

June 10, 2008

George E. Thibault, MD
President, Josiah Macy, Jr. Foundation
44 East 64th Street
New York, New York 10065

Dear Doctor Thibault,

We are writing, as staff of three major U.S. continuing professional education accreditation systems to comment and provide important clarifications to matters raised in the proceedings of the conference on *Continuing Education in the Health Professions: Improving Healthcare Through Lifelong Learning* held in November 2007 and convened by the Josiah Macy, Jr. Foundation ("the Conference Proceedings"), which contends that our CME/CE industry needs a major overhaul.

As the chief executives of three professions' continuing education accrediting bodies we believe it is important for us to say that we disagree with, or take exception to, most, if not all, of the Conference Proceedings. Our concern stems from our observation that neither the Conference, its observations, its assumptions, its conclusions nor its recommendations seem to be based on the facts and circumstances that we know to be extant in our three professions' continuing education, or continuing education accreditation systems, today.

For example, the Chairman's Summary of the Conference says,

"Participants identified a set of principles they believe should underlie and guide continuing education of the health professions:

- *Integrate continuing education into daily clinical practice.*
- *Base continuing education on the strongest available evidence for practice.*
- *Minimize, to the greatest extent possible, both the reality and the appearance of bias.*
- *Emphasize flexibility and easy accessibility for clinicians.*
- *Stress innovation and evaluation of new educational methods.*
- *Address needs of clinicians across a wide spectrum, from specialists in academic health centers to rural solo practitioners.*
- *Support interprofessional collaboration.*
- *Align continuing education efforts with quality improvement initiatives at the level of health systems."*

These are laudable and valuable. In fact, these are basic to our current systems, to our

programs in place, and to our programs under development. However, these statements are presented in a way that implies their absence from our systems. It implies these still need to be recognized as important. We believe the Chairman's Summary does not recognize the current state of affairs.

We also believe that the basic findings of the participants as expressed in the Chairman's Summary in the Conference Proceedings are not supported by adequate evidence. We read that the "*participants found, current systems of CE do not meet the needs of health professionals as well as they should.*" They went on to say,

- *Too much CE relies on a lecture format and counts hours of learning rather than improved knowledge, competence and performance.*
- *Too little attention is given to helping individual clinicians examine and improve their own practices.*
- *Insufficient emphasis is placed on individual learning driven by the need to answer the questions that arise during patient care.*
- *CE does not promote interprofessional collaboration, feedback from colleagues and patients, teamwork, or efforts to improve systems of care, activities that are key to improved performance by health professionals.*
- *CE does not make adequate or creative use of Internet technology, which can help clinicians examine their own practice patterns, bring medical information to them during patient care, and aid them in learning new skills.*
- *There is too little high quality scientific study of CE.*

These statements reflect concerns that we, as CE accreditors, had 5-10 years ago. Over this past decade we have made significant changes to our systems to address these concerns. Therefore, we question the reliability and validity of the evidence base from which these statements are made.

Some examples of the Chairman's Summary findings (in italics) that appear flawed to us are:

Conference Finding #1: Too much CE relies on a lecture format and counts of hours of learning rather than improved knowledge, competence and performance"

Data from our organizations show that the CE accreditation systems have integrated new formats of continuing education and that CE providers are utilizing these formats within their CE programs. For example, almost 50% of the continuing **medical** education enterprise is not didactic in nature. The Conference may have assumed, wrongly, that plenary sessions are necessarily 'lecture.' This has not been the case for many years. Accreditation has provided explicit guidance to providers on the development of new formats of CE in the context of accreditation standards. All three accreditors (medicine, nursing, and pharmacy) require that CE providers use the appropriate format to meet the

identified needs of their own learners. Accreditation requirements have reflected this since 2006.

In stating that CE *“relies on a lecture format and counts of hours of learning rather than improved knowledge, competence and performance,”* the conference failed to acknowledge that a considerable portion of the CE enterprise is exactly about promoting changes in competence, performance and patient outcomes. For example, the continuing **medical** education accreditation requirements explicitly state that, *“**The provider generates activities/educational interventions that are designed to change competence, performance, or patient outcomes as described in its mission statement.*** Since these requirements were adopted by ACCME in 2006, all continuing medical education is required to be designed to change competence, performance or patient outcomes. Moreover, since 2006, continuing **medical** education is entirely about answering questions that arise in professional practice. Among ACCME’s Criteria is the requirement, *“**The provider incorporates into CME activities the educational needs (knowledge, competence, or performance) that underlie the professional practice gaps of their own learners.**”*

Nursing and pharmacy standards require similar changes. The definition of continuing nursing education is *“**Systematic professional learning experiences designed to ... enrich the nurse’s contributions to quality health care...**”*. Indeed, ANCC requires evaluation of the learning activity to be in one of the accepted categories of evaluation (i.e. learner satisfaction, knowledge enhancement, skill and attitude change, change in practice/performance, relationship of the practices change to quality of service).

Continuing education for the profession of pharmacy is defined as, *“**a structured educational activity designed or intended to support the continuing development of pharmacists ...to maintain and enhance their competence.**”* Continuing education for the profession of pharmacy promotes problem-solving and critical thinking by incorporating active learning strategies to enhance knowledge retention and application in practice.

Conference Finding #2: Too little attention is given to helping individual clinicians examine and improve their own practices.

Conference Finding #3: Insufficient emphasis is placed on individual learning driven by the need to answer questions that arise during patient care.

Continuing education is entirely about answering questions that arise in professional practice as the source of the needs data that drives the education. As has already been stated, ACCME’s Criteria includes the requirement, *“**The provider incorporates into CME activities the educational needs (knowledge, competence, or performance) that underlie the professional practice gaps of their own learners.**”*

We believe there is strong evidence to support the assertion that standards for continuing

education, **in 2008**, are exactly about practice-based learning and improvement. This is a common educational principle that is, and has always been, addressed in CE.

Conference Finding #3: CE does not promote inter-professional collaboration, feedback from colleagues and patients, teamwork, or efforts to improve systems of care.

It is not valid for the Chairman's Summary to say "CE does not promote inter-professional collaboration". Our three organizations have worked productively and collaboratively for many years to bring order and efficiencies to CE accreditation.

For example,

1. We have one national standard for managing the boundary issues associated with the complicated, ubiquitous and important financial relationships our professions have with the manufacturers, marketers and re-sellers of healthcare products and services used by, and on, patients. ACCME, ANCC and ACPE all have adopted and implemented the 2004 **ACCME Standards for Commercial Support™**.
2. Since 2002, we have had a single unified application for accreditation for those providers interested in being a CE provider for an audience that includes more than just one of our three professions.
3. As a result of our long standing collaboration we have developed and announced a proposal for a joint accreditation process to support CE providers developing CE by the healthcare team for the healthcare team.

In addition, we feel it is inaccurate to state that "***CE does not promotefeedback from colleagues and patients, teamwork, or efforts to improve systems of care.***"

For example, the ACCME Update Criteria explicitly state,

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| 16. The provider operates in a manner that integrates CME into the process for improving professional practice. | 19. The provider implements educational strategies to remove, overcome or address barriers to physician change. |
| 17. The provider utilizes non-education strategies to enhance change as an adjunct to its activities/educational interventions (e.g., reminders, patient feedback). | 20. The provider builds bridges with other stakeholders through collaboration and cooperation. |
| 18. The provider identifies factors outside the provider's control that impact on patient outcomes. | 21. The provider participates within an institutional or system framework for quality improvement. |
| | 22. The provider is positioned to influence the scope and content of activities/educational interventions. |

CE does incorporate “**feedback from colleagues and patients**”. For example, ANCC criteria require feedback be solicited from a number of external individuals and sources during the needs assessment as well as the evaluation phases.

Criterion 2.1: Continuing education activities are developed in response to The unique educational needs of the target audience; criterion.

Criterion 2.5: A clearly defined method, which includes learner input, is used to evaluate the effectiveness

Criterion 3.1: An ongoing and systematic process is carried out at the overall unit-level to evaluate the provider unit’s (c) outcomes and results, and (d) progress toward goals for improvement; criterion

Criterion 3.2: Designated nurse planner(s), other collaborating planners (content specialists and target audience representatives), activity presenters, learners, and additional unit staff, as appropriate, participate in the process used to evaluate the overall effectiveness of the provider unit.

Criterion 3.3: Evaluation data are used to confirm, expand, or change the operations of the provider unit.

Criterion 3.4: Efforts toward improvement include addressing issues, identifying strategies for working on targeted goals, evaluating progress toward goals, and revising or establishing new goals.

Additionally, on an annual basis each organization accredited by ANCC must report its progress towards its established goals and its goals for the upcoming year. These reports are reviewed closely and generate (1) a collection of ‘best practices’ and (2) a discussion between the accredited organization and the accreditor resulting in direction and growth of the accredited organization as a health care organization.

Similarly, the ACPE’s Standards for Continuing Pharmacy Education ensure that the provider’s continuing pharmacy education program has a clearly articulated mission, desired goals and a planning process to achieve the mission and goals. The mission, goals, and activities must be related to the vision and educational needs of the profession of pharmacy to better serve society. As recommended by the Institute of Medicine for all health care professionals, pharmacists must be educated to deliver patient-centered care as members of an interprofessional team, emphasizing evidence-based practice, quality improvement approaches, and informatics.

We believe these expectations clearly “**promotefeedback from colleagues and patients, teamwork, or efforts to improve systems of care**”.

Conference Finding #4: CE does not make adequate or creative use of Internet technology, which can help clinicians examine their own practice patterns, bring medical information to them during patient care, and aid them in learning new skills.

Published quantitative data, which we know the Macy conference participants had access to prior to the Conference, do not support these statements. For example, in CME since 1998, there has been a reported 24-fold increase in the number of Internet CME activities (to 93,582 in 2006); a 68-fold increase in physician participants (to 2.4 Million in 2006), and a 62-fold increase in non-physician participants (to 1.5 Million in 2006). Qualitatively, these educational activities are judged directly through our accreditation processes. They have not been found to be lacking. If, as the Conference finds, they are particularly more useful than other formats of education, then we believe future evaluation will surely make this evident.

We find that the Conference Chairman's Summary, the Conference assumptions along with the Conclusions and Recommendations directly and indirectly specifically promote "*Internet point-of-care learning.*" We observe that persons in a position to control the content of the Conference and its derivative written products have personal financial relationships with a proprietary entity marketing such a product. These financial relationships were not disclosed in the Conference Chairman's Summary although we note that the Proceedings now have a list of Statements of Potential Conflicts of Interest. We ask, "Did the Macy Foundation manage this conflict of interest during the conference development process? Were steps taken to resolve this conflict of interest prior to the Conference?" We know that according to our common **ACCME Standards for Commercial Support™** and widely held interprofessional opinion that disclosure alone would have been an insufficient mechanism to manage such a conflict of interest.

We also observe that the literature does not yet support such a high prioritization of this format of information gathering as the future of CE in support of continuing professional development.

Conference Finding #4: There is too little high quality scientific study of CE.

We are not sure of the validity of this statement. A "Pub Med" search on 'continuing education' produces over 35,000 citations which range through a myriad of relevant topics. We are not aware of a published meta-analysis of all this literature that has drawn the conclusion that "***There is too little high quality scientific study of CE.***" We know that the education literature is a complex mix of qualitative and quantitative studies and the educational outcomes literature is understandably a mix of educational evaluation and educational measurement. This is a complex literature, across professions. We wholeheartedly agree this literature needs to be as strong and diverse as possible and we would agree that more study is needed.

We also know that insufficient emphasis has been put on research productivity by the CE units within professional schools and academic health centers. There is data to show that over the last decade the academic credentials of those leading CE units has been moving away from those with Doctorate or professional degrees.

In late 2004, the ANCC established an Institute for Credentialing Research to further credentialing research in areas such as accreditation. Research in CE is being coordinated through this Institute. In 2000, the ACCME developed a proposal for a "Foundation for Accreditation Excellence" that had as a goal the funding and promotion of quality research in continuing education and continuing education accreditation. This proposal was blocked at the ACCME by people and organizations who now say more high quality research is necessary.

We agree that there is a constant need for research regarding continuing education and a need for adequate funding for this research.

Conclusions

We strongly believe that neither CE accreditation, nor CE itself, is in 'disarray' as is purported in the Chairman's Summary in the *Conference Proceedings*.

The continuing education enterprise for health professionals in the United States is a resource that supports practitioner continuing development. The CE enterprise shares with practitioners the evidence-based findings of translational clinical research - where problems from the bedside are taken to the lab and where solutions from the lab are taken back to the bedside - that can positively affect patient-care outcomes. Our continuing education accreditation organizations provide quality standards as a framework to support this construct. Our accreditation of the respective and collective CE providers in our health professions (medicine, nursing, pharmacy) denotes that the providers have met the applicable standards.

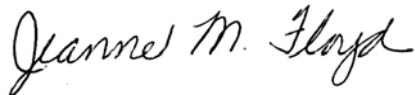
Finally, we believe that the Conference presents broad opinions and offers some dramatic changes for the CE enterprise, yet provides little evidence to support the need for, or the desirability of these recommendations. Some of the conclusions and recommendations for the future of CE would be better characterized as expressions of what is already in place. We find it disappointing that the Conference seemed to be unaware of the current state of continuing healthcare education.

We see the Conference as a missed opportunity. The Macy Foundation Conference brought together a group of important people without a universal understanding of the current CE delivery system or its outcomes -- but with firmly held beliefs about what the deliverables of the system should be. We always appreciate the input relative to continuing education of stakeholders in the field.

We also believe that the deliverables described by the participants of the Macy Foundation Conference could have useful applications. They could easily be packaged as benchmarks by which we could evaluate and monitor our CE systems. They could provide a future framework for organizational and system self-assessment and improvement.

The United States has an excellent and admirable continuing education system. Our belief and position is that everything can be improved. If the Macy Foundation is committed to assisting with the improvement of the system of CE for healthcare professionals, we would welcome new opportunities to present our systems and to collaborate in identifying benchmarks, timelines and the facilitating conditions through which our accredited system of CE can continue to lead the world in continuing education for healthcare professionals.

Yours truly,



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