The Scope of Social Mission Content in Health Professions Education Accreditation Standards

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Data: The authors used publicly available data from the selected accreditors.
Abstract

Purpose
Health professions education accreditation standards influence institutional practices and policies
and ensure high quality education that meets the needs of patients and society. Social mission is
the contribution of a school in its mission, programs, and the performance of its graduates,
faculty, and leadership to advancing health equity and addressing the health disparities of the
society in which it exists. This study examined the scope of social mission content in major U.S.
and Canadian health professions education accreditation standards.

Method
The authors analyzed publicly available accreditation standards documents from 9 accreditors
across 5 disciplines—dental, medical, nursing, pharmacy, and physician assistant schools—with
effective years from 2016 to 2020. They created a codebook from the previously published social
mission metrics survey, which includes 18 social mission activity areas and 79 indicators within
those areas. The authors then conducted detailed document reviews to identify the presence of
the social mission areas and indicators within the accreditation standards.

Results
Across all 18 activity areas and 9 accreditors, the authors identified 93 instances of social
mission. Curriculum was the most well represented area with 34 instances. Interprofessional
education in curriculum was the most prevalent indicator with 17 instances. The Committee on
Accreditation of Canadian Medical Schools included more social mission areas and indicators
than the other accreditors.
Conclusions

There is substantial variability in the social mission content in accreditation standards across accreditors and disciplines. The authors found little representation of key aspects of social mission, including community collaborations, faculty training, and pipeline programs. These findings highlight areas of potential interdisciplinary collaboration to enhance the social mission content of health professions education.
Social mission—defined as the contribution of a health professions school in its mission, programs, and the performance of its graduates, faculty, and leadership to advancing health equity and addressing the health disparities of the society in which it exists—is gaining prominence as a key pillar of health professions education.\textsuperscript{1-3} This heightened attention to social mission is timely given the continuing racial and health inequalities exposed by the COVID-19 pandemic.\textsuperscript{4,5} COVID-19 has revealed systemic differences in health outcomes among the U.S. population, with greater mortality and morbidity in minority groups and in people with underlying medical conditions.\textsuperscript{6,7} To reverse this and other longstanding trends, higher standards for promoting social mission in health professions education—as a means of advancing health equity—are needed. Schools must go beyond traditional pedagogy in biology and basic science to include elements such as interprofessional collaboration, public health training, and community-based care to better equip future health care professionals with the knowledge, skills, and behaviors to combat deeply entrenched health inequities.\textsuperscript{8} For schools to achieve this improved vision of health professions education, they must be able to measure and track their social mission. In 2010, researchers created a novel ranking system to report on 3 health workforce equity related outcomes of medical schools—primary care physician output, workforce distribution, and underrepresented minority representation.\textsuperscript{2} These researchers chose these outcomes based on identified gaps between population health needs and the physicians medical schools were producing. As a follow up to this report, in a 2020 article, we described the social mission metrics (SMM) survey, a formalized method to assess dental, medical, and nursing schools’ social mission values, programs, and activities.\textsuperscript{3} This work resulted in the description of 18 social mission activity areas, which encompass wide-ranging aspects of a health professions school’s functioning that have the potential to advance
The 18 areas and their associated indicators were developed based on a review of existing tools and frameworks (including social accountability\textsuperscript{9-11} and social justice\textsuperscript{12}), related literature, and key informant interviews, from which an extensive list of social mission enhancing activities were identified. An advisory committee consisting of leaders of dental, medical, and nursing schools, students and trainees, members of national education associations, and a patient advocate further refined these activities using a modified Delphi process and group consensus to select measurable social mission promoting indicators. These indicators were organized into the 18 activity areas.

In 2019, more than 240 health professions schools completed a voluntary self-assessment composed of 79 indicators within the 18 activity areas.\textsuperscript{3} This work demonstrated that social mission can be measured and that there is widespread interest in its adoption amongst school leaders. However, systemic progress will require additional stakeholders, including accreditors, to play active roles.

In health professions education, accreditation is a key mechanism for schools to demonstrate the quality and value of their services. Accreditation is a process of institutional regulation conducted by nongovernmental organizations to advance academic quality, maintain high standards in the production of a competent health workforce, and provide quality assurance to the public.\textsuperscript{13} Achieving the educational “gold standard” of becoming fully accredited brings distinction to a school. This recognition influences schools’ decisions to pursue certain practices and policies, therefore accreditation is a significant policy lever to advance institutional change.\textsuperscript{14} The stewardship mechanism of accreditation is not novel. Calls for the engagement of accreditors to support common goals in health professions education are well established.\textsuperscript{9-11,13,15} Actions by accreditors, including developing new standards and expanding the scope of existing
ones, have been shown to influence institutional policies. For example, in response to health systems change and the need to prepare students for collaborative practice, interprofessional education (IPE) standards were added in recent years to accreditation standards across multiple health professions.\textsuperscript{16-18} The number of interprofessional collaborations across schools has increased with the explicit inclusion of IPE in the Commission on Dental Accreditation (Standard 2-15) and Liaison Committee on Medical Education (Standard 19-A) standards.\textsuperscript{19,20} In addition, the impact of accreditation on the health care workforce can be observed in the temporal association between the addition of diversity standards and increased female, Black, and Hispanic matriculants in U.S. medical schools.\textsuperscript{21} Similarly, the integration of public health standards by the Accreditation Council for Pharmacy Education incentivized pharmacy schools to align their curricula to meet these requirements.\textsuperscript{22} These examples showcase the potential for accreditors to encourage widespread change through explicit mention of previously omitted concepts.

The health professions education community and policymakers have called for accreditors to take a more active role in adopting standards to advance health equity and social movements in health.\textsuperscript{1,23} A number of accreditors have already begun to meet the changing needs of health professions education, as noted above. However, little is known about how well social mission is represented in the standards of major U.S. and Canadian accreditors of health professions schools.

**Method**

In this study, we aimed to answer the following 2 research questions: (1) To what extent is social mission represented in the standards of major accreditors for health professions schools? and (2)
Are there differences in the scope of social mission inclusion in accreditation standards across disciplines?

**Framework**

We first developed a framework for qualitative content analysis\(^ {24,25}\) using the activity areas and indicators adapted from our SMM survey.\(^ 3\) This framework laid out 18 areas that are key drivers of social mission in health professions schools: curriculum, extracurricular activities, targeted education, global health, school mission, curriculum and community needs, community collaborations, student diversity, faculty diversity, academic leadership diversity, pipeline programs, student training, faculty training, student-run clinics, student activism, faculty activism, primary care, and research. Each of these 18 areas included between 1 and 13 measurable indicators that collectively define the area. We translated the 18 areas and corresponding indicators into a codebook. See Supplemental Digital Appendix 1 at [http://links.lww.com/ACADMED/B192](http://links.lww.com/ACADMED/B192) for the complete codebook.

**Data sources**

The scope of our review included U.S. and Canadian accreditors across 5 disciplines that provide direct clinical care—dental, medical, nursing, pharmacy, and physician assistant schools. We chose specific accreditors to include based on several criteria. First, following the conventions of the SMM survey,\(^ 3\) we focused on U.S. accreditation standards for dental, medical, and nursing (diploma, associate, bachelor’s, and master’s degree) programs. Canadian medical accreditation standards were included because social accountability, a term we associate with social mission, was recently included as a performance measure.\(^ {26}\) Finally, standards for pharmacy education were included given the discipline’s leadership in IPE,\(^ {27}\) and standards for physician assistant
education were included due to expressed interest in social mission from individuals within the discipline during the SMM survey.

To ensure parity in comparisons, only the main standards document from each accreditor was included in our formal analysis since not all supplemental materials were publicly available. Documents for self-study and/or those that elaborated on a main standards document were not included. We excluded preambles describing the intent of the accreditation standards, glossary terms, and appendices within the standards documents.

By profession, the 9 accreditors and the effective year of the corresponding standards that we examined were:

- Dentistry: Commission on Dental Accreditation (CODA), 2019
- Medicine: Liaison Committee on Medical Education (LCME), 2020, American Osteopathic Association’s Commission on Osteopathic College Accreditation (COCA), 2019, and Committee on Accreditation of Canadian Medical Schools (CACMS), 2020
- Nursing: Accreditation Commission for Education in Nursing (ACEN), 2017, Commission on Collegiate Nursing Education (CCNE), 2018, and National League for Nursing’s Commission for Nursing Education Accreditation (CNEA), 2016
- Pharmacy: Accreditation Council for Pharmacy Education (ACPE), 2016
- Physician assistant: Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), 2020

In October 2019, we uploaded all publicly available accreditation standards across the 9 accreditors to NVivo Pro 12 (QSR International, Melbourne, Australia) for qualitative data analysis.
**Data analysis**

Two members of the research team (J.O. and C.X.) independently conducted a codebook-based qualitative content analysis of the accreditation documents. We indexed only excerpts that explicitly mentioned or fit the description of an area or indicator. When applicable, we coded data into multiple indicators within a single area or across areas. Because we were using a deductive approach, we anticipated a high degree of intercoder agreement. To increase the reliability of our results, the core research team (J.O., C.X., S.R., and S.B.) reviewed and discussed coding discrepancies and established consensus while actively referencing the codebook. We adjusted, as needed, the code labels through multiple meetings with the core research team for review and arbitration.

We conducted a final query search for social mission terms based on a comprehensive list of keywords to capture any potential textual data the manual review may have missed. See Supplemental Digital Appendix 2 at [http://links.lww.com/ACADMED/B192](http://links.lww.com/ACADMED/B192) for a complete list of these keywords. One of the original coders (J.O.) indexed any newly discovered data and presented it for group review.

Utilizing a qualitative content analysis approach, we then counted the total number of coding instances of the individual areas and indicators in each accreditor’s standards. Below, we describe these counts as well as share illustrative examples of accreditation standards within select areas.

**Results**

**Prevalence of social mission areas in accreditation standards**

Across all 9 accreditors, we identified 93 instances of social mission in the accreditation standards. Curriculum was the most commonly identified area, with 34 of 93 instances (37%)
falling within this area. The next most prevalent areas were student training (13/93, 14%), student diversity (8/93, 9%), faculty diversity (7/93, 8%), and primary care (7/93, 8%). We found several areas with 5 or fewer mentions across accreditation standards: community collaborations (5/93, 5%), targeted education (4/93, 4%), extracurricular activities (3/93, 3%), school mission (3/93, 3%), academic leadership diversity (3/93, 3%), curriculum and community needs (2/93, 2%), pipeline programs (2/93, 2%), faculty training (1/93, 1%), and faculty activism (1/93, 1%).

We did not identify the following areas in any accreditation standards: global health, student-run clinics, student activism, and research. CACMS included more social mission areas than the other accreditors we analyzed.

Below, we summarize a selection of the most prevalent social mission areas as well as areas that were connected to those frequently identified. For example, we connected student training, a prevalent area, and faculty training, an infrequent area, to illustrate the different amount of data we found for each area and to raise awareness of this variation. We also explore the school mission area given recent evidence of an association between mission statements and social mission outcomes. Table 1 provides a summary of the social mission areas we identified by accreditor.

**Examples of social mission areas and indicators in accreditation standards**

**Curriculum.** We defined curriculum as the inclusion of social mission content within the formal curriculum of a health professions schools. “Interprofessional education in curriculum” was the most common indicator we identified in the accreditation standards, representing 17 of 34 (50%) total instances of the curriculum area. Other indicators included “clinical experiences with underserved populations” (5/34, 15%), “health disparities in curriculum” (5/34, 15%), “social determinants of health in curriculum” (4/34, 12%), “setting of IPE” (2/34, 6%), and “LGBTQ
health in curriculum” (1/34, 3%). ACPE included more instances of social mission in the curriculum area than any other accreditor.

The following examples are illustrative of standards coded to the curriculum area:

ACEN 4.6: The curriculum and instructional processes reflect educational theory, interprofessional collaboration, research, and current standards of practice.\(^{32}\)

(Indicator: interprofessional education in curriculum)

CODA 2.17: Graduates must be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment…Such an environment should facilitate dental education in…the importance of meeting the health care needs of dentally underserved populations…\(^{28}\) (Indicators: health disparities in curriculum and clinical experiences with underserved populations; also coded to the student training area and student training in cultural competency indicator)

**Targeted education.** Targeted education, or the inclusion of other health career training programs and public health within the curriculum, was found a total of 4 times across all accreditors. All instances were represented by the “public health” indicator, which was found once in each of the ACPE, ARC-PA, CACMS, and CODA standards (1/4, 25% each).

The following example represents a standard related to this area:

ACPE 2.4: Population-based care –The graduate is able to describe how population-based care influences patient-centered care and the development of practice guidelines and evidence-based best practices.\(^{35}\) (Indicator: public health)
Table 2 demonstrates the prevalence of specific indicators within the curriculum and targeted education areas as well as the related extracurricular activities area.

**School mission.** The school mission area refers to whether or not the written governance documents—the mission statement and strategic plan—of a health professions school include social mission terms or identify a community of commitment. This area was found only in the CACMS standards and was identified 3 times. Two instances (67%) represented the “mission statements include social mission terms” indicator and a third (33%) represented the “mission statements include community of commitment” indicator.

The following example is illustrative of a standard related to this area:

CACMS 1.1.1: A medical school is committed to address the priority health concerns of the populations it has a responsibility to serve. The medical school’s social accountability is: a) articulated in its mission statement; b) fulfilled in its educational program through admissions, curricular content, and types and locations of educational experiences; c) evidenced by specific outcome measures. (Indicator: mission statements include social mission terms)

Table 3 demonstrates the prevalence of specific indicators within the school mission area, along with the other areas pertaining to meeting urgent health care needs: curriculum and community needs, community collaborations, and primary care.

**Student diversity and faculty diversity.** The SMM survey included 4 areas related to diversity, including student diversity, faculty diversity, academic leadership diversity, and pipeline programs. These were each comprised of multiple indicators related to diversity-enhancing processes and policies as well as outcomes. For student diversity, indicators included general student diversity, enrollment/graduation rates by racial and ethnic identity, gender identity,
sexual orientation, socioeconomic status (first generation to go to college), the allocation of
grants for financial need, utilization of holistic review in admissions, and enrollment/graduation
of students from the school’s community of commitment.

We identified 8 instances of the student diversity area in the accreditation standards, distributed
across CODA (3/8, 38%) and ACPE, ARC-PA, CACMS, COCA, and LCME (1/8, 13% each).
All instances were of the “general student diversity” indicator.

Similar to student diversity, within the faculty diversity area, we only identified instances of the
“general faculty diversity” indicator. CODA had 2 of 7 total instances (29%) across accreditors,
while ARC-PA, CACMS, CNEA, COCA, and LCME each accounted for 1 instance (14% each).

The following examples represent standards related to the student diversity and faculty diversity
areas:

ARC-PA 1.11: The sponsoring institution must demonstrate its commitment to
student, faculty and staff diversity and inclusion by: a) supporting the program in
defining its goal(s) for diversity and inclusion…d) making available resources
which promote diversity and inclusion.36 (Indicators: general student diversity and
general faculty diversity)

LCME 3.3: A medical school has effective policies and practices in place, and
engages in ongoing, systematic, and focused recruitment and retention activities,
to achieve mission-appropriate diversity outcomes among its students, faculty,
senior administrative staff, and other relevant members of its academic
community. These activities include the use of programs and/or partnerships
aimed at achieving diversity among qualified applicants for medical school
admission and the evaluation of program and partnership outcomes.29 (Indicators:
general student diversity and general faculty diversity; also coded to the pipeline programs area)

CNEA III-A: The program’s faculty are qualified, diverse and adequate in number to meet program goals…The nursing program exhibits an inclusive organizational environment and resources supportive of recruiting and retaining a diverse faculty.  

(Indicator: general faculty diversity)

Table 4 shows the prevalence of specific indicators within the student diversity and faculty diversity areas as well as the related areas of academic leadership diversity and pipeline programs.

**Student training and faculty training.** The student training and faculty training areas focused on schools providing training in specific skills and competencies related to health equity. Student training was identified 13 times, primarily the “student training on cultural competency, humility” indicator (9/13, 69%). Additional indicators included “student training on health advocacy” (2/13, 15%) and “student training on unconscious, implicit bias” (2/13, 15%). This is in contrast to the faculty training area, which we only identified once across all accreditation standards, in COCA’s inclusion of the “faculty training on cultural competency, humility” indicator.

The following example is illustrative of a standard related to both student training and faculty training:

COCA 5.1: A [college of medicine] must ensure that the learning environment of its osteopathic medical education program is conducive to the ongoing development of professional behaviors in its osteopathic medical students, faculty, and staff at all locations and is one in which all individuals are treated
with respect. This should also include exposure to aspects of patient safety, cultural competence, and interprofessional collaborative practice. (Indicators: student training on cultural competency, humility and faculty training on cultural competency, humility)

Table 5 shows the prevalence of specific indicators within the areas that pertain to the culture and climate of a school, specifically student training, faculty training, and faculty activism.

Discussion
Health professions schools are beginning to examine their social mission in an attempt to educate health care leaders who will rise to the challenge of promoting health equity and adapting to patient demographic changes. The professional governance role of the accreditation process carries the potential to hold schools accountable for outcomes and for adopting approaches to optimally reflect their societal obligations. Our findings describe the current state of social mission in accreditation standards and identify elements that are relatively well represented and those that are notably absent. We also demonstrate differences across accreditors in the extent to which social mission is included in accreditation standards.

We found that the curriculum area is the most well represented in accreditation standards. This finding is largely driven by the widespread inclusion of the “interprofessional education in curriculum” indicator. This reflects the history and rise in prominence of IPE in U.S. health professions education. The 1972 Institute of Medicine report, entitled *Educating for the Health Team*, identified the need for interdisciplinary education at the administrative, teaching, and national level for health professions education. IPE gained traction with the 2003 Institute of Medicine report, entitled *Health Professions Education: A Bridge to Quality*, which called for health professions education to integrate interdisciplinary team competencies. This report led to
the formation of the Interprofessional Education Collaborative and IPE guidance from the Health Professions Accreditors Collaborative and the National Center for Interprofessional Practice and Education. This concerted effort by numerous stakeholders to highlight the value of IPE and advance its adoption by accreditors and schools can be an instructive model for organizations promoting social mission in health professions education.

Other fundamental elements of social mission varied in their representation in accreditation standards. For example, despite growing calls for optimizing the relationship between academic institutions and their surrounding communities, only the 3 nursing accreditors (ACEN, CCNE, and CNEA) explicitly included standards related to community collaborations or requiring feedback from local communities. While graduating students may not stay in their school’s local community for practice, modeling asset-based, bidirectional, meaningful community engagement is vital to ensuring the health care workforce in all professions is prepared to advance population health goals.

Conversely, none of the nursing accreditors included requirements related to student diversity or addressing health disparities in the curriculum, despite the critical role nurses play in advancing health equity. It is also important to note that only the LCME required pipeline programs and partnerships, despite health care workforce diversity being a concern across disciplines. COVID-19 is calling attention to racism as a serious public health threat, prompting national declarations of support to combat the crisis. However, the term racism was not found in any accreditation standards. Accreditors can shape the scope of health professions education by including explicit language to help achieve the desired outcome of health equity.
In addition, we found notable differences between expectations related to social mission training for students and those for faculty. Every accreditor included a requirement related to cultural competency or humility for students, but only one (COCA) explicitly included this requirement for faculty. While it is admirable that accreditors value this topic, focusing on student training alone and ignoring expectations for faculty competency may fall short of intended outcomes. Overall, the Canadian medical accreditor, CACMS, had a greater prevalence of social mission indicators than the other accreditors. Indeed, CACMS is the only accreditor to require that a school’s mission statement reflect social mission, despite research demonstrating that such content in mission statements is positively associated with graduates working in primary care and medically underserved areas.\textsuperscript{37} The distinguishing difference may be attributed to CACMS’s move in recent years to align Canadian medical education programs with social accountability.\textsuperscript{9,26}

We were not surprised by the absence of several social mission areas and indicators in accreditation standards. Targeted education included indicators related to degree programs outside of the primary program being accredited, for example, the presence of training programs for community health workers or dental hygienists. An organization accrediting programs awarding the degrees we included in our study would not be expected to include standards related to different degrees or certificate programs. Similarly, the social mission areas of global health and research were absent from accreditation standards. Not all health professions schools have a focus on global health or a research portfolio, and it would be unlikely that a domestic accreditor would include standards related to these topics. We do not see this as a deficiency by accreditors, as we developed these areas and indicators for our SMM survey,\textsuperscript{3} which was the \textit{a priori} basis for the codebook we used in this
review. We did not explicitly target the SMM survey to accreditation standards; consequently, certain components were less germane to this review.

**Limitations**

Our findings should be interpreted in the context of several limitations. First, the accreditation process encompasses much more than the written accreditation standards documents. Accreditation typically involves self-assessments, site visits, and the submission of numerous supporting documents. There is not uniformity across accreditors in the types of guidance documents or templates used or made publicly available. While all 9 accreditors we analyzed made their accreditation standards publicly available, we were only able to access self-study guides for 6 accreditors and data collection instruments for 2 accreditors. Other accreditors included a variety of supplemental documents, such as rubrics and examples. To ensure parity for comparisons, we did not analyze supporting documents in this review, focusing solely on the core accreditation standards. It is possible that additional support for social mission in the accreditation process can be found in these supplemental documents.

Second, we did not evaluate how schools translate accreditation standards into practice. Standards are typically written non-prescriptively; for example, LCME Standard 3.3 requires that a school ensures diversity but leaves it to the school to define mission-specific diversity and does not identify particular metrics that must be met. In addition, both across and within accreditation standards, student diversity is referred to using broad terms such as simply “a qualified and diverse student body” and “culturally diverse environments.” Similarly, CODA uses the following broad terminology: “diversity among its students,” “students from diverse backgrounds,” “institutional climate for diversity,” “dimensions of diversity including structure, curriculum, and institutional climate,” “diversity across its academic community,”
“diversity…gender, racial, ethnic, cultural, and socioeconomic,” and “suitably diverse students.”

We did not address the important question of how the terms and phrases used in standards affected their translation into practice. While evidence suggests accreditation standards are associated with changes in outcomes, there is likely variability in the extent to which this is true across accreditors, disciplines, and schools. Further research on the impact of accreditation standards on school, student, patient, and population level outcomes is warranted.

Conclusions

Our findings highlight the wide variability in health professions education accreditation standards related to social mission. Although most accreditors have social mission content in their standards pertaining to the curriculum, student diversity and training, and faculty diversity, the extent and scope of the included social mission indicators varies across accreditors and disciplines. In some areas, such as community collaborations, faculty training, and pipeline programs, social mission was infrequently identified in accreditation standards. While schools should have the ability to innovate and adapt to their own unique mission, culture, and geography, and to prioritize some aspects of social mission over others, accreditors should establish baseline standards related to social mission that schools can then build on. The dual pandemics of COVID-19 and systemic racism underscore this imperative now more than ever. A deliberate and coordinated effort from health professions education will require the engagement of accreditors to amend educational content and quality standards to meet the needs of an increasingly diverse population.
References


33. Commission on Collegiate Nursing Education. Standards for Accreditation of Baccalaureate and Graduate Nursing Programs. Published 2018.


Table 1  
**Presence of Social Mission by Activity Area in the Standards Documents of Selected Accreditors, 2016-2020**

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</tr>
<tr>
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<td>-</td>
<td>-</td>
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</table>

Abbreviations: Cur, curriculum; EA, extracurricular activities; TE, targeted education; GH, global health; SM, school mission; Cur-Com, curriculum and community needs; Coll, community collaborations; SD, student diversity; FD, faculty diversity; ALD, academic leadership diversity; PP, pipeline programs; ST, student training; FT, faculty training; SRC, student-run clinics; SA, student activism; FA, faculty activism; PC, primary care; RF, research focus; ACEN, Accreditation Commission for Education in Nursing; ACPE, Accreditation Council for Pharmacy Education; ARC-PA, Accreditation Review Commission on Education for the Physician Assistant; CACMS, Committee on Accreditation of Canadian Medical Schools; CCNE, Commission on Collegiate Nursing Education; CNEA, Commission for Nursing Education Accreditation; COCA, Commission on Osteopathic College Accreditation; CODA, Commission on Dental Accreditation; LCME, Liaison Committee on Medical Education.
### Table 2  Instances of the Curriculum, Extracurricular Activities, and Targeted Education Activity Areas in the Standards Documents of Selected Accreditors, 2016-2020

<table>
<thead>
<tr>
<th>Accreditor</th>
<th>Clinical experiences with underserved population in curriculum</th>
<th>Health disparities in curriculum</th>
<th>IPE</th>
<th>Setting of IPE</th>
<th>LGBTQ health in curriculum</th>
<th>SDOH in curriculum</th>
<th>Service learning</th>
<th>Public health</th>
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</tbody>
</table>

**Abbreviations:** IPE, interprofessional education; SDOH, social determinants of health; ACEN, Accreditation Commission for Education in Nursing; ACPE, Accreditation Council for Pharmacy Education; ARC-PA, Accreditation Review Commission on Education for the Physician Assistant; CACMS, Committee on Accreditation of Canadian Medical Schools; CCNE, Commission on Collegiate Nursing Education; CNEA, Commission for Nursing Education Accreditation; COCA, Commission on Osteopathic College Accreditation; CODA, Commission on Dental Accreditation; LCME, Liaison Committee on Medical Education.

\(^a\)There were no coding instances for the following indicator in Area 1: social mission in curriculum.

\(^b\)There were no coding instances for the following indicators in Area 2: extracurricular activities and service learning sub-indicators: duration or time commitment and participation.

\(^c\)There were no coding instances for the following indicators in Area 3: other training programs sub-indicators: community health workers, dental assistants, dental hygienists, medical assistants, and nurse’s aides; and public health sub-indicator: PH cert, degree participation.

\(^d\)ACEN had the same coding instances across degree programs: diploma, associate, bachelor’s, and master’s degree.
Table 3
 Instances of the School Mission, Curriculum and Community Needs, Community Collaborations, and Primary Care Activity Areas in the Standards Documents of Selected Accreditors, 2016-2020

<table>
<thead>
<tr>
<th>Accreditor</th>
<th>Area 5: School mission&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Area 6: Curriculum and community needs</th>
<th>Area 7: Community collaborations&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Area 17: Primary care&lt;sup&gt;c&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACEN&lt;sup&gt;d&lt;/sup&gt;</td>
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<tr>
<td>ACPE</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ARC-PA</td>
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<td>1</td>
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<td>CACMS</td>
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<td>CCNE</td>
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<tr>
<td>CNEA</td>
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<tr>
<td>CODA</td>
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<td>0</td>
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<tr>
<td>LCME</td>
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Abbreviations: ACEN, Accreditation Commission for Education in Nursing; ACPE, Accreditation Council for Pharmacy Education; ARC-PA, Accreditation Review Commission on Education for the Physician Assistant; CACMS, Committee on Accreditation of Canadian Medical Schools; CCNE, Commission on Collegiate Nursing Education; CNEA, Commission for Nursing Education Accreditation; COCA, Commission on Osteopathic College Accreditation; CODA, Commission on Dental Accreditation; LCME, Liaison Committee on Medical Education.

<sup>a</sup>There were no coding instances for the following indicators in Area 5: mission statements include social mission terms sub-indicators: inclusion of community of commitment, inclusion of health equity or health disparities, inclusion of social determinants of health, and inclusion of underserved, underrepresented, disadvantaged populations; and strategic plan includes social mission terms sub-indicators: inclusion of health equity or health disparities, inclusion of social determinants of health, and inclusion of underserved, underrepresented, disadvantaged populations.

<sup>b</sup>There were no coding instances for the following indicators in Area 7: developed collaborations sub-indicators: collaborations with community colleges, collaborations with faith organizations, collaborations with federally qualified health centers, collaborations with health department, collaborations with K-12 schools, collaborations with legal professions, and collaborations with philanthropic organizations; student participation in off campus rotations, learnings; and faculty compensation for off campus rotations, learnings.
There were no coding instances for the following indicators in Area 17: grads entering primary care and sub-indicators: dental – grads entering general practice dentistry, public health dentistry, pediatric dentistry, medicine – grads entering residency in family practice, medicine – grads entering family medicine, general internal medicine, general pediatrics, med-peds, or general ob-gyn following residency, nursing – grads entering public health nursing, work with underserved populations, and nursing – grads entering primary care practice, family medicine, pediatrics, preventive health; and grads practicing in community health centers, federally qualified health centers.

ACEN had the same coding instances across degree programs: diploma, associate, bachelor’s, and master’s degree.
Table 4
Instances of the Student Diversity, Faculty Diversity, Academic Leadership Diversity, and Pipeline Programs Activity Areas in the Standards Documents of Selected Accreditors, 2016-2020

<table>
<thead>
<tr>
<th>Accréditeur</th>
<th>Général diversité des étudiants</th>
<th>Général diversité du corps professoral</th>
<th>Service d'apprentissage</th>
<th>Programmes de pipeline pour les K-12</th>
<th>Programmes de pipeline pour les undergraduates</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACEN</td>
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<td>0</td>
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</tr>
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<td>ACPE</td>
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<td>ARC-PA</td>
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<tr>
<td>CACMS</td>
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<tr>
<td>CCNE</td>
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<td>CNEA</td>
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<td>COCA</td>
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Abréviations: ACEN, Commission d'accréditation en soins infirmiers; ACPE, Commission d'accréditation en éducation pharmaceutique; ARC-PA, Commission d'accréditation en aide médicale; CACMS, Commission d'accréditation des écoles médicales canadiennes; CCNE, Commission d'accréditation des écoles d'infirmières; CNEA, Commission d'accréditation des écoles d'infirmières; COCA, Commission d'accréditation des écoles d'ostéopathes; CODA, Commission d'accréditation des écoles dentaires; LCME, Commission de liaison en éducation médicale.

a There were no coding instances for the following indicators in Area 8: underrepresented minority representation and sub-indicators: African American graduation, Hispanic, Latinx graduation, and collection of gender identity, sexual orientation information; first generation to go to college and sub-indicator: first-generation college student graduation; grant and fellowship dollars awarded for financial need; holistic review; and students from the community of commitment.
b There were no coding instances for the following indicators in Area 9: underrepresented minority faculty representation and sub-indicators: African American diversity and Hispanic, Latinx diversity; gender diversity and sub-indicators: men in nursing faculty and women in medicine, dentistry faculty; and openly self-identified LGBTQ faculty.
c There were no coding instances for the following indicators in Area 10: underrepresented minority academic leader representation and sub-indicators: African American diversity and Hispanic, Latinx diversity; gender diversity and sub-indicators: men in nursing academic leadership and women in medicine, dentistry academic leadership; and academic leader identifying as LGBTQ.
There were no coding instances for the following indicators in Area 11: pipeline programs for K-12 students sub-indicators: K-12 pipeline students from minority groups and K-12 pipeline students in the free or reduced lunch program; and pipeline programs for undergrad students sub-indicators: undergrad pipeline student from minority groups, undergrad pipeline students who are first generation, and undergrad pipeline students that enter health professions.

ACEN had the same coding instances across degree programs: diploma, associate, bachelor’s, and master’s degree.
Table 5
Instances of the Student Training, Faculty Training, and Faculty Activism Activity Areas in the Standards Documents of Selected Accreditors, 2016-2020

<table>
<thead>
<tr>
<th>Accreditor</th>
<th>Area 12: Student training</th>
<th>Area 13: Faculty training&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Area 16: Faculty activism&lt;sup&gt;b&lt;/sup&gt;</th>
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</thead>
<tbody>
<tr>
<td>ACEN&lt;sup&gt;c&lt;/sup&gt;</td>
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Abbreviations: ACEN, Accreditation Commission for Education in Nursing; ACPE, Accreditation Council for Pharmacy Education; ARC-PA, Accreditation Review Commission on Education for the Physician Assistant; CACMS, Committee on Accreditation of Canadian Medical Schools; CCNE, Commission on Collegiate Nursing Education; CNEA, Commission for Nursing Education Accreditation; COCA, Commission on Osteopathic College Accreditation; CODA, Commission on Dental Accreditation; LCME, Liaison Committee on Medical Education.

<sup>a</sup>There were no coding instances for the following indicators in Area 13: faculty training on health advocacy; faculty training on social determinants of health; and faculty training on unconscious, implicit bias.

<sup>b</sup>There were no coding instances for the following indicators in Area 16: faculty involved in advocating for health, social determinants of health; and faculty involved in community programs on health disparities, social determinants of health.

<sup>c</sup>ACEN had the same coding instances across degree programs: diploma, associate, bachelor’s, and master’s degree.