

Academic CME/CPD in the United States and Canada: An Executive Summary of the 2015 AAMC/SACME Harrison Survey

Integration, Innovation, and Impact in the Academic Medical Center

This brief summary of the Harrison Survey outlines several trends and directions in academic continuing medical education/continuing professional development (CME/CPD). The survey is distributed by the Association of American Medical Colleges (AAMC) and the Society for Academic Continuing Medical Education (SACME) in odd-numbered years. The phrase “academic CME/CPD” refers to the continuing professional development or continuing education activities of the medical schools of the United States and Canada and those of the teaching hospitals, academic medical centers, and academic health systems of the United States. The offices and programs responsible for these activities in these settings are termed “CME/CPD units” throughout this brief summary.

The purpose of the survey is to help identify and understand the placement and alignment of the CME/CPD unit within the academic medical center (AMC). Survey findings will benefit those in the CME/CPD field who can use the data to assess and enhance the shape and scope of CME/CPD and who will share the information with AMC leaders, including deans, CEOs, and others.

SURVEY RESPONSE RATE AND RESPONDER CHARACTERISTICS

Of the 269 eligible academic CME/CPD units, 155 (58%) responded to the survey (see Survey Methodology below). Of these, 90% were in the United States and 10% in Canada. Three-quarters (75%) reported national accreditation in the United States by the Accreditation Council for Continuing Medical Education (ACCME) and 15% by state accrediting agencies. Thirteen reporting Canadian schools (8% of the total respondents) indicated accreditation by the Committee on Accreditation of Continuing Medical Education (CACME). See Table 1.

Table 1 also lists those units reporting accreditation of non-MD health professionals. A little over one-third (35%) indicated no such accreditation. The remainder were accredited by nursing (38%), pharmacy (20%), and others (18%)—psychology, sociology, dentistry, physical therapy, and public health, among many others. In the 2013 AAMC/SACME academic CME/CPD survey, “Pharmacy” was listed as “ACPE” and “Nursing” as “ANCC,” for each profession’s respective accreditation body. In 2015, the numbers were much higher for both of these options.

The 94% response rate of Canadian schools varied significantly from 2013, when only half the schools responded. The overall 58% response rate in 2015 was slightly less than the 61% in 2013.

Table 1. Response Rate and Accreditation of CME/CPD Programs (155 respondents)

Institution Type	Total Invited	Total Responding	Response Rate	MD Accreditation			Accredited to Provide Continuing Education for Other Health Professions			
				CACME	ACCME	State Accrediting Body	No	Yes – Pharmacy	Yes – Nursing	Yes – Other
Canadian	16	15	94%	13			12	1	1	2
United States	253	140	55%		116	23	42	43	85	38
Total	269	155	58%	13	139		54	170 (some with multiple responses)		

For comparison with the 2013 AAMC/SACME academic CME/CPD survey, it is important to note that of the 155 total respondents to the 2015 CME/CPD survey, 98 (63%) also responded to the 2013 CME/CPD survey. This overlap is slightly higher for U.S. CME/CPD units (64%) compared with Canadian units (53%).

MAJOR FINDINGS

The seventh biennial AAMC/SACME Harrison Survey documents an academic enterprise that displays three major characteristics somewhat in opposition to its traditional image as an isolated, passive educational entity. First, CME/CPD is increasingly integrated into the functions and missions of AMCs, academic health systems, and medical schools of the United States and Canada. Second, it demonstrates numerous examples of innovation and scholarship in educational design and operation. Finally, possibly as a result of the first two elements, there is an increased focus on assessing the impact of CME/CPD activities on learner competence, performance, and health care outcomes.

The survey generates broad but important findings for discussion and analysis in three areas: CME/CPD's structure, its function relative to relationships and educational methods, and its scope, reach, and impact. Throughout this report, data from the last Harrison Survey in 2013 are used for comparative purposes.

Structural Elements

- **Overall Integration with Academic Medical Centers.** AMCs continue to integrate their services and structures, and along with them, their CME/CPD services and programs. There are numerous examples of robust organizational relationships with residency programs, faculty development, and quality improvement and patient safety initiatives.
- **The Perception of Academic Medical Leaders.** Academic leadership appears supportive of the role of an integrated academic CME/CPD unit. While this perception appears to be increasing, based on comparisons of 2013 and 2015, it is by no means widespread.
- **The CME/CPD Committee.** Many examples of highly representative, system-integrating CME/CPD advisory committees exist, providing broad-based, system-wide models representing an extensive constituency.
- **Finances and Operations.** Institutional support for CME/CPD activity and the operating budget has increased from previous years. The report notes wide variability in the size and scope of CME/CPD activities and CME/CPD staff and budgetary requirements.

Function: Relationships and Methods

- **Patient Care, Access/Use of Quality Data.** The 2015 results note a decrease in the access to and use of quality data for CME/CPD planning purposes when compared with 2013. While this finding may seem contrary to accreditation and other expectations, it may reflect the increased understanding of the nature, complexity, and granularity of meaningful, actionable quality data. At a minimum, this finding should inspire dialogue regarding the value and use of such data in CME/CPD activity planning and execution and, in turn, the role of CME/CPD in the larger context of the AMC. In contrast, the use of other objective data in planning—annual reports and more general population health data—has increased.
- **Use of Evidence-Based Educational Methods.** Academic CME/CPD units display widespread use of interactivity as an example of one effective educational method. CME/CPD research, implementation science, and knowledge translation studies also indicate the positive effect of other innovations—including online, asynchronous activities that have enjoyed a strong growth since the 2013 survey, as well as live streaming of and tweeting from meetings, online journal clubs and webcasting, and an increase in massive open online courses (MOOCs).
- **Intra-Institutional Relationships.** CME/CPD units continue to show strong collaboration with other programs and departments within the AMC. The relationships are particularly strong in faculty development, allied health professional programs, simulation units, and residency education. Collaboration with quality and performance improvement programs is the third most frequently cited relationship among the 16 types identified in the survey. Significant missed opportunities remain for the academic CME/CPD unit in building collaborations with faculty practice plans, undergraduate medical education, health services research, hospital accreditation, and patient education.
- **Faculty Development.** CME/CPD programs are increasingly engaged in the organization, accreditation, and delivery of educational activities for faculty related to clinical affairs, research and regulatory matters, and educational methods.

Scope, Reach, and Impact

- **Learners.** CME/CPD participation in academic centers represents a blend of internal (i.e., AMC staff and full-time faculty) and external (i.e., community-based) participants. These individuals represent a mix of health professionals as indicated in increased numbers of providers accredited by nursing, pharmacy, and other health professional bodies.
- **Internal and External Programming.** Academic CME/CPD units develop and deploy a wide variety of educational methods tailored to their program goals and objectives. These include both traditional methods for an internal audience (e.g., grand rounds, morbidity and mortality conferences) and for an external audience (e.g., visiting speaker programs, teleconferencing). A new method represented in the 2015 data reflects involvement in the American Board of Medical Specialties Maintenance of Certification® Part IV (ABMS MOC® Part IV) program and Performance Improvement CME (PI-CME). Both are based on anchoring CME/CPD activities in the context and needs identified by practice.
- **Faculty Development Impact.** Educational programs designed for faculty members—increasing in number and their relationship to CME/CPD operations—benefit roughly from an equal mix of undergraduate, (post) graduate, and continuing educational programs. Content areas focus on improving teaching skills, leadership, and educational techniques, with an increasing emphasis on quality improvement and patient safety (QI/PS).
- **Outcomes Measurements.** Academic CME/CPD providers have moved beyond standard evaluation methods, many by including the use of commitment-to-change models to assess the impact on practice and performance. The survey notes smaller but important efforts dedicated to assessing competence and performance and even to patient and population health outcomes. Challenges may exist in the area of access to meaningful quality data, but once these are overcome, the linkage between access and assessment displays enormous potential for the integration and impact of CME/CPD in AMCs.
- **Research.** The report discloses a somewhat shrinking body of CME/CPD units committed to scholarship that contributes to the research enterprise in—and the body of knowledge about—health professional learning and change. This activity, reflected by the increased number of studies, appears to be the product of collaboration both within and across AMCs and is supported by funding sources internal and external to the institution. New data illustrate that funding for all CME/CPD is twice as likely to be provided internally (by the unit or institution) than by any single external funding source (commercial interests, grants, or other sources).

CONCLUSION

The report is limited to some extent by a response rate of just under 60% and nonidentical populations of respondents over a two-year period. Nonetheless, CME/CPD in the academic setting demonstrates three major trends.

There is consistent evidence of CME/CPD *integration* into the functions of the AMC, including a growing relationship with (post)graduate medical education. There is a clear movement to develop *innovation* in the methods and delivery of continuing education to the health professional population—both external to the AMC and, increasingly, within the AMC. This movement is buttressed by a solid if not yet universal commitment to scholarship and best practices. Finally, there is clear evidence of the efforts of many CME/CPD units to measure the *impact* of CME/CPD activities—an effort that can be increased by enhanced access to quality metrics. Many opportunities exist within the AMC and in the regions and with the patients they serve for further integration, innovation, and assessment of impact, including improving the most important outcome of all: patient care.

SURVEY METHODOLOGY

In summer 2015, an internet search identified a total of 593 academic CME/CPD units, located in 365 U.S. teaching hospitals/health care systems, 66 U.S. Department of Veterans Affairs medical centers, 17 Canadian medical schools, and 145 U.S. medical schools. Of that number, we noted 502 in which a defined CME/CPD office and/or institutional contact information could be identified. Unit information was matched with that of the ACCME (www.accme.org) and the Royal College of Physicians and Surgeons of Canada (www.royalcollege.ca), when possible, to confirm a contact name—generally the CME/CPD director. When a director's name could not be identified electronically, telephone calls were placed to CME/CPD units and offices.

Among medical schools, 41 CME/CPD units were located in the United States and 16 in Canada. At the time of this survey, the University of Alberta had no CME/CPD unit. U.S. teaching hospitals in close association with their academic health systems (AHS) were represented by 79 CME/CPD units. An additional 134 U.S. CME/CPD units indicated that they provided CME/CPD services to both their medical school or teaching hospital and one or more additional medical school, teaching hospital, or health care system. In all, this generated a grand total of 270 academic CME/CPD units. Of the total contacts for the 270 CME/CPD units, 269 surveys were successfully delivered via email.

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Harrison Survey Writing Group

Lois Colburn, Chair
Ginny Jacobs, MEd, MLS, CHCP
Mila Kostic, CHCP
Jack Kues, PhD
Connie LeBlanc, MD, CCFP, FCFP, MAEd, representing the AFMC
David Price, MD
Janine Shapiro, MD
Mary Turco, EdD

AAMC Staff

Dave Davis, MD, FCFP
Carol Goddard

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