The Critical Role of Evaluation and Improvement in the Updated ACCME Criteria for Accreditation

Steven M. Passin, FACME, Judy M. Sweetnam, MEd
Steve Passin and Associates, LLC, Newtown Square, Pennsylvania

Although evaluation is nothing new to CME providers, the comprehensiveness and complexity of criteria 11-15 in the “Evaluation and Improvement” chapter of the updated Accreditation Council for Continuing Medical Education (ACCME) Criteria for Accreditation [1], released in 2007, may be confounding to even the most sophisticated of ACCME providers. Prior to this update, the evaluation chapter of the ACCME criteria asked providers to explain how CME activities and programs were evaluated, but in the updated version the requirements have changed.

**ABSTRACT**

The accreditation requirements listed in the updated ACCME Criteria for Accreditation (Table 1) can be daunting or even overwhelming. Thus the internal systems and practices to enable this self evaluation must be implemented early in the accreditation process. The “evaluation” referred to encompasses not only activity-based evaluations of outcomes but also the impact that those evaluations have made, or not made, on the overall CME program. Implementation of this evaluation requires data collection and analysis leading to changes in the overall CME program. This process can have a transformational impact on the staff skills required for successful and effective CME in all types of organizations, including settings involving academic institutions such as medical schools, hospital or health-care systems, and accredited medical education companies, because many such organizations do not have dedicated personnel with the analytical skills needed for such complex data handling. The type of data now required by the ACCME cannot be generated at the last minute; rather, it must be strategically planned, well designed, executed, and evaluated as carefully as any CME activity. Evaluation, at all levels, has now become a fundamental part of every educational organization.

An alternative to the development of internal human resources is the hiring of consultants who specialize in evaluation methods and can assist in training staff, developing an evaluation process, setting up systems for data analysis, and interpreting data. This approach offers only a short-term solution, however. Ultimately, successful provider accreditation requires long-term dedication of human and financial resources.

**THE REQUIREMENTS OF CRITERIA 11-15**

The mission connection

The “enhancement mission” referred to in the new ACCME criteria is a central force in the new accreditation paradigm. The CME mission must focus on changing outcomes, particularly in competence, performance-practice, and/or improved patient health. The accomplishment of this mission requires support of the mission drivers, reflected in the way the provider selects the issues to be addressed. At a minimum, these fundamental questions must be answered:

- Is content based on evidence that is considered best practice?
- Is content based on a gap that exists between current and best practices?
- Does closing the gap between current and best practices result in improvement in the health and/or outcomes of patients?
- Will the proposed educational intervention result in changes in current practice (see Figure 1)?

Correspondence: Steven Passin, FACME, Steve Passin & Associates, 1 Drew Circle, Newtown Square, PA 19073; 610-325-3611; fax: 610-325-0787 (e-mail: passin@passinassociates.com).
If the answers to these questions are no, then the rationale and the utility of current CME efforts must be considered. The reporting of the provider’s list of activities to the ACCME requires that each activity be evaluated to ascertain whether it was designed to change competence, performance, and/or patient outcomes. “Not applicable” or “other” are not acceptable choices. Once 1 or more of the 3 options is identified to be applicable to a CME activity, changes in competence or performance must be measured.

As adult educators, instructional designers, and CME providers are aware, the educational method can make or break a CME activity. The ACCME now asks for a defense of the rationale for the educational design or teaching method, the formerly overlooked and underemphasized learning process that links knowledge gaps to learning objectives, content, and evaluation. Adding this important link to the process assures that the activity produces change, not just in the short term, but change that endures over time. According to adult-learning literature, single interventions are not highly successful in sustaining behavior change [2,3], so the focus must be on a comprehensive and enduring process. Points to consider include the choice of sequential educational formats to reinforce education, the engagement of learners in case studies and vignettes to reinforce their competence in applying knowledge to practice, and the fostering of a commitment to change in learners [4].

**THE LINKAGE FROM MISSION TO EVALUATION**

The new mission must very specifically address the measurement of CME program outcomes such as changes in competence, performance, and/or patient outcomes. Thus it is no longer appropriate to think of an evaluation template for which every CME activity applies. Henceforth, there must be a set of tools from which to select the appropriate type and format of the educational activity. Importantly, the ACCME now expects every CME activity to be measured for changes in competence, performance, or patient outcomes.

**Compliance**

The ACCME defines competence as the ability, not yet put into practice, to do something as a result of knowledge in the presence of experience and judgment. It is what a professional would do in practice, if given the opportunity. If an activity focuses on improving competence, then a simple option for outcome measurement is to include one or more clinical vignettes at the conclusion of the activity that will measure the ability—or competence—of the learner in applying knowledge learned in the context of a practice reality. A second option is a question at the conclusion of the activity asking the learner to use newly acquired knowledge to explain how a strategy can be incorporated into practice. Note that competence is not related to outcomes measurements, which have historically been defined as an inquiry into the incorporation of new learning into the practice environment within a certain window of time. Because competence does not need to be demonstrated after the fact, the achievement of competence as a goal can be measured at the conclusion of the activity. The ACCME defines competence as the ability, not yet put into practice, to do something as a result of knowledge in the presence of experience and judgment. It is what
a professional would do in practice, if given the opportunity [5]. Figure 2 provides examples of measurement tools for improved competence.

Performance

The outcomes measurement for performance in practice requires a follow-up outcomes measurement to determine if learners actually implemented the desired result. Typically, this information is determined by asking learners to provide information that is directly related to the learning objectives. Questions should be specific and relate to whether or not the new behavior was actually implemented in practice. For behaviors not implemented it is critical to ask learners to explain why in order to identify barriers that prevented implementation.

The best evaluative measures use a combination of strategies [6], and generally there is no requirement to evaluate outcomes with every learner. In addition to quantitative questionnaires, practice results can be measured qualitatively by conducting personal interviews, phone interviews of a selected sampling of the target audience, or focus groups.

Patient Outcomes

If the evaluation process involves measuring patient outcomes, this measurement process must be demonstrated.
**Measurement of Competence**

(OPTION 1: case studies or vignettes and questions that measure application of knowledge to practice)

<table>
<thead>
<tr>
<th>WRITE A CASE STUDY OR VIGNETTE BELOW</th>
<th>WRITE MULTIPLE CHOICE QUESTIONS FOR LEARNERS TO ANSWER RELATED TO THE CASE AND INDICATE CORRECT ANSWER WITH ASTERISK (*)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Question</td>
</tr>
<tr>
<td></td>
<td>A.</td>
</tr>
<tr>
<td></td>
<td>B.</td>
</tr>
<tr>
<td></td>
<td>C.</td>
</tr>
</tbody>
</table>

**Measurement of Competence**

(OPTION 2: using question pairs—add rows as needed)

PRE-ACTIVITY QUESTION: How often do you currently use each of the following patient care strategies? (1 = never to 5 = always)

<table>
<thead>
<tr>
<th>&lt;insert strategy 1&gt;</th>
<th>☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;insert strategy 2&gt;</td>
<td>☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5</td>
</tr>
<tr>
<td>&lt;insert strategy 3&gt;</td>
<td>☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5</td>
</tr>
<tr>
<td>&lt;insert strategy 4&gt;</td>
<td>☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5</td>
</tr>
</tbody>
</table>

QUESTION TO ASK AT THE END OF ACTIVITY: Based on your participation in this CME activity, how often do you now plan to use each of the following patient care strategies? (1 = never to 5 = always)

<table>
<thead>
<tr>
<th>&lt;insert strategy 1&gt;</th>
<th>☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;insert strategy 2&gt;</td>
<td>☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5</td>
</tr>
<tr>
<td>&lt;insert strategy 3&gt;</td>
<td>☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5</td>
</tr>
<tr>
<td>&lt;insert strategy 4&gt;</td>
<td>☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5</td>
</tr>
</tbody>
</table>

Figure 2. Two educational outcomes measurement (EOM) tools that measure improved competence. EDM templates suggested by Derek Dietze, president of Improve CME, LLC.
Although patient charts are the most desirable source of information, there is no requirement for chart data when patient outcomes can be reported by the learner. For example, a treating physician can be asked questions regarding the impact on the patient from the implementation of new practices learned from the educational activity. An example of a follow-up survey question that measures impact on patient outcomes is:

"Please describe 2 patient outcomes you’ve observed based on your use of new patient care strategies recommended in the CME activity you attended (hint: make the strategy specific)."

**OVERALL PROGRAM EVALUATION AND IMPROVEMENT**

Activity evaluation seeks to determine if an activity achieved the desired goal. The ACCME requires that a set of activities be evaluated regularly (eg, quarterly and then annually) to determine how each mission component has been met. Figure 3 represents a format for completing a self-assessment of a provider's compliance with the ACCME updated criteria (available at http://www.passinassociates.com/2008allianceworkshop/cme_program_self_assessment_tool_20080118.pdf.)

In the process of deconstructing and reconstructing an evaluation system, the importance of ongoing assessment of compliance with both the CME mission and the 22 updated ACCME criteria for accreditation cannot be overemphasized.

**ASSIGNING STAFF RESPONSIBILITY FOR EVALUATION**

A key to ongoing overall program evaluation is assigning responsibility for evaluation management to one or more staff persons. In the new CME paradigm, evaluation management is not an occasional function; it is
ongoing and analytical. Recruiting new competent staff with evaluation skills, or training existing staff for these competencies, should be a priority. It is not enough to design and implement evaluative tools that support the teaching rationale or to summarize evaluations. The critical component is the analyses of the overall evaluation results, a feature that is an important ACCME focus and also provides vital information to commercial supporters, who are less inclined to fund CME that doesn’t have solid educational outcomes measurement and analysis of results. Attaining educational grants may be dependent on your staff competencies in this and the other new educational areas.

ROLE OF THE CME COMMITTEE OR ADVISORY BOARD
The degree of engagement of CME committees and advisory boards varies according to each provider. However, the new evaluation criteria practically demand the critical input of an advisory board with members who are physicians, allied health care professionals, quality assurance departments, or other experts. The CME committee or advisory board can assist in the assessment of educational effectiveness and in devising improvements to the overall program. Formal quarterly analyses of related sections of the new criteria can be used to involve the committee or advisory board in the deliberations, engaging them in the discussions and gaining their critical input into your CME Program. The previously mentioned self-assessment document was developed based on suggestions from the ACCME and can be used to engage the help of the committee or board. This tool provides guidance through an extensive analysis, strategic planning, and solution-driven process. Used correctly, this tool will become the basis for the ACCME’s self-study criteria 11-15 and will position your organization well among supporters who are well aware of the focus on quality improvement in CME.

Finally, and most importantly, those struggling with the terms and requirements of the updated ACCME criteria must not rely on old methods of evaluation, which are no longer adequate to satisfy the demands of the new accreditation criteria.

REFERENCES