therapy care to individuals with diseases/disorders involving the major systems, individuals with multiple system disorders, and individuals across **the lifespan** and continuum of care, including individuals with chronic illness.	Standard 6L3: …involvement in **interprofessional practice**.

Table 3. Examples of explicit and implicit content in accreditation standards.

Number	Final Explicit Terms	LCME	ARC-PA	ACPE	CAPTE	APA	Total Final
1	Ageism						0
2	Geriatric specialization						0
3	Older adult		*1*				*1**
4	Aging	1		1	1	2	5
5	Lifespan	1	3	2	3		9
	TOTAL EXPLICIT	**2**	**3**	**3**	**4**	**2**	**14**
Number	**Final Implicit Terms**	**LCME**	**ARC-PA**	**ACPE**	**CAPTE**	**APA**	**Total Final**
1	**Learning Environment**	**1**	**14**	**2**	**1**	**2**	**20**
2	Behavioral Health		1				1
3	Function						0
4	Health Promotion			1	1		2
5	**Ethics**	**2**	**2**	**3**	**6**	**5**	18
6	Safety		2	1	4		7
7	Care Coordination			1	2		3
8	End-of-life						0
9	Person-Centered Care			2	3		5
10	Quality of Life						0
11	**Cultural Competence**	**2**	**1**	**2**	**1**	**4**	**10**
12	**Interdisciplinary Team**	**2**	**1**	**6**	**5**	**2**	**16**
13	Caregiving						0
14	Disability						0
15	Payment		2		3		5
16	Population Health	3	1	1			5
17	**Contemporary Practice**	**2**	**4**	**6**	**13**	**5**	**30**
18	Abuse				1		1
19	**Evidence-based**	**1**	**2**	**1**	**2**	**3**	9
20	**Curriculum)**	**5**	**10**	**8**	**6**	**6**	35
21	Preceptors	1	4	1			6

22	**Program**	**8**	**21**	**8**	**6**	**11**	54
23	**Communication**	**3**	**2**	**5**	**4**	**2**	**16**
24	**Faculty**	**2**	**10**	**4**	**5**	**5**	**26**
25	Workforce	1			1	1	3
	TOTAL IMPLICIT	33	77	52	64	46	272

Table 4: Content Analysis.

Discussion

Having a sufficient quantity and quality of healthcare providers prepared to deliver competent, compassionate care to the growing population of older adults is a long-standing and ongoing concern in the USA [7-17]. Accreditation is foundational to ensuring quality HPE. However, the degree to which accreditation criteria guide education and training specific to older adults remains unclear. As noted by Frank and colleagues, the role of accreditation in the 21st century should evolve to enhance training and as a result, enhance care.[1] HPE commissions could consider a greater focus on outcomes versus process. For example, does the student learn about frailty in older adults (process) versus can the student effectively manage the older adult who is frail (outcomes) [1]. Building on Philibert and Blouin's review on the role of accreditation and social accountability, commissions could influence HPE programs to emphasize content to align with aging population needs and add unambiguous language to existing standards and/or requirements for demonstration of successful didactic and clinical attainment of competencies for older adult care [28]. Contemporary language updates to words such as "older adults" or "older people" could replace potentially less-positive terms of "elderly" or "aged." Standards and outcomes aligned with older adult competencies could result in better-prepared students who would become better-prepared healthcare providers [1,28].

Regardless of enhanced accreditation criteria, programs must accept the challenges of teaching students about the complexity of care required for older adults. Ultimately, the responsibility for this rests with the HPE programs themselves. Educators could consider specific ways to meet and/or exceed accreditation standards including requiring courses focused on geriatrics and gerontology, incorporating geriatric core competencies, overlaying contemporary frameworks of older adult care such as the 4Ms of *the Age-Friendly Health System and Geriatric 5Ms*, tracking and reporting clinical education/experiential learning encounters with older adults, and addressing older adults' lived experiences through teaching pedagogies including health humanities, interprofessional education, and service-learning [24, 29-32]. Educators could provide more explicit learning experiences that highlight the complex changes that occur in later life through inclusion of cases that address the management of geriatric syndromes through end-of-life, ageism or age bias, social determinants of health, and the diversity of age and aging [33,34]. There is great value in HPE programs having latitude in how they demonstrate meeting accreditation criteria. However, there might be too much variability in the quantity and quality of older adult content. This variability in content may contribute to unacceptable variations in practice [1].

Strengths and Limitations

The study design using content analysis was a strength as it was based on systematic procedures that can be replicated by others, with attention to methodologies that strengthen validity and reliability. Trustworthiness was enhanced though the coding scheme which provided a clear record of documentation across the data sources, was based on recognized terminology from the literature and practice, and included expert consultation beyond the authors. A limitation of this study is that accreditation standards are routinely revised and this study is a snapshot in time. Additionally, while contemporary documents were carefully considered, the codebook was not exhaustive. Regarding generalizability, the review demonstrated similar trends addressing older adult content across the data sources reviewed. Consideration of other professions' accreditation documents, such as nursing, is warranted.

Conclusion

The results of this study provide an opportunity for stakeholders to engage in discussions regarding accreditation standards and criteria which ultimately impact older adults' healthcare and outcomes. Given that almost 99% of healthcare providers in the USA do not have specialization in geriatrics or caring for older adults, it is incumbent upon all stakeholders - professional organizations, commissions, and clinician-educators - to advocate for enhanced program requirements across undergraduate, graduate, and post-graduate training programs to enhance student preparedness to address and manage the complexities of aging and provide comprehensive care to older adults. If healthcare education programs rely on existing accreditation standards to set the bar for preparing providers for practice, it might also correlate with producing practitioners who are underprepared to directly address the needs and preferences of older adults.

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Competing interests

The authors declare that they have no competing interests.

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