Alliance for
Continuing Education
in the Health Professions

February 24, 2016

Graham McMahon, MD, MMSc
President and CEO
Accreditation Council for Continuing Medical Education
515 State St., Suite 1801
Chicago, IL 60654

Dear Dr. McMahon,

The Alliance for Continuing Education in the Health Professions (Alliance), following input from its Board of Directors, wishes to offer commentary regarding the proposed new Criteria for Accreditation with Commendation. We urged all of our Alliance members to offer comments during the survey comment period and hope that many chose to do so, as our membership represents CME Professionals working in a variety of provider practice settings.

We applaud the ACCME for thinking deeply about how to encourage innovation and excellence in CME; we have the same mission at Alliance. We value our relationship and dialogue with all of our accrediting bodies and look forward to continuing that dialogue whether on these Proposed Criteria for Accreditation with Commendation or other issues moving forward.

Looking broadly at the Proposed Criteria, several themes emerge:

- A much expanded view of the role of CME, such as involving students and patients, and having a focus on public health/population health;
- An emphasis on Interprofessional Education;
- A need to access clinical data from a broad perspective down to a more focused perspective at the individual practitioner's level; and,
- Percentage metrics regarding the frequency of criteria usage.

An overall concern we have with the Proposed Criteria is that they appear to represent a significant shift that may not be obtainable for CME Providers unless they operate in a large hospital, medical group, clinic or academic medical setting. Many of our members belong to organizations that do not have the financial or personnel resources or access to clinical data that are needed to comply with the Proposed Criteria. For these CME Providers, the Proposed Criteria, if considered unattainable, may become a disincentive to achieving excellence, and may have the unintended consequence of promoting a minimal approach to CME; one that focuses on "just getting accredited."

Some specific concerns are:

- Overall: The measure of use seems to be too high. Twenty-five percent (25%) of activities for many criteria will be difficult, if not impossible, depending on the CME Provider setting, to achieve. Other questions related to the criteria include:
    - How to accurately document compliance with the criteria selected without adding significantly to the workload?
    - Would providers have the ability to change the criteria they are tracking from year to year if they make changes to their program or are unable to meet certain standards?
    - Without flexibility in the criteria, would providers not implement certain activities or topics that do not fit their identified criteria?
- Overall: Certain types of providers, especially, academic medical centers, seem to be much more likely to be able to address these Criteria.
- Overall: Many Criteria use "And" for Critical Elements when "and/or" would be much more likely to happen.
- Overall: Clearer definitions are needed for terms such as, "healthcare professional", team-based evaluation, CME team, and "innovative programming" for examples.
- C24 & 25: Many providers may not have access to students, even if involving them would be desirable. We suggest involving students and patients in planning or in the implementation as an option.
- C28: Developing objective criteria for assessing communication skills and providing feedback to learners may be beyond the capabilities for most providers when, while much needed, few providers offer much in the way of communication skills training currently.
- C28: This Criterion favors providers that teach procedural skills, but is potentially unattainable even for those who do offer procedural skills, given the low number of participants in this type of education (i.e., they may not meet the 10% threshold if they do other larger-scale activities in addition).
- C30: In our view, this Criterion will be impossible to meet without vast new resources and most likely changes in infrastructures to meet the current standard of 10% or greater.
- C32: Most CME Providers do not have a research Mission. Even for those that do, one publication per year of term is a very high bar.
- C35: The definition of "creative" and "innovative" is unclear and we are uncertain as to how these could be applied evenly across the CME Enterprise.
- C36-38: These outcomes goals require that CME Providers have access to performance data and population health data. Very few CME Providers will be able to demonstrate compliance with these Criteria.

While we have offered critical comments, we do want to reinforce that the Alliance is very supportive of efforts to encourage excellence among CME Providers and to establish goals that raise the performance bar and reward the demonstration of program excellence. We applaud C33, the reestablishment of a requirement of continuous professional development for CME professionals, which is directly aligned with the mission and vision of Alliance.

In general, we believe that if the ACCME is willing to modify some of its Standards (i.e. 25% or greater), allow somewhat more flexibility in the Critical Elements ("or" rather than "and'), and provide definitions, the Criteria could both be strengthened, and be made more accessible and motivating for a wider range of CME Providers.

As always, we appreciate your efforts to promote the highest standards of professionalism in the CME community and look forward to continuing our dialogue.

Sincerely,

Robert L. Addleton, EdD, CHCP, FACME
President