The ACCME Announces a Bold and Innovative New Set of "Beyond Engagement" Criteria for *Accreditation with Commendation*

By

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The Accreditation Council for Continuing Medical Education (ACCME) has released its long-awaited new *accreditation with commendation* advanced criteria that are designed to eventually replace the current *Engagement with the Environment* Criteria in the future. Called the "Beyond Engagement" Criteria, these new Criteria are bold and innovative, challenging providers to truly plan and execute CME that reflects the current and future environment in which CME is a valuable asset that changes behaviors and improves the quality of healthcare and patient safety.

While these new criteria are well-conceived and appear to be ready-for-prime-time, the ACCME is seeking comments from stakeholders in the CME community through a number of yet-to-be-announced forums over the next several months. After all of the feedback is reviewed and digested, the new criteria will be finalized. In the interim, the existing *Engagement with the Environment* criteria (16-22) will remain in place and it is anticipated they will coexist with the new criteria (23-37) for a period of time to allow providers to transition.

Menu-Driven Process

To allow for inherent differences between the various types of CME providers, the ACCME is proposing a menu-driven process from which providers will choose the criteria that are relevant to their specific organizations. The number of criteria to be selected and addressed in the menu has not yet been determined.

The New Criteria

The 15 new criteria are organized into four categories:

- Creation of CME
- CME Activities
- The Program
- Outcomes

CREATION OF CME (CRITERIA 23-26)

- **Criterion 23—Multi-interventional approaches to maximizing the impact of CME** (e.g., more than one format within an activity combined in a series of activities; a series of sessions/formats to address one professional practice gap). This criterion encourages providers to take a curriculum approach to addressing one professional practice gap, in which multiple formats

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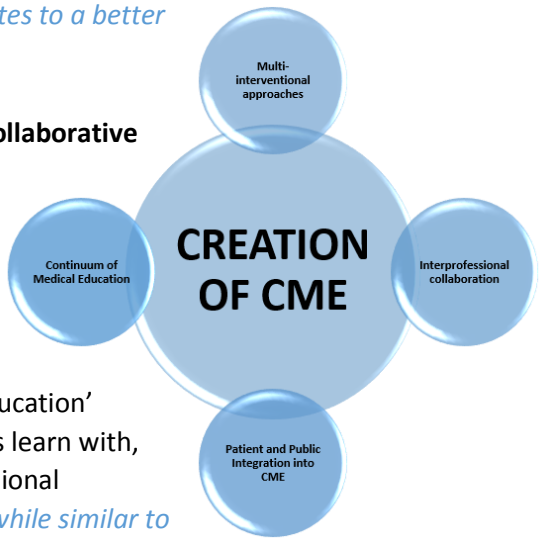
could be employed to reinforce results through a sequential education approach. This is consistent with adult learning principles. *[NOTE: This criterion will require a purposeful approach to designing CME that builds one result on top of another to deliver a true change in learner behavior. By engaging in sequential education, learners will be able to stage new practice changes and improve competence, which contributes to a better result from CME.]*



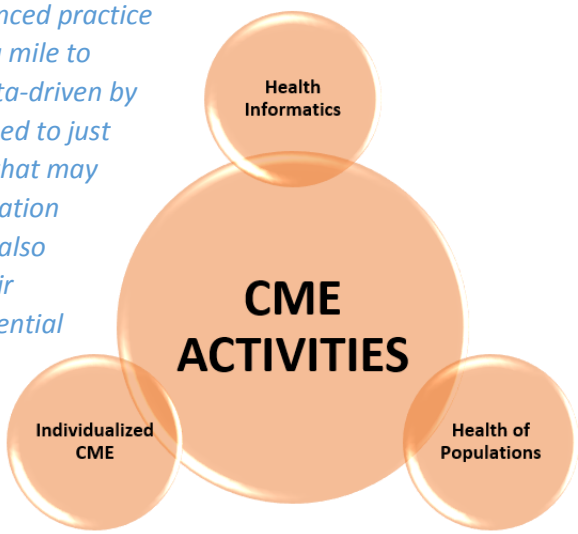
- **Criterion 24—Engagement in Interprofessional Collaborative Practices** in the planning and delivery of interprofessional continuing education activities. 'Interprofessional collaborative practice' includes multiple health workers from different professional backgrounds who work together with patients, families, care-givers, and communities to deliver care. 'Interprofessional Education' means that learners from two or more professions learn with, from, and about each other to enable interprofessional collaborative practice. *[NOTE: This new criterion, while similar to Criterion 20, is consistent with the ACCME's support for Joint Accreditation. It is more than that, though, in that for the first time we see a recognition that the family unit, including caregivers, the team or village, if you will, surrounding the patient, and the patient him or herself, can be part of or included in the planning process.]*

- **Criterion 25—Integration of Patient and Public Representatives into the Process of Planning CME** as planners, teachers, and learners in CME. Because accredited CME needs to advance the interests of the people who are served by the healthcare system, the involvement of patients and the public in the planning process and presentation of CME advances the public interest. *[NOTE: Consistent with the inclusion of a public representative on the ACCME Board of Directors, this criterion brings this heretofore public representative into the process of CME. It also integrates the perspective of the patient, who now joins with physician experts and physician-based needs, to offer a unique and important perspective on the topic of education.]*

- **Criterion 26—Integration of Undergraduate or Postgraduate Health Professions' Students as CME Researchers and CME Planners**. Because CME is an integral part of the continuum of medical education in the United States, the ACCME is facilitating the involvement of using students and other physicians-in-training or students from other health professions in the research and planning of CME as a form of practice-based learning. *[NOTE: This criterion will be of interest in particular to hospitals, health systems, and academic centers in which the continuum of medical education is manifested. In RSS, for example, the presence of residents and other housestaff has always been a known component in planning. The inclusion of students legitimizes this process and gives weight to the importance of lifelong learning and the seamless integration of undergraduate, graduate and continuing medical education.]*

CME ACTIVITIES (CRITERIA 27-29)

- **Criterion 27—Activities that Teach about the Implementation of Health Informatics** and the use of health information in improving health. This criterion encourages providers to teach learners how to apply the wisdom gained from health information to improve health and promote changes in practice. *[NOTE: This advanced practice criterion will reward providers that go the extra mile to develop CME based on real-time events and data-driven by healthcare outcomes. This criterion does not need to just apply to health systems and academic centers that may have direct access to informatics. Medical Education Companies and Specialty Society providers can also access this data through their planners and their planners' institutions. This criterion has the potential to be among the more impactful changes to the ACCME system, but it will require a little more time and effort by providers to truly develop CME that makes a difference.]*



- **Criterion 28—The CME Program Addresses Factors Beyond Clinical Care that Affects the Health of Populations**, as demonstrated by teaching learners how they can intervene in health behaviors, social and economic factors, and the public's physical environment. *[NOTE: This advanced criterion may be difficult for many providers to address because it requires access to longitudinal data that can be connected to their program of CME. However, there are several schools of medicine that have developed population health divisions or have combined schools of medicine and public health. Some specialty societies have access to programs that have tracked the health of patients associated with the disease state represented by the association and can derive data showing a substantial link to population health improvements.]*

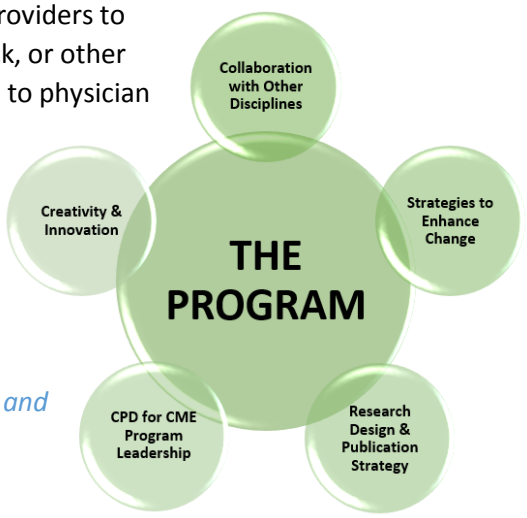
- **Criterion 29—Development of Individualized CME Activities**. Consistent with Maintenance of Certification (MOC), where physicians are facilitated in assessing their personal gaps in performance, or with some medical centers that are asking their clinical departments to meet with physicians within departments to identify areas of practice in which there is a personal gap, this criterion rewards providers that use CME to address the specific needs of an individual with a customized set of educational interventions. The needs may be derived from a variety of sources (e.g., performance measures, formal assessments) but the sources must produce data and information about the individual's professional practice gaps and educational needs. Demonstration of compliance for this criterion will require evidence of an individual curriculum for each learner, or customization of an already existing curriculum for the learner, which is designed to close the individual's professional practice gaps. Providers will be expected to evaluate changes in the competence, performance, or patient outcomes of each individual learner, relative to the identified gaps and needs. *[NOTE: In the era of mass-produced CME, this criterion adds gravitas to the concept of individualized CME, which many experts predict will be a substantial part of CME in the near future. For hospitals and health systems, this criterion can reinforce the link between privileges and CME, between quality outcomes and CME, and provide a tailored approach to individual physician curricula that will be useful for those learners and*

strengthen the impact CME has on changing practice behaviors. For any provider that supports their learners in preparing for MOC and recertification and has the technical expertise to design systems for individual physicians to assess their own needs, this criterion will be provide justification for expansion into customized CME.]

THE PROGRAM (CRITERIA 30-34)

- **Criterion 30—Works with Other Healthcare Disciplines or Other Elements of Healthcare on Local, National, or Global Initiatives** intended to improve health or healthcare. This criterion would eventually replace and is similar to current criterion 20 (collaboration). Criterion 30 encourages organizations and professionals to cooperate or collaborate with each other in a stronger, more empowered enterprise. The principles of collaboration and cooperation could apply to multiple departments or divisions within a larger complex health system or between the provider's organization and one or more stakeholders related to the goal of the educational activity or curriculum. In addition, this criterion requires a demonstration of how the provider takes responsibility for jointly provided activities. *[NOTE: While this new criterion is essentially a replacement for Criterion 20, it has evolved into a more clear statement of intent on the ACCME's part and also incorporates the requirement for control over jointly provided CME, which was previously contained in criterion 22.]*

- **Criterion 31—Utilizes Strategies to Enhance Change** as an adjunct to its CME activities (e.g., reminders, patient feedback, or other strategies to remove, overcome, or address barriers to physician change). This criterion may eventually supplant existing criteria 17 (ancillary tools) and 19 (barriers to physician change), and encourages providers to utilize strategies such as reminders, patient feedback, or other strategies to remove, overcome, or address barriers to physician change. *[NOTE: This new criterion amalgamates the existing criteria 17 and 19 and may eliminate Criterion 18. It links the concepts of designing ancillary tools and support materials to assist learners in reaching the results intended for the activity. It does so with an understanding of other barriers to implementation that are experienced by targeted learners. It drives planners to analyze data and their own experience to address what is needed to make the activity impactful and achieve the desired result.]*



- **Criterion 32—Implementation of a Research Design and Publication Strategy in the Evaluation of CME.** This new criterion will be of interest to those providers that see continuing professional development (CPD) as a scholarly pursuit and who actively explore and research new ways to advance the arena of CME through scholarship pursuits.

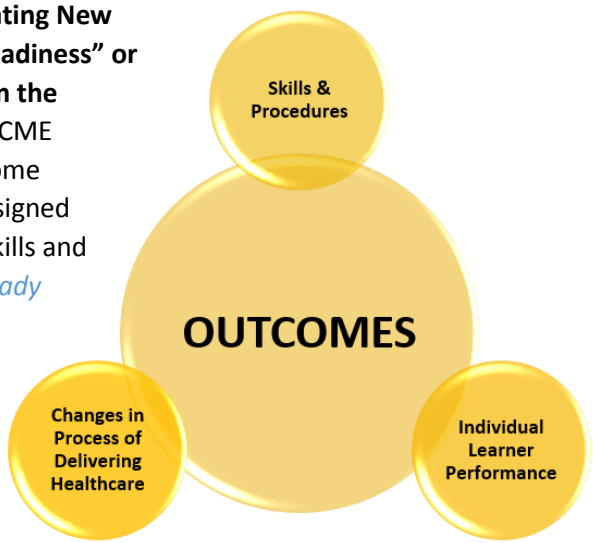
- **Criterion 33—CME Program Leadership Engages in Continuing Professional Development.** This criterion seeks to encourage the leadership of an accredited provider to participate in its own

CPD throughout the year in domains relevant to the CME enterprise. *[NOTE: While many providers engage in periodic in-service training for staff, this criterion recognizes the value of providers' ongoing professional improvement and expanding their own CPD not only to their own program staff but to the rest of the leadership team in the CME enterprise.]*

- **Criterion 34—Creativity and Innovation in the Development and Delivery of CME.** This is an open-ended criterion in which the ACCME will subjectively judge compliance relevant to the CME program's uniqueness or impact or for improving efficiency.

OUTCOMES (CRITERIA 35-37)

- **Criterion 35—CME Related to the American Medical Association Physician's Recognition Award (AMA PRA) (1) "Requirements for Designating New Procedures and/or (2) "Verification of Proctor Readiness" or "Verification of Physician Competence to Perform the Procedure."** This criterion places added value on CME providers' implementation of two AMA PRA outcome designations for educational activities that are designed with the specific purpose of learning about new skills and procedures. *[NOTE: For certain providers that already offer skills-based training, this recognition will be welcome. For others that could add a hands-on component to skills education, especially those that involve proctors, this criterion will add an incentive to implement this see one-do one-teach-one process that has been a bedrock of medical education.]*



- **Criterion 36—Improvement by Individual Learners in Their Own Performance-in-Practice.** This criterion goes beyond designing activities to change performance and measuring those changes. It rewards providers that can demonstrate that individual learners have improved their performance-in-practice. *[NOTE: This new criterion seems to relate to new criterion 29, but focuses on the measurement of individual learner improvement. This criterion will be prosaic for those providers that engage in remedial education for physicians. However, it is certainly a corollary to other criteria relating to individualized CME in that it provides evidence of compliance with Joint Commission requirements for health systems and hospitals. It also provides healthcare organizations with a management system to control and incentivize physician learning. Finally, it would serve to both identify performance gaps for physicians and as a means to resolve them with documentation that improvements were made.]*

- **Criterion 37—The CME program Contributed to Changes in Processes of Delivering Healthcare.** This criterion focuses on systems-based practices that are beyond changing individual learners' performance. It seeks to identify providers that have contributed to change in areas that could include:

- The interaction of CME and Quality Improvement
- The coordination of patient care
- Interprofessional collaborative practice
- Population-based care
- Enhancing patient safety
- Identifying system errors and implementing potential systems solutions

[NOTE: This extension of and companion to existing Criterion 21 puts extra power behind the CME-Quality Continuum in hospitals, health systems and academic centers. For specialty society CME programs, this criterion would incentivize measurement of the impact of education that focused on a specific area of medicine and become a causal link to the implementation of clinical guidelines and the impact on quality results. Importantly, this criteria reinforces the importance of CME existing as a part of a system, rather than an individual silo, that identifies areas of medical care that requires improvement, a multipart process of attacking the problem and a systemwide commitment to correcting the problem.]

Figure 1: Photo of Steve Passin if needed for article

Figure 2: Photo of Susan C. O'Brien if needed for article

Figure 3: Photo of Judy M. Sweetnam if needed for article

Figure 4: Photo of Denise J. Doyle if needed for article