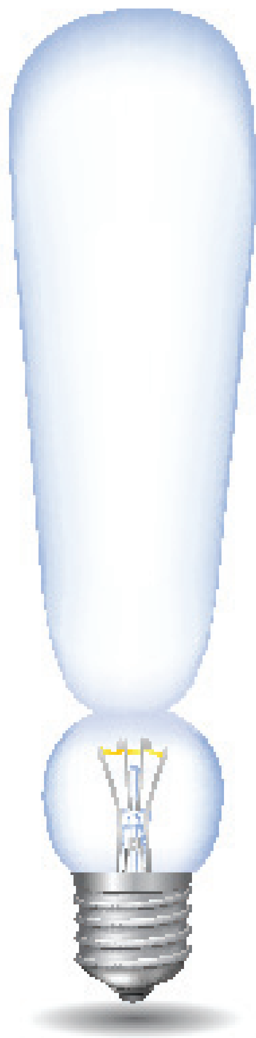
VITALS

CME AND PHARMA
INTEL AND INSIGHT

Edited by SUE PELLETIER



Editor's note: **In late May, the Accreditation Council for CME proposed some changes to its system that are designed to simplify the process of becoming ACCME-accredited. We asked columnist Steve Passin and his colleagues at Steve Passin & Associates to outline and provide their perspectives on the proposed changes.**

ACCME PROPOSES SIMPLIFICATION OF ACCREDITATION PROCESS

HOW THE CHANGES PROPOSED BY THE ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION MIGHT AFFECT YOU.

The ACCME's recently announced series of changes, initiated by the ACCME board of directors, are intended to simplify the accreditation process. We applaud the ACCME leadership for proposing these changes as they serve to clean up vestigial requirements that predate the 2006 Criteria for Accreditation, remove requirements that seem superfluous, and recognize the electronic world in which we live today that made some requirements no longer necessary or appropriate.

Please note: These changes are in a proposal format; they must be vetted, commented on, and finalized before they are ready for implementation by the CME community. The ACCME emphasized that no changes should be implemented by CME providers at this time.

MEETINGSNET.COM

GAVIN HOUSTON, Universal WorldEvents' CEO Americas and a regular contributor to the Pharma Forum conferences co-organized by *Medical Meetings* and The Center for Business Intelligence, has been named by the *Philadelphia Business Journal* as one of the top 40 business leaders under the age of 40 in the Philadelphia region.

Situated on more than 1 million square feet of real estate near Lake Erie in downtown Cleveland, the newly renamed **GLOBAL CENTER FOR HEALTH INNOVATION** and convention center, which was poised to open in July—was scheduled for completion June 1. This is not only ahead of schedule, but the project came in under budget too,

Summary of Proposed Changes by Criterion or Policy

The ACCME did not propose changes to any criteria not discussed below.

The Standard Criteria

Criterion 1: The provider has a CME mission statement that includes all of the basic components (CME purpose, content areas, target audience, type of activities, expected results) with expected results articulated in terms of changes in competence, performance, or patient outcomes that will be the result of the program.
Proposed Change: The requirements for a CME mission statement would be changed to require only discussion of expected results and remove requirements for purpose, content, audience, and types of activities.
Discussion: This allows CME providers to shape their mission in any way that suits them as long as the expected results of their program are explicit.

Criterion 4: The provider generates activities/educational interventions around content that matches the learners' current or potential scope of professional activities.
Proposed Change: Deleted in its entirety.
Discussion: This criterion was redundant, provided the professional practice gaps have been clearly articulated.

Criterion 12: The provider gathers data or information and conducts a program-based analysis on the degree to which the CME mission of the provider has been met through the conduct of CME activities/educational interventions.
Criterion 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.
Proposed Change: Criteria 12 and 13 would be joined to provide a more logical flow of overall assessment of the CME program and changes to improve the program.

Criterion 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 under way or completed.
Criterion 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.
Proposed Change: Criteria 14 and 15 would be deleted.
Discussion: This change consolidates the existing Criteria 12, 13, 14, and 15 into a single requirement covering the key information for program analysis and planned improvements.

While these changes will simplify the process, they also will require providers to ADD SOME SOPHISTICATION to their skill sets.

STEVE PASSIN, FACME, CCMPE

Accreditation with Commendation

The ACCME proposes to delete three criteria and add three (or perhaps more) new criteria. Please note that they also propose to allow CME providers some flexibility to select the Engagement with the Environment criteria that are applicable to their unique CME environments. While the ACCME hasn't stated how this would be accomplished, they propose to require a minimum number of criteria to be addressed in this subset of criteria (let's say five out of seven) but give the provider the choice of which five to address.

Criterion 16: The provider operates in a manner that integrates CME into the process for improving professional practice.
Proposed Change: Deleted in its entirety (but reflected in new Engagement with the Environment criteria; see below).
Discussion: The ACCME believes that C16 is redundant with Criteria 2 and 3; if gap analysis is managed correctly the gaps will become the basis for the activity.

Criterion 18: The provider identifies factors outside the provider's control that impact on patient outcomes.
Proposed Change: Deleted in its entirety.
Discussion: Often methods or content to address the barriers of C18 were consistent with those of C19. Moreover, a complete gap analysis would already have uncovered the barriers to quality and patient safety.

Criterion 22: The provider is positioned to influence the scope and content of activities/educational interventions.
Proposed Change: Deleted in its entirety.
Discussion: Other documentation in the self-study or the new performance-in-practice abstracts will clarify whether or not the CME provider is positioned to influence the scope and content of its CME program.

Proposed Additions

New Engagement Criterion: The provider routinely demonstrates and promotes interprofessional collaborative practice in the operation of its CME program and in the

design and implementation of its educational activities.
Discussion: This new criterion speaks to "routine interprofessional collaborative practice" and seeks to ensure that CME providers are working together in the best interest of quality and outcomes. While "interprofessional" needs further definition, we believe that it embodies collaboration between nurses, pharmacists, and physicians, as well as between various specialties—depending on the mission of each provider and the activity's identified needs.

New Engagement Criterion: The provider routinely incorporates patient data (for example, data from registries or electronic health records) into the process for identifying professional practice gaps and educational needs.
Discussion: This new criterion may be the most challenging of the new guidance for some providers, but it also creates an expectation that CME providers should be connected to real patient outcomes data in the way they plan CME. It introduces the reality of EMR and the ability of some providers to access current information. For providers without access to such information, it offers other methods such as morbidity and mortality data and registry information that will require more due diligence. Accredited medical education companies will have to develop processes to access real patient clinic data through public registries, collaborative partners, or other EMR data gleaned from their course directors and faculty.

New Engagement Criterion: The program of CME conducts assessments of the individual's professional competence and performance and designs and implements individualized learning activities to address the needs that were identified through the assessments.
Discussion: This advanced criterion will require CME providers to measure competence through mechanisms that are more sophisticated than commitment-to-change questions, and to demonstrate that outcomes analyses results were used to develop additional CME interventions that reflected the findings of the original outcomes assessments. This criterion will move CME stakeholders toward maintenance of certification, new and creative online methods for learners to assess their own needs and individually tailor CME to those personal gaps, and toward using CME as a tool to correct critical performance gaps.

Changes to the Standards for Commercial Support

Standard 4.3: Educational materials that are part of a CME activity, such as slides, abstracts, and handouts, cannot contain any advertising, trade name, or product-group message.
Proposed Change: Prohibit the use of corporate logos in any educational materials.

Standard 6.4: "Disclosure" must never include the use of a trade name or a product-group message.
Proposed Change: Prohibit the use of a corporate logo in the disclosure of the receipt of commercial support.
Discussion: These changes are consistent with the recommendations of all organizations that have previously reviewed areas of potential bias in CME.

Other Proposed Policy Changes

- **Joint sponsorship:** The phrase would be changed to "Joint Providership," which in turn will impact a revised Joint Providership Accreditation Statement.

Discussion: This change serves to clear up confusion between the words "sponsor" and "provider."

- **Enduring materials and Internet CME:** The ACCME proposes to eliminate all special language requirements for enduring materials, such as principal faculty and their credentials, medium or combination of media used, method of physician participation, estimated time to complete the activity, dates of original release and/or update, and termination date. Similarly, the ACCME proposes to eliminate the special language requirements for Internet CME, such as listing special requirements prior to the beginning of the activity, hardware and software requirements, provider contact information, policies on privacy and confidentiality, and copyright information.

Discussion: The ACCME felt these requirements predated the 2006 Criteria for Accreditation and were inconsistent with learners' current familiarity with electronic media.

- **Journal CME:** The ACCME proposes to eliminate special requirements for journal CME, including the requirement to communicate required information prior to the journal activity, but that is supplanted by the general Standards for Commercial Support requirements to inform learners of disclosure information before the start of the activity.

Discussion: This also simplifies ACCME policy and removes special requirements.

- **Regularly scheduled series:** The ACCME proposes to eliminate the requirement for describing an RSS monitoring system.

Discussion: This change recognizes that processes for compliant CME practices for all types of activities include RSS—there's no need for special documentation. This proposed change will need to be clarified as the monitoring of hospital or medical school departments' application of the criteria is essential to demonstrating compliance.

- **Initial application for accreditation:** The ACCME is proposing to eliminate the requirement that the initial

accreditation interview be conducted at the offices of applicant, but still requires an activity review for initial accreditation.

Discussion: This recognizes that there no longer is a need to examine the actual office of the prospective provider.

- **Performance-in-practice abstract review:** The sticker system of documenting and providing evidence of compliance would be replaced by an "abstract" method in which the provider completes a new form for each activity selected for review. It would essentially contain the same evidence of compliance, but eliminate the labels.

Discussion: This removes rote processes and stickers.

Analyzing the Changes

While these changes will simplify the accreditation and reaccreditation process, they also will require providers to add some sophistication to their skill sets.

For example, performance-in-practice change entails assessing and summarizing how the provider complied with the criteria through an ACCME-supplied template. Staff members who merely copy and paste lengthy needs assessments from commercial support proposals will now need to truly comprehend the needs, be engaged in selecting educational formats appropriate to the activity's goals, and be able to analyze outcomes instead of just summarizing data. It will also require providers to succinctly demonstrate their understanding of and compliance with each criterion.

Providers will have to develop a proactive, system-wide approach to comply with the new emphasis on promoting interprofessional practice in the operation of a CME program. Likewise, to routinely incorporate patient data into the process for identifying professional practice gaps, providers will have to consider sources of relevant patient data, from registries to electronic medical records, or find ways to incorporate informatics to support decision-making.

Also, while providers can assess individual learners' performance gaps and design boutique CME experiences, they will have to creatiively develop systems and processes to make it happen. This process naturally occurs in maintenance of competence processes conducted by all specialty boards as a part of recertification, as well as in AMA PRA-defined performance improvement activities.

Six Recommendations

While the new accreditation system won't be implemented until 2014 or later, it is prudent to think now about the skills and processes your organization will need to develop:

1. Consider a strategic planning meeting with your CME committee or advisory board. Be sure to discuss ways in which your organization can access patient data.

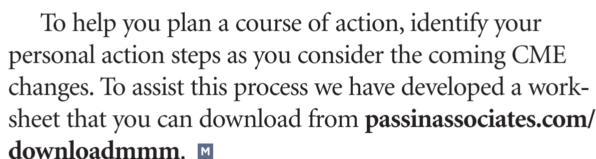
2. As the ACCME moves toward individualized learning, have you considered designing CME activities that fulfill specialty board requirements for MOC?

3. In what other ways can your organization address your learners' individual practice gaps? Will new technology be required? Do you have the outcomes measurement tools in place to quantify the individualized changes that have taken place after engaging in CME?

4. Identify areas of personal growth that will position your staff, as educational professionals, to be more engaged in the process of CME. For example, do you know how to synthesize lengthy needs statements into clear, 25-word expressions of the professional practice gaps as expressed by physician planners? Do you know how to review a gap analysis, write learning objectives, and design outcomes questions that will measure improvement in competence and/or performance? Do you know how to rewrite learning objectives submitted by faculty so that they express what the learner is expected to be able to do in their practice after the CME intervention? Find a trainer or coach to help you plan personal education to hone those skills.

5. What about interprofessional education? Is that type of education indicated in your organization's purpose and mission? If so, are you currently providing education that is only intended for physicians or nurses or pharmacists, or have you thought about how to use your CME/CPD as a tool to hone an effective care team that meets the needs of patients and their families? In other words, it's not just about offering a lot of education for different professionals; it's about how those professionals interrelate to advance the quality of care!

6. In terms of your CME/CPD mission statement, while we don't advocate changing anything yet, it's not too early to start thinking about what you want CME to achieve for your learners and their patients. How will the outcomes of your education advance quality and patient safety? How will your activities be planned to effect real and meaningful outcomes? What does that change mean in terms of the training needs for your staff and planners? Do you have the skills onboard to effect those outcomes? If not, what budget will help you achieve that goal and where will those funds come from?



To help you plan a course of action, identify your personal action steps as you consider the coming CME changes. To assist this process we have developed a worksheet that you can download from **passinassociates.com/downloadmmm.**

STEVE PASSIN is president and CEO, **SUE O'BRIEN** and **JUDY SWEETNAM** are senior associates, and **DENISE DOYLE** is an associate with Steve Passin & Associates—based in Newtown Square, PA. Send questions or comments to Steve Passin at **passin@passinassociates.com**.