ACCME Board of Directors Roundtable with Stakeholders Held December 3, 2009
Comments and Positions of Participants

On December 3rd, 2009, the ACCME Board met with representatives of the following stakeholder organizations.

ACCME Member Organizations

American Board of Medical Specialties
American Hospital Association
American Medical Association
Association for Hospital Medical Education
Association of American Medical Colleges
Council of Medical Specialty Societies (CMSS)
Federation of State Medical Boards

CME Organizations

Alliance for Continuing Medical Education
Alliance of Independent Academic Medical Centers
CMSS CME Directors' Component Group
North American Association of Medical Education and Communication Companies
Society for Academic Continuing Medical Education

CME Accreditors

American Academy of Family Physicians
American Osteopathic Association
Illinois State Medical Society
Oklahoma State Medical Association
Pennsylvania Medical Society
Texas Medical Association

This special meeting was conceived in 2008 as part of a larger strategy for updating the Board's communications with member organizations and stakeholders.

Dr. Barnes and Dr. Perina welcomed everyone and expressed appreciation for their making time to participate in the roundtable. They noted that the goal for the discussion was constructive engagement with the key stakeholders in CME to help the Board understand the challenges and opportunities for the ACCME system, and to help the ACCME adapt its current practices. Dr. Barnes thanked the participants for the discussion items they had submitted in advance, noting that certain themes had emerged:

- Enhanced coherence and alignment between ACCME and other accreditation and credit systems
- Equivalency between national and state medical society systems
- Implementation of the Updated Accreditation Criteria
- Impact of fee increases on providers
- Issues relating to new formats of CME
- New activity reporting system

In addition, other topics discussed during the roundtable included the operational challenges of the ACCME accreditation requirements, the relationship of CME to maintenance of certification and licensure, and communicating CME's value to the broader health care system.

The following represents comments and positions of roundtable participants.

The 2006 ACCME Accreditation Criteria: System-Level Challenges

Participants discussed a wide range of issues related to the 2006 Accreditation Criteria, including their impact on accredited providers as well as their integration into the ACCME accreditation process.

The Updated Accreditation Criteria have"raised the bar of CME" – but at a cost. At the state and national levels, there have been concerns expressed about the perceived burdens of the Criteria and the accreditation process. From the state accreditation perspective, the ACCME must assess the potential impact on small hospitals, and allow some level of flexibility in how the Criteria are implemented in diverse settings. Despite these challenges, the state system is committed to demonstrating the value of CME accreditation just as hospital associations demonstrate the value of Joint Commission accreditation.

Participants requested: 1) Specific clarifications of the wording and intent of some Criteria, 2) a reduction in redundancy of the information requested on the self-study report tabs, and 3) a simplification of the ACCME labels used for activity-file documentation to make them relate more closely to the Criteria.

The current paperwork requirements may take away time from engaging in planning and execution of the educational processes. The observation was made that the Updated Accreditation Criteria seem focused on file minutiae and this takes away from the CME system's perceived contribution in the larger system to improve health care.

The participants pointed out some specific issues with the wording of some Criteria and with the wording of some of the accreditation process documents. Some Criteria are overlapping and intertwined. This creates redundancy and causes confusion. For example, compliance with Criterion 22 (The provider is positioned to influence the scope and content of activities/educational interventions) is dependent on the provider being in compliance with other Criteria. Some Criteria are linked, in series, so if the provider cannot meet the first criterion, then subsequent Criteria will also not be met. For example, Non-compliance in C13 will be expected to be followed by Non-compliance in C14 and C15[1]

In addition, some of the Criteria are difficult to address effectively in the self study report when documentation goes to the support of a negative, e.g., "Describe how you ensure that social events do not compete with or take precedence over educational activities (SCS 3.11)."

To address some of these challenges, it was suggested that the level of assessment move in the direction of the overall program rather than specific activities and that criteria be "bundled" in coherent groups on which compliance would be determined.

The group transmitted an overall feeling that the ACCME did not need to abandon the underlying principles of its requirements. The participants expressed support for the accreditation requirements in terms of content. Concern was expressed about implementation challenges, duplication, lack of clarity and consistency in interpretation for end users. The ACCME needs to look at administrative

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[1] ***Criteria 13.*** *The provider identifies, plans and implements the needed or desired changes in the overall program (e.g., planners, teachers, infrastructure, methods, resources, facilities, interventions) that are required to improve on ability to meet the CME mission.*
Criteria 14*. The provider demonstrates that identified program changes or improvements, that are required to improve on the provider's ability to meet the CME mission, are underway or completed.*
Criteria 15. *The provider demonstrates that the impacts of program improvements, that are required to improve on the provider's ability to meet the CME mission, are measured.*

simplification and documentation simplification. It was suggested that the current methods for assessing compliance with the 2006 Accreditation Criteria be re-examined, with input from the provider community and other stakeholders.

The ACCME responded that it will consider strategies for reducing documentation requirements and clarifying the requirements. The ACCME will also continue to offer education and resources to assist providers with implementation of the Criteria.

Accreditation Outcomes and the Standards for Commercial Support

The ACCME shared its concern that a large cohort of providers are not able to demonstrate compliance with one or more elements of the Standards for Commercial Support. The major area of Non-compliance is the failure to identify and resolve activity planners' conflicts of interest. In these Criteria there is a cascade effect. If disclosure is not obtained initially, then the provider cannot resolve conflicts of interest and the provider cannot disclose relevant relationships. Sometimes the problem is a verification issue — the providers describe appropriate practices but do not provide documentation of compliance. In some cases, there is an actual performance issue. Standards 2 and 6 of the SCS present challenges because of the wide range of people and the variety of circumstances in CME. It was suggested that perhaps accreditation needs to focus on identifying the presence of overall processes rather than verification through documentation — because CME needs to be about education, not documentation.

The suggestion was offered that one factor contributing to this problem might be that people still believe that if there is no commercial support for an activity then there are no conflicts of interest to resolve or disclose. Also, as the frequency of financial relationships increases and the system becomes more sensitive to the importance of disclosure, the system may need to find new strategies to ensure proper behavior and to demonstrate that accreditation requirements have been met. It was suggested that perhaps accreditation outcomes would improve if disclosure and the resolution of conflicts of interest became an institutional commitment, not just a CME commitment. If these became core values and were associated with personal accountability and professionalism, it might make a difference to the ACCME's compliance findings.

It was felt that CME professionals should take this issue beyond the CME community to talk about why this is important – even if the conversation has to start at the medical school level. Discussions of the medical profession's role in ensuring that physicians manage their conflicts of interest and meet their professional obligations may be assisted by the CMSS's development of a new code of conduct for specialty societies – encompassing continuing medical education, research, the development of practice guidelines, and relationships with industry. In addition, the ABMS' new Ethics and Professionalism Task Force will also explore these issues.

Expected Outcomes of Accredited CME

There was concern expressed that the ACCME's language regarding the design and expected results of accredited continuing medical education has been perceived as a problem. For example, some have the impression that the ACCME only accepts CME that changes physicians' performance in practice. Others read the Criteria as preventing education that is only designed to change knowledge – which would be a serious constraint to those who identify a knowledge need underlying a professional practice gap.

Others questioned the assumption that the ACCME Criteria require providers to improve performance for every single CME activity. It was pointed out that a physician's journey of learning and improvement has multiple steps and often starts with seeking new knowledge. Knowledge is a starting point. AMA-defined Performance Improvement CME comprises different stages and requires that physician learners engage in whatever stage will help continue that journey.

It was suggested that organizations with certain requirements for learning (e.g., credit systems, Maintenance of Certification® programs, credentialing bodies, a hospital Ongoing Professional Practice Evaluation program) should set the desired or expected outcome from accredited CME for a learner— rather than the CME accrediting body doing so.

ACCME Engagement Regarding Changes in Policy

The notion of a call for comment is critical. Equally important is the obligation for the ACCME to provide a thoughtful response to those comments before policy is made. When there are new rules it is helpful to understand why policy is adopted or not adopted. Prior to policy call for comment, there should be a wide-ranging dialogue with stakeholders to make them part of the process. Stakeholders and the ACCME need to move from confrontational to collaborative relationships. Dialogue with stakeholders should include interactive formats (e.g., webinars, conference calls, in person meetings at ACCME, regional forums, conversations with end-users). Providers need to understand and be part of discussions about changes that impact the complexity or burden of the system. Process is important. Conversations and dialogue will help ensure that the language of the ACCME's requirements is understandable and meaningful. The system will be able to take ownership, as partners, of new accreditation standards and better communicate them to the end-user. If we are clear, we can speak with a common voice.

Participants with concerns about the recent fee increases asked about the process to determine such changes. They indicated that such increases could place a significant burden on some providers. In the current economic environment, the ACCME realizes the financial strain on all of the institutions is significant; therefore the ACCME has done some financial "belt tightening" and some increases will be incremental over time.

Participants from the state medical society system feel it is important that, going forward, the system develop its physician leadership so that they can communicate the importance of new standards. There is value in advancing a paradigm shift in how our leadership perceives CME. At the 2009 ACCME SMS conference it was noted that there was a lack of volunteers, especially MDs, at local levels. We need the ability to identify CME leaders and raise them up in the system.

Provider Activity and Reporting System (PARS)

ACCME provided clarification on the scope and intended outcomes of this web-based system. PARS, which has been built using Medbiquitous® standards, has been under development since 2007. It will be the vehicle for managing provider activity data that currently is submitted to ACCME as Microsoft Excel® spreadsheets. ACCME is transferring an existing function to a new tool. PARS includes the same data fields currently being submitted by providers within the ACCME accreditation process, along with those used to calculate the ACCME Annual Report (activity revenue, activity expenses, amount of commercial support, number of participants, hours of education). Additional fields built into the system – that will be optional — include names of commercial supporters, type of in kind commercial support and content

of the activity. PARS does not ask for, or store, information about participants in activities. The potential value of ACCME reporting can be multidimensional: providers and the public would benefit. The data collected by PARS could communicate the value of institutional commitment to CME and CME's contribution to patient care/performance improvement. Participants noted the need to evaluate/assess the administrative burden of reporting, and what the scope and intent of the data collection is. There is considerable cost associated with the manipulation of data, but reporting can help to force a paradigm shift.

The system is in a pilot phase. A sample of users has already provided feedback on the direct entry interface. The ACCME has identified some technical corrections to make. Using the National Library of Medicine (NLM) Medical Education Subject Headings (MESH) could be beyond the capability and resources of some providers and might not serve the intended purpose of the ACCME. A free-text, keyword system would be an easier and simpler alternative, as would an NLM system for identifying keywords from activity titles. The ACCME online reporting system will not go live in January 2010. The next step in the pilot process is testing the system's capacity to batch upload activity information directly from providers. The core functionality of the system will be operational and available to providers during 2010. It is intended that the 2010 ACCME Annual Report will be submitted to the ACCME using PARS, by the end of March 2011.

The overall value of PARS needs to take into account the value of the activity information for providers (e.g., benchmarking, analysis for overall program evaluation) and the overall value of the public reporting of information about the CME system beyond that which is currently available. This needs to be balanced against the resources consumed by the system in reporting.

Information sharing and involvement of providers by the ACCME as development proceeds is important. As PARS evolves, the information available to the CME system needs to be updated and clarified. There also needs to be an opportunity for the system to have input along the way.

Thirty Thousand Foot Perspective from /about Accreditors, Credit Systems and ACCME Member Organizations

CME needs to expand beyond its silo and into the broader health care community. A unique CME taxonomy and nomenclature may be acting as a barrier to this. There is a problem with language—the taxonomy for CME is different than the taxonomy of the larger health care environment, creating confusion and becoming a barrier to integration and compliance.There is a need for a common taxonomy that includes CME and the health care environment. We need to look at how to standardize language across the spectrum of health professions.

Accredited CME providers should be held accountable for ensuring that their program meets or exceeds the accreditation criteria. Although it is also important that the expectations of learners, as articulated by credit and MOC® systems, are met, this may be outside CME providers' scope of responsibility.

Some credit systems are now requiring that any provider applying for PI CME must identify which core competencies will be aligned with the activity. The intent of PI CME (this is the “new” CME) is to begin to give credit for assessing practice, learning what and why, and making changes in the practice. At the same time, we need to recognize that it is important to identify whether an intervention is intended as ”education” or intended to drive a change — recognizing that the rules or regulations for each may be

very different. Some participants felt that time is not the best measure of educational participation and learning and a new system of metrics for success needs to be determined. PI CME is not time specific, but live activities are still time sensitive.

ABMS boards have not historically required CME and are just now looking at CME's role in board certification/recertification as a part of the overall process. The MOC perspective is that knowledge acquisition is more of a CPD model – but that the gaps in knowledge are relevant to physicians and health care professionals. MOC® systems are beginning to recognize that some CME activities are more relevant than others to scope of practice. Because MOC has to be linked to scope of practice, perhaps there are certain CME activities that should be tagged as MOC® CME because they fit within the specialty board' s scope of practice . Part of the MOC® discussion about CME will be about documentation process. Certifying boards are serious about documentation that requirements are met. Certifying Boards can be interested in going back and reviewing a diplomate's CME activities for relevancy within that diplomate's practice.

FSMB tracks credit requirements primarily by attestation, but also conducts random audits. If a physician is found non-compliant, then intensive analysis/review is implemented at a state level. It was suggested that licensure will still require CME credit rather than practice improvement change or a connection to scope of practice. At the same time, credit systems have been working effectively over the years to move credit away from a time metric. Maintenance of Licensure is an important part of the equation as 30 percent of currently practicing MDs are not board certified. MOL may focus on being about QI processes within a designated practice area.

The needs of individual learners over a lifetime and activity-based assessments do not always align or translate from one framework to another. For example, some Tumor Boards/Cath Conferences and Morbidity & Mortality Conferences provide some of the optimal contextual learning for performance improvement for physicians and health care professionals, yet planning and documenting compliance for these types of activities can be challenging under the current ACCME expectations. To provide quality CME, geared to patient care with an appropriate process, may be too great a burden for those currently assigned that responsibility (e.g., CME coordinator and rounds coordinator). This challenge needs to be addressed by the whole "house of medicine" so that we can meet the needs of MOC and MOL in a seamless fashion. The AAMC can be helpful in taking the lead to ensure academic centers take responsibility for institutional commitment to continuous quality improvement and PI CME.

Local CME incorporates knowledge for knowledge's sake and creates a community of peers who can interact and gauge each other's performance and involvement as part of the overall educational process. It holds communities accountable to professional standards for performance and education. There is the perception of the lack of value from the ACCME for knowledge-based group-learning opportunities. Knowledge for its own sake is important as it may provide insights about what physicians need to know in the future. The value of CME at the local level includes collegiality, accountability and encouragement within the profession of medicine. It is thought that peer pressure produces accountability within communities of practice. In the face of new learning media we should ask: When do we need to gather MDs together and what will that learning be? What will be the impact of "free" content available on the Internet and how can that access to content be balanced with the need to get people together? The physician's journey requires multiple steps, starting with knowledge and

engagement with a variety of formats that meet their defined needs. It involves the physicians at different levels. CME needs to match educational activities to physician learning stages.

The institutional framework in which CME occurs is important. It would be helpful if the CME enterprise could get the corporate leadership of institutions to recognize that CME is part of a bridge to quality, a desirable and necessary step in improving patient care. CME could better utilize health care's core measures. Perhaps CME organizations need to be more transparent and, for example, report failures to disclose or resolve COI. CME providers need to elevate their status and demonstrate their contribution to process improvement, so that institutional leaders will allocate CME offices more resources than 25 percent of a full-time employee. This would assist the CME offices of small community hospitals in moving CME from lectures to practice improvement. This may help CME become part of the conversation in risk management meetings, for example. At the recent ACCME State Medical Society meeting, there was discussion about CME providers as agents of change — the consensus was that this is an appropriate role for CME providers. Hospital organizations are looking at the effect of traditional CME on practice improvement. The American Hospital Association noted that from the evidence they have reviewed, CME appears to have a limited effect on performance improvement at the administrative level. Administrators need to see strong linkages between CME and performance improvement before they would consider increasing funding.

MOC is encouraging physicians to get involved in system-based improvement activities as a way to move physicians into a new way of thinking and to get their CME programs linked with the quality departments of their institutions. These processes also create a readiness for change among learners. If physicians could use hospital-based PI CME to meet MOC requirements, it would be very helpful, as CME does not currently have that kind of "stick." Three primary care boards are currently working on a Part 4 Pilot Project with the Mayo Clinic, looking at systems-based improvement. This may offer the best option. The work with Mayo has finally linked education to quality improvement and transformed an individual physician issue into an institutional commitment. This organizational framework of institutional/organizational recognition of acceptable MOC PI activities may change the "framework."

Closing remarks

The roundtable afforded participants an opportunity to share perspectives with each other and with the ACCME. It was a unique opportunity to get diverse and complementary feedback. It was important that we came together. It was a learning experience and demonstrated many interpretations, many challenges and a range of concerns. The roundtable has set the stage for future interactions and communications.

The ACCME has a commitment to continuous improvement. The ACCME needs to receive ongoing feedback and reshape expectations. The ACCME has a strong commitment to following through with the information points collected in this roundtable discussion and thanks all participants. Similar meetings will be conducted on at least an annual basis and the ACCME will communicate its progress in addressing the above initiatives and concerns to stakeholders on a regular basis.