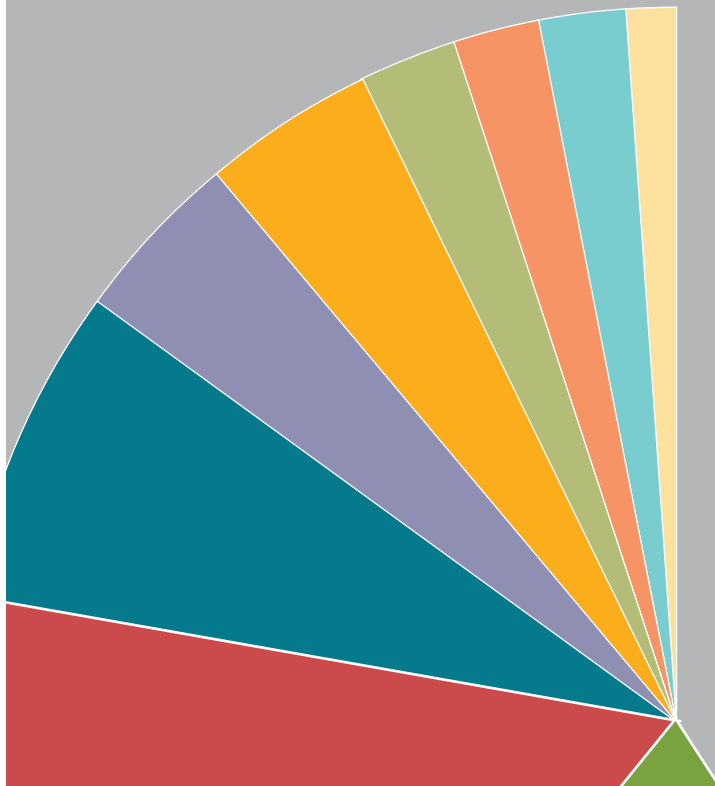


# Continuing Medical Education as a Strategic Resource

More than  
**1,100** hospitals  
and health  
systems  
provided  
**35%** of the  
accredited  
CME in **2013**.

How is your  
organization  
using this  
resource?



American Hospital  
Association's  
**PHYSICIAN LEADERSHIP FORUM**



Suggested Citation:

Combes J.R. and Arespachoga E. Continuing Medical Education as a Strategic Resource. American Hospital Association's Physician Leadership Forum, Chicago, IL. September 2014.

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# Executive Summary

Continuing medical education (CME) provides support for continuous improvement and learning to help physicians address gaps in their professional practice and as such is required of physicians for renewal of license, maintenance of specialty board certification, credentialing, membership in professional societies, and other professional privileges. Many hospitals, as part of their educational programs, offer accredited CME activities. In fact, hospitals account for a large proportion of the CME-granting programs with about 35 percent of the activities and 38 percent of the credit hours offered in 2013. And, according to the Accreditation Council for Continuing Medical Education (ACCME), hospital CME programs were part of the more than \$1.5 billion in support for 2013 CME activities. So what do hospitals and health systems get for their CME investment?

Historically, CME has focused on the sharing of medical knowledge rather than developing professional and institutional competencies that might be necessary to transform care, improve outcomes, and practice efficiently and effectively in the hospital setting. Today's rapidly changing health care delivery system requires physicians and hospitals to partner to transform the delivery model, and CME, as an existing mechanism, can enhance and strengthen that partnership.

To that end, the AHA's Physician Leadership Forum, with input from our members, examined the value of CME to hospitals as a strategic resource for physician-hospital alignment. This report, "Continuing Medical Education as a Strategic Resource," provides an assessment of the value of CME, recommends ways to improve the value of CME and identifies case examples of hospitals that are using CME to improve performance and align the delivery system.

## Recommendations

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CME provides an opportunity to share medical knowledge, help physicians understand their connection to the health care delivery system and underscore the need for system-based practices and behaviors. To improve the value of CME as a strategic resource, stakeholders should consider the following steps:

- Hospital associations should share best practices to increase adoption and explore partnerships with medical societies and others to increase awareness of CME.
- Hospitals and health systems should facilitate greater communication between the CME professionals, physician leadership, and organization leadership to improve CME offerings. Organizations should develop physician champions to drive engagement of the staff, and encourage the use of data from community health assessments to spur education on population health issues.
- The accreditation community should review accreditation standards for areas of improvement and simplification. For example, accrediting bodies should consider accreditation for smaller group projects that address current physician work. Hospital leaders also recommended using technology to streamline the paperwork burden in meeting accreditation requirements.
- Finally, as health care delivery is changing, so must the educational system. Greater use of performance-based CME, moving away from time-based activities, and increasing the diversity in accredited programs to adapt to the changing environment should all be considered.

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# Continuing Medical Education as a Strategic Resource

## Hospitals and CME

Continuing medical education (CME) provides support for continuous improvement and learning to help physicians address gaps in their professional practice. Many hospitals, as part of their educational program for physicians, have long offered accredited continuing education activities. Participation in accredited CME helps physicians meet requirements for renewal of license, maintenance of specialty board certification, credentialing, membership in professional societies, and other professional privileges.

Each year, almost 2,000 accredited CME providers offer more than 138,000 activities, with more than 24 million contacts ranging from live meetings and regularly scheduled series such as grand rounds, to performance improvement projects and medical journals. Hospitals account for a large proportion of the CME-granting programs with about 35 percent of the activities and 38 percent of the credit hours offered in 2013. In addition, hospitals account for nearly 90 percent of the activities and credit hours offered by state medical society accredited providers within the Accreditation Council for Continuing Medical Education (ACCME) system, reaching nearly 4.5 million health care professionals.<sup>1</sup> In fact, more than 1,100 hospitals and health systems were accredited to provide CME in 2013, and they provided nearly 48,000 accredited activities.

The AHA's Physician Leadership Forum, in its 2012 report *Lifelong Learning: Physician Competency Development*, identified two key domains where gaps were evident between the competencies expected of physicians in practice and those displayed – system-based practice and communication skills.<sup>2</sup> Hospitals play a vital role in the education and training of not only students and residents, but also serve as a forum for continuous improvement and learning for all practicing clinicians. As such, the *Lifelong Learning* report recommends that hospitals create an environment that fosters the development of and continuously supports the competencies, provide ongoing feedback to physicians on competency mastery, involves physicians in



In 2013, hospitals  
accounted for **35%** of  
all CME activities and  
nearly **90%** of locally  
accredited activities,  
reaching nearly **4.5**  
**million** contacts.

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<sup>1</sup> 2013 ACCME Annual Report. Accessed at [http://www.accme.org/sites/default/files/630\\_2013\\_Annual\\_Report\\_20130724\\_1.pdf](http://www.accme.org/sites/default/files/630_2013_Annual_Report_20130724_1.pdf)

<sup>2</sup> From ACGME/ABMS competencies, system-based practice involves demonstrating awareness of, and responsibility to, larger context and systems of health care. Being able to call on system resources to provide optimal care (e.g., coordinating care across sites or serving as the primary case manager when care involves multiple specialties, professions or sites).

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the full scope of care delivery including quality improvement projects and ensures an understanding of the realities of health care policy, regulation and economics.

As with all medical education, mastery of the competencies is a continuous process. System-based practice and practice-based learning, for example, lend themselves to emphasis during and following residency training through CME. However, in 2012, hospital-based accredited CME activities were still over half didactic sessions while less than two percent of activities were formal performance improvement. Institutional conference and rounds made up 30 percent of hospitals' accredited CME.

The *Lifelong Learning* report also recommended the use of ongoing professional development and CME to further competency development over a lifetime of learning. The report recommended several paths for using accredited CME to address competency or training gaps, such as providing credit for involvement in practice/hospital-based improvement projects or system-based practice efforts. CME offers a rapid response opportunity to close competency gaps for practicing physicians. Several case examples highlighted in the *Lifelong Learning* report have shown success in linking CME with hospital quality improvement projects, changing performance using data, and partnering with community organizations to develop CME around local health priorities.

In the past, CME involved a larger role for commercial support, i.e., support provided by any entity producing, marketing, re-selling, or distributing health care goods or services

consumed by, or used on, patients, but not those providing clinical services directly to patients. To address the lack of regulation of commercial support and the desire to maintain clear boundaries between educational content and commercial interest, the 1992 ACCME Standards for Commercial Support<sup>SM</sup>: Standards to Ensure Independence in CME Activities were developed. The standards were updated in 2004 and the field has seen a reduction in commercial support in the last decade. In 2013, commercial support accounted for only 26 percent of the total CME income while support from other sources, such as registration fees and allocations from providers, has steadily increased to 61 percent of CME income, or more than \$1.5 billion in 2013.<sup>3</sup>

While many hospitals and health systems offer CME to their medical staff, historically it has been focused on the sharing of medical knowledge rather than developing professional and institutional competencies that might be necessary to transform care, improve outcomes, and practice efficiently and effectively in the hospital setting. The rapid changes occurring in the health care delivery system require physicians and hospitals to partner to transform the delivery model; CME as an existing mechanism can enhance and strengthen that partnership. However, more work is needed to increase the availability, use and ease of obtaining CME credit for those projects that foster this collaboration between physicians and hospitals. By focusing CME opportunities on gaps in delivering streamlined and cohesive health care, it can be used to improve performance and align the delivery system.

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<sup>3</sup> ACCME 2013 Annual Report.

## AHA Field Assessment of the Value of CME

The AHA's Committee on Clinical Leadership (CCL), a Board of Trustees specialty committee which oversees the work of the Physician Leadership Forum, spearheaded an in-depth examination of the value of CME to hospitals as a strategic resource for physician-hospital alignment. The committee felt that the changes in medical education and the move toward lifelong learning provided an opportunity to use CME not only to share medical knowledge but also to help physicians understand their connection to the health care delivery system and underscore the need for system-based practices and behaviors. CCL members view hospitals as a unique environment where clinical professions intersect and function as a team and thus should be a crucible for team-based training. Additionally, the CCL agreed that CME could provide better integration and a stronger team perspective when employed as part of a strategic aim to drive better alignment and integration between physicians and hospitals.

As a result, during the fall 2013 meeting of AHA's policy development and governance groups, approximately 500 engaged members were asked to share their views on the value of CME to hospitals, how it is currently being used, particularly to engage physicians in practice-based learning, and to identify challenges to its use. Members also were asked to develop recommendations to the field and the CME accreditation community to enable greater use of CME as a strategic resource.

In 2013 commercial support for CME accounted for only **26%** of total CME income while other sources of income (including registration fees, grants and allocations from providers) totaled **61%** or more than **1.5 billion**.

### Survey results

The AHA survey asked members to rate the value of CME and its overall effectiveness in addressing the ACGME/American Board of Medical Specialties (ABMS) six core competencies: professionalism, patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, system-based practice. Results indicate that members found value in CME (rated 4.2 on a five point scale), but agreed that it has largely been used to address medical knowledge and patient care within their organizations. Respondents indicated CME was most effective in addressing medical knowledge and improving quality and patient care, but found it least effective in improving efficiency of physician practice, encouraging system-based care delivery and communication across the continuum, promoting team-based care delivery, and increasing physician engagement in the organization (Table 1).

**Table 1**

<b>Overall value of CME</b>	4.22
<b>Perceived effectiveness of CME in addressing the following:</b>	
Increasing medical knowledge	4.44
Improving quality of care	4.09
Improving patient care	4.07
Increasing physician understanding of the health care environment	3.52
Increasing physician communication	3.50
Increasing physician engagement in organization	3.40
Promoting team-based care delivery	3.36
Encouraging system-based care delivery and communication across the continuum	3.28
Improving efficiency of physician practice	3.05

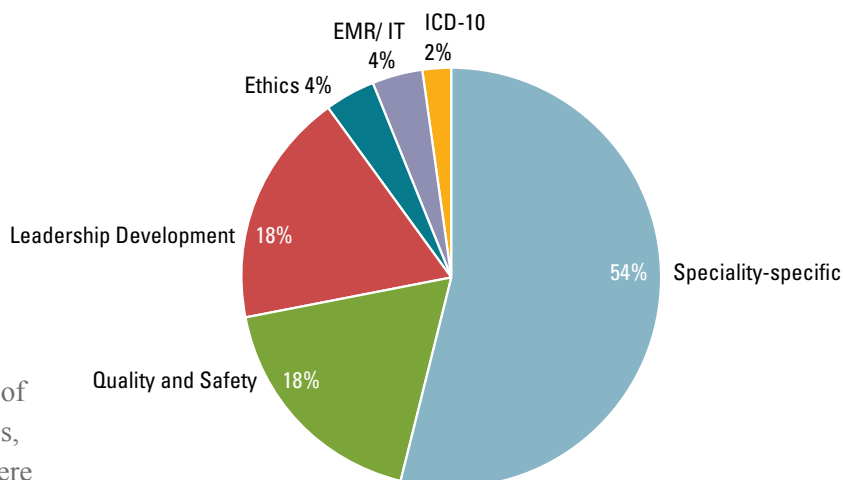
In discussions, many members felt that existing CME failed to emphasize the importance of clinical integration, performance improvement, and system-based practice. These survey results are consistent with the *Lifelong Learning* report findings, which found the largest gaps in system-based practice, and interpersonal and communication skills.

## CME Topics and Formats

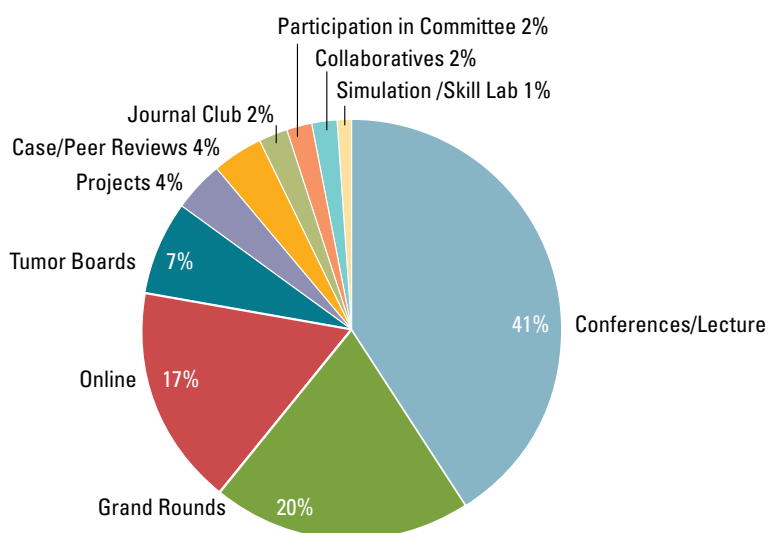
Members reported the majority of topics (54%) were specialty-specific or clinical in nature with only 18 percent focused on professional or leadership development and 18 percent on quality improvement.

While some organizations experimented with different educational modes, the majority of CME is still provided via lectures, conferences or grand rounds. There is a sizeable minority reporting online education, but participation in committees, projects or collaborative endeavors still accounts for less than 10 percent, and simulation for only one percent of reported formats. While the 2012 Harrison Survey reported 69 percent of academic medical centers surveyed utilized simulation as a teaching method at least occasionally, the total number of simulation-based activities remains small. In general terms, larger hospitals and health systems reported having in-house continuing education programs while many smaller hospitals chose to contract with other facilities or provide stipends for physicians to pursue CME outside of their organization.

### CME Topics



### CME Formats





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## Value of CME as Strategic Resource

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**Most respondents** who viewed CME as a strategic resource found it had value in addressing care coordination, implementing changes (electronic health records, etc.), improving teamwork, developing future leaders, driving behavior change, addressing system-based performance improvement, reaching community physicians, and reducing medical liability premiums. Members did caution that CME content needs to be aligned with hospital goals and relevant to physicians' needs to be effective.

While CME traditionally has been lecture-based, didactic sessions focused on medical knowledge and patient care, some hospitals are beginning to use it to engage both employed and independent physicians in the life of the hospital. Several organizations have offered CME credit for programs that increase clinical integration, drive the hospital quality agenda, and performance improvement projects. Members also reported using CME to reach out to community physicians to participate in projects with the hospital to address community chronic disease management. In addition, team-based CME across departments and clinical professions was reported. Finally, some hospitals are using CME to encourage physician involvement in hospital strategic planning and visioning.

Those using CME to address strategic issues found it initially challenging to integrate strategic content, but felt the resulting improvements were worth the effort. Most members felt their CME programs were more successful when led by a physician, especially to increase credibility and buy-in with CME not focused on the more



**Successful CME programs also often link CME offerings with ongoing physician practice evaluation, credentialing requirements, and other existing certifications while tying content to the hospital strategic needs.**

traditional areas of medical knowledge and patient care. Successful CME programs also often link CME offerings with ongoing physician practice evaluation, credentialing requirements, and other existing certifications while tying content to the hospital strategic needs.

A few members indicated they had not thought to use CME as a strategic resource and found the discussion enlightening. Others indicated that they had not thought of using CME to assist their physicians in fulfilling Maintenance of Certification (MOC) requirements or granting CME credits for activities related to Ongoing Professional Practice Evaluation (OPPE) or Focused Professional Practice Evaluation (FPPE).

Many of those who felt that CME, as currently offered, was valuable in teaching medical knowledge and patient care felt it was less useful in addressing the other competencies. A handful of members indicated they did not find CME of value, largely because their organizations do not offer CME or their physicians get required CME through medical society participation. While there were those who did not see CME as a strategic resource, the majority of members did recognize it as an alignment opportunity that, if done right, could help manage patient care and improve performance.

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## Challenges in Using CME

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**Survey respondents** found the process for obtaining CME accreditation to be paper-work-intensive, time-consuming, and somewhat expensive and felt that the standards were not sufficiently in tune with new learning modes to allow for experimentation. They also suggested greater use of technology to streamline processes associated with offering CME. Members also indicated challenges in garnering attendance and a lack of “buy-in” or cooperation from physicians.

For smaller organizations, complying with CME certification standards can be prohibitively staff-intensive. These members were particularly concerned with the time commitment needed for developing organization-specific programming and that non-traditional content might be more difficult to accredit. They were concerned performance improvement or other “non-traditional” program requirements are not sufficiently robust and asked for greater clarity. There also was concern raised regarding moving to different modes of education delivery. Many indicated that physicians, especially the younger generation, were interested in online learning opportunities and other modes, but organizations were finding the development and approval process to be more challenging, with little room for experimentation within the regulations.

While roughly one quarter of the 2012 CME activities were conducted online, they still account for only 6 percent of the credit hours granted. Online CME-granting programs typically are short in duration and thus grant

fewer credit hours, even though they may provide increased learning in more concentrated doses. These online activities reach a large audience with 34 percent of physician participants and 53 percent of non-physician participants completing some online CME in 2012. Studies have shown that Internet-based education has similar effects on knowledge and skills as traditional CME, making it a viable option, especially for participants with time and resource limitations (Shojania 2012). Given the demands on physicians’ time, alternative learning methods that do not require the sacrifice of practice or family time should be encouraged.

According to several studies, online education works well as a supplement for non-controversial or complex topics, but those topics with greater controversy or potential to be misapplied, benefited from the increased interaction and in-depth discussion of in-person education. One study indicated that “face-to-face CME was preferred for new or controversial content and eCME was preferred for filling individuals’ knowledge gaps.” (Bower, 2008)

AHA member discussions highlighted the challenges in garnering physician participation in both development of and attendance at CME activities. Some found greater uptake among employed physicians and increased interest in performance improvement and system-based practice within this group. Others indicated that physicians in their organizations did not see themselves as leading performance improvement and thus were less interested in that type of CME. A few members raised concerns regarding team-based care delivery being difficult to

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coordinate given clinical schedules, while others mentioned difficulty in getting physicians who are not often in the hospital to participate in hospital-based CME. Finally, some noted that inter-departmental differences and specialty-based silos can be barriers to cross-departmental training and organization-wide programs.

To engage medical staff, “physician champions” are needed, especially in non-clinical skills education. Such champions could ease the fear that using CME to address system issues would take away from clinical education time. The need for physician leadership in CME education design and delivery is supported in the literature, as one study states, “physicians learn through interaction with colleagues, whether in formal small-group learning sessions or informal collegial interactions” (Sargeant, 2006:133). Several other studies highlight the importance of CME programs to improve care delivery being designed and led by physicians who understand the complexity and challenges of care delivery. (Van Hoof, 2011; Sargeant, 2006; Eiser, 2013; Pletcher, 2011).

In addition to physician leadership, commitment from the top to drive change through the CME process is essential, especially for those issues that cross disciplines and departments. Researchers have found that successful educational interventions required administrative and clinical buy-in to generate a climate of change across the organization (Ramaswamy, 2011).

## Recommendations

AHA members encouraged review of the accreditation standards for areas of improvement and simplification, broader sharing of best practices, increased communication between CME departments and senior leadership, and earlier and greater involvement of physician leaders as champions in CME as ways to improve the use of CME as a strategic resource for hospitals. Members recommended several areas for hospitals and health systems to encourage the use of CME, approaches for associations to increase access and awareness for CME and successful practices, and recommendations for the accreditation community.

### Recommendations to Hospital Associations

Members suggested two areas in which AHA and state, metropolitan and regional hospital associations can increase the use of CME as a strategic resource among hospitals and health systems:

- **Share successful practices.**

Many hospital and health system leaders indicated they are looking for examples or suggestions that could be adapted for use in their own organizations and recommended the AHA and allied associations promote successful practices. Specifically, several groups emphasized the need for greater communication between the CME education professionals, physician leadership, and organization leadership as essential to improving CME offerings and encouraged AHA to share practices in this area. Finally, members suggested hospital associations

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could assist in gathering data from community health assessments to drive engagement in population health.

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EXAMPLE: ACGME's recently released Clinical Learning Environment Review (CLER) "Pathways to Excellence" highlights six pathways for improvement in the learning environment for residents and interns which could be applied to CME. Visit [www.acgme.org](http://www.acgme.org) to learn more about CLER.

- **Explore partnership opportunities.**

Members suggested that hospital associations work to integrate offerings with state medical societies and medical specialty organizations in promoting and offering CME. They also encouraged state hospital associations and medical societies to invest in physician leadership development programs. In addition, work at the medical specialty societies and the AMBS regarding the requirements for MOC could provide an additional opportunity for partnership.

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EXAMPLE: Washington State Medical Association and the Washington State Hospital Association collaboratively published a welcome packet for chief medical officers (CMOs) that identifies leadership development opportunities. For example, there is an interactive hybrid distance learning course – combining face-to-face and online learning – focused on leadership and conflict management, strategic planning, safety and quality, finance, communication and advocacy. This

educational opportunity is offered in partnership with the University of Washington (UW) Graduate Programs in Health Administration, and UW Professional and Continuing Education. For more information, visit <http://www.wsha.org/files/82/CMOOrientationpacket.pdf>.

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EXAMPLE: The Ohio Medical Society and Ohio Hospital Association have partnered to create a physician leadership institute. The Physician Leadership Institute of Ohio will enroll between 12- 20 physicians to provide an individualized and comprehensive assessment to ensure improvement in leadership skills, knowledge and experience. For more information, visit: <https://www.osma.org/Documents/Education/PLIO/2013-physician-leadership-institute-of-ohio-flyer.pdf>.

- **Advocate for harmonization of MOC, quality improvement and OPPE/FPPE requirements with CME.**

AHA members suggested CME value could be enhanced with better coordination of the requirements for MOC and OPPE/FPPE activities. Physicians would have the benefit of not having to fulfill multiple requirements and would see the value in participating in hospital quality improvement activities which provided CME credit that also could be used to satisfy MOC and OPPE/FPPE.

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EXAMPLE: The AHA's Physician Leadership Forum, in partnership with the ABMS, conducted a series of interviews

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with hospital and health system CMOs to understand current usage of OPPE/FPPE in hospitals and how it can and might integrate with the requirements of MOC. Work is underway with ABMS and The Joint Commission to find ways to integrate these activities.

### Recommendations to the Hospital and Health System Field

Members agreed that a larger focus on performance improvement and practice-based learning would be very relevant and felt there was a need for greater communication between the CME professionals, physician leadership, and organization leadership to improve CME offerings.

- **Use CME to advance strategic goals and engage physicians as partners in strengthening organizational competencies.**

Members encouraged hospitals and health systems to consider using CME to advance the strategic aims of the organization and suggested that there be a closer link between the C-suite, those developing the strategic plan, and the CME committee. Several groups emphasized the need for greater and more regular communication between CME professionals, physician leaders, and organization leaders to enhance CME offerings. They also encouraged hospitals

to especially communicate the value of strategically oriented CME to the physician community to engage them as partners in improvement efforts within the organization.

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**EXAMPLE:** The Multi-Specialty MOC Portfolio Approval Program of the ABMS offers a single process for health care organizations to support physician involvement in quality improvement and MOC across multiple specialties. This pathway offers a streamlined approach for organizations that sponsor and support multiple well-designed quality improvement efforts involving physicians across multiple disciplines to work with ABMS Member Boards to grant MOC Part IV credit to physicians who are involved in those improvement efforts. For more information, visit <http://mocportfolioprogram.org/about/>.

- **Consider the use of existing non-traditional CME applications to encourage improvement efforts and physician engagement in strategically oriented CME.**

Time and travel constraints have increasingly pushed the popularity of online and just-in-time CME opportunities that can be adapted to busy physician schedules. Hospitals and health systems are encouraged to employ these options where they are available.

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**EXAMPLE:** Non-traditional CME applications, such as the American College of Physicians Smart Medicine

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clinical decision support program, provide CME through question and answer sessions. For more information, visit <http://smartmedicine.acponline.org>.

- **Develop physician champions.**

AHA members felt it was essential to develop physician champions to highlight the importance of CME in improving health care delivery. Through physician engagement in the full scope of the organization's strategic plan, CME could be used to broaden the understanding of the organization and community needs. Physicians value CME focused on medical knowledge and patient care as essential to their dedication to lifelong learning. Physician champions can communicate the value proposition in strategically-focused CME and the need to work collaboratively to improve the clinical enterprise.

- **Encourage stronger links between CME and quality improvement.**

Members felt that hospitals should work to increase CME related to performance and quality improvement to enhance the full team's understanding of the system aspects of improvement. According to the 2012 Harrison Survey, linkage of CME to quality and performance improvement among academic medical centers has increased from less than 10 percent to about 15 in the last six years, but there is still much room for improvement. Members felt the need for structured links between CME and quality improvement, and where appropriate links to graduate medical education through sharing of staff, participation on shared committees

and other formal crossover arrangements. The use of performance improvement CME (PICME) also could provide opportunities to expand and link CME with hospital quality improvement efforts. Finally, integration of ongoing professional practice evaluation data into the development and prioritization of CME activities could reinforce practice improvement efforts.

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EXAMPLE: Scottsdale (Ariz.) Healthcare created a quality curriculum for its residency programs that has driven interest across the medical staff. Scottsdale Healthcare uses CME to align physicians across the health care system and to drive performance improvement. <http://www.ahaphysicianforum.org/webinar/2013/using-cme/index.shtml>

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EXAMPLE: Lancaster (Pa.) General Hospital has had success integrating education with quality improvement and medical staff services at a community hospital. Efforts include a physician leadership development course that Lancaster's CME department developed and implemented. For more information, visit <http://www.accme.org/education-and-support/video/interview/integrating-cme-quality-improvement-and-promoting-physician>.

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- **Use community health assessment and other available data to inform CME.**

Members suggested using community health data from assessments to drive engagement in population health education and projects to improve community health and help physicians understand their roles in changing the delivery system. Hospitals also should look at ways to use outcome data, ongoing professional practice evaluations and other data for improvement and CME efforts in a structured way.

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**EXAMPLE:** HealthPartners Institute for Education and Research in Bloomington, Minn developed a regional initiative to address professional practice gaps for family physicians and other health care practitioners treating returning U.S. veterans with significantly higher incidence of mental health disorders and suicide risk. For more information, visit [https://www.healthpartners.com/ime/clinician-resources/returning-military/DEV\\_017506](https://www.healthpartners.com/ime/clinician-resources/returning-military/DEV_017506).

- **Encourage inter-professional and team-based learning opportunities.**

Traditional continuing education has been conducted by profession but as health care moves to a team-based activity, training and education should embrace team-based and

inter-professional opportunities. Team-based training across professions increases collegiality and the understanding of everyone's role. As health care reform continues to move forward, all caregivers will need a clear understanding of the responsibilities of each professional to ensure efficiency and teamwork. The Harrison survey has shown increases over the years of cross-departmental collaborations among academic medical centers, however, there are opportunities for building additional collaborations.

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**EXAMPLE:** Creighton University Health Sciences in Omaha, Neb. offers continuing education for the physician, dentist, pharmacist, nurse and other healthcare professional to "enhance the quality of clinical practices and provide comprehensive and compassionate care for diverse populations." <http://healthsciences.creighton.edu/continuing-education/courses/namdr-2014-clinical-management-and-health-policy-issues-pulmonary>.

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## Recommendations to the Accreditation and CME Credit Systems Community

AHA members were interested in clearer guidelines for accreditation quality and performance improvement projects and programs, as well as those addressing clinical integration, system-based practice and practice-based learning. They encouraged accreditation for smaller group projects that address current physician work as a way to make CME more meaningful. Hospital leaders also were interested in looking at greater use of technology to streamline the paperwork burden in meeting accreditation requirements. While some of these recommendations are addressed through the criteria for accreditation with commendation, additional education and communication to encourage their adoption should be considered.

- **Employ standards that foster closer collaboration between CME and hospital quality improvement and patient safety.**

Members felt strongly that hospitals and others should be encouraged to use CME to increase education on improvement science and patient safety and suggested that standards could reward such efforts.

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EXAMPLE: The ACCME, through its accreditation with commendation program, has sought to reward programs that work to integrate CME into the process for improving professional practice, increase collaboration among clinicians, and encourage CME within a system

framework for quality improvement. In April, ACCME proposed a new menu for accreditation with commendation which is designed to reward work in areas such as the integration of health data, inter-professional collaborative practice, individualized learning activities, and higher levels of outcomes measurement. For more information, visit: <http://www.accme.org/node/58132>.

- **Employ standards that encourage team-based, inter-professional training.**

Members also felt that accreditation standards should encourage a greater emphasis on team-based and inter-professional learning opportunities.

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EXAMPLE: The ACCME, Accreditation Council for Pharmacy Education, and American Nurses Credentialing Center, have created a process to offer joint accreditation for nursing, medicine and pharmacy through one review process. Joint Accreditation promotes inter-professional education activities specifically designed to improve inter-professional collaborative practice in health care delivery.

- **Develop clearer guidelines for non-traditional CME activities.**

Members expressed concern regarding non-traditional CME activities including projects and other practice-based learning



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opportunities and the difficulty in meeting CME requirements. They asked that guidelines be developed for hospital-based improvement projects to ensure that physicians can earn CME credit. While non-traditional approaches exist, additional communication and clarity could improve uptake.

- ***Consider increasing the use of performance improvement CME or other means to allow for activities where learning does not occur in measured credit hours.*** Improvement projects, just-in-time education, and other modes do not lend themselves to a time-based system to recognize educational outcomes. Opportunities to provide commensurate credit for these activities through different measurement mechanisms should be encouraged in hospitals and health systems. Additional communication and opportunities to connect PICME and other ongoing improvement efforts should be highlighted.

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**EXAMPLE:** The University of Utah School of Medicine is employing PICME for projects within the hospital which allow credit to be granted not for hours spent, but for work to learn about specific performance measures, assess practice using the measures, implement interventions to improve performance related to these measures over a useful interval of time and then reassess their practice using the same performance measures. PICME also

may qualify for satisfying certain specialty board maintenance of certification requirements. For more information, visit [http://medicine.utah.edu/cme/performance\\_improvement/index.php](http://medicine.utah.edu/cme/performance_improvement/index.php).

- ***Consider moving away from time-based activities to outcomes-based activities for granting CME.*** Online learning, performance improvement projects, and other non-traditional activities may not lend themselves to measurement in hours of education provided and should instead be assessed on outcomes. While live activities are the only ones still measured in time units, the CME system still depends on assignment of credit hours to non-time-based activities such as journal articles and enduring materials. The accreditation and credit system community should consider working together to define metrics for CME that reflect how physicians learn and improve their practice. This would need to be undertaken in a deliberate way involving all stakeholders to ensure that the metrics used would not pose undue burden on credit seekers or the system.

- **Increase diversity in accreditation.** Related to the above, members hoped to see increased opportunity for hospital-based projects to be eligible for accreditation to allow physicians participating in improvement efforts within hospitals to earn CME credit as well as apply the learning to other certifications. Members also were interested in accreditation standards recognizing new

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modes of educational content delivery, particularly online options and those of short duration that might not meet the credit hour format.

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**EXAMPLE:** Referred to colloquially as “Jeopardy for docs,” Qstream is a real-time learning analytics platform developed at Harvard that uses a question and answer system pushed to a user’s mobile device to drive learning. For more information, visit <http://www.houstonmethodist.org/what-is-qstream>.

- **Streamline process for application.** Members were very concerned that the process to become accredited to provide CME is staff intensive and time consuming, creating a barrier for smaller organizations. They suggested a simplified application process as well as a standardized application across professional continuing education accreditations. Greater use of technology to streamline application processes and record-keeping also was suggested.

### Recommendations for Hospitals, Health Systems and the Accreditation and Credit System Community in Partnership

- **Develop a curriculum focused on transition to practice.** Physicians completing residency move not only from student to practitioner, but often to different settings and practice from their training. Health policy and economics, regulation, change management, and team-based skills not necessarily emphasized in medical school and residency are required to thrive in practice. Members suggested that the medical education path consider a curriculum of structured learning for cementing these skills in early practice which could be integrated into the CME system.
- **Ensure links to state licensure and certification requirements.** Physicians face a myriad of requirements for state licensure, board maintenance of certification, and other requirements. CME should address and satisfy these requirements, including a strong assessment component and robust learning objectives, to avoid duplication. Hospitals also should consider collaboration with the licensing and certification organizations to develop more strategically oriented CME.

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