Validation of the Clinical Content of CME
The ACCME Expectations of Providers and of the Accreditation Process

Background and Introduction

The ACCME accreditation system and its requirements have been challenged by a number of forces to demonstrate that it values and requires that the clinical content of certified CME activities is valid. It is the expectation of the ACCME member organizations, and others, that ACCME requirements assure the accuracy and reliability of the information disseminated in continuing medical education that is used to maintain licensure, credentials and competence in the United States.

Following a period of discussion and information-gathering, the ACCME, at the recommendation of its Task Force on Content Validation and Eligibility for Accreditation, approved the dissemination of a draft framework on content validation for the review and input of accredited CME providers, recognized state medical societies, and other interested parties. That feedback period ended in March 2002, with over 100 responses being submitted to the ACCME for consideration.

'..implications behind the proposal insulting...'

'..bothered by the ever increasing documentation'

' defeats the purpose of CME..to learn about new before in print'

'proposal prevents discussion about CAM'

'We commend the ACCME...'

'In full support of the general proposal...'

'We applaud the intention ...to ensure that CME activities are evidence-based or meet legal, legislative, licensure or certification requirements'

Reaction on the part of accredited providers was mixed. Half of the respondents believed the proposal to be insulting and/or overly burdensome. The other half of the respondents believed their CME programs were already set up to review and ensure the clinical content of their CME activities was valid.

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The ACCME's Task Force carefully reviewed the responses and took the approach of stepping back to examine the intent of a proposal on content validation. The Task Force identified a subset within a physician's continuing professional development that is CME, and within CME, another subset that deals with patient care recommendations. It is the validity of those **patient care recommendations** that is the concern of the accreditation system.
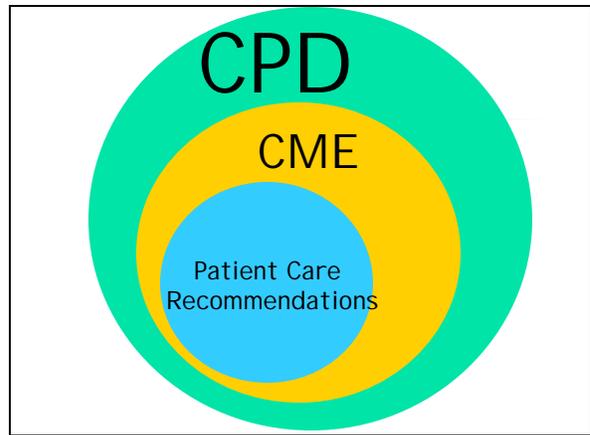
How CME is used…..

CME supports learning and improvement that contributes to maintenance of,

- Competence
- Licensure
- Certification *and*
- Privileges

In the context of competency in,

- Professionalism
- Patient care
- Systems based practice
- Interpersonal skills
- Medical knowledge

CME supports learning and improvement by the physician that can be directly tied to maintenance of competence, licensure, board certification, credentialing by hospitals.

In 2002, there are high expectations of CME on the part of those who expect it to explicitly support and perhaps contribute to assuring the physician's continuing ability.

ACCME's Actions: July 2002

In keeping with the highly effective public health model of using education to improve practice, the ACCME Task Force recommended and the Council agreed, at its July 2002 Meeting, that the ACCME should incorporate into its education projects and collaborations strategies, examples, and information about content validity and to begin to move toward a situation where the principles adopted become 'shared values' within the CME community.

The ACCME will incorporate into its education projects and collaborations

- Strategies to enhance provider capabilities with the process of reminding faculty of the need to incorporate levels of evidence into clinical presentations
- Examples for and collaboration with providers to develop methods of disclosure to audiences
- Information to raise the general awareness among providers, physicians, and faculty about the principles of EBM and clinical practice.

ACCME Action July 2002

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To assist the ACCME and providers with this educational process, the Task Force also recommended, and the Council adopted as policy, three value statements to express the expectations of the accreditation system with respect to content validity and eligibility for accreditation.

"All the recommendations involving <u>clinical</u> medicine in a CME activity must be based on *evidence that is accepted within the profession of medicine* as adequate justification for their indications and contraindications <u>in the care of patients</u>."

Adopted by ACCME July 2002

Statement 1

The first statement concentrates on that subset of CME that deals with recommendations involving the <u>clinical care of patients</u>. It says that such clinical recommendations must be based on <u>evidence that is accepted within the profession of medicine</u> as adequate justification for their use. This value, the ACCME believes, is one that all CME providers will agree upon with respect to the integrity and scientific validity of the clinical content of their CME activities.

The statement says that a recommendation on clinical care must be more then firmly held beliefs or hopes for efficacy. There must be data or information available "<u>that is accepted within the profession of medicine</u>" that backs-up the recommendation (this statement does **not** say that the **recommendations** need to be generally accepted by the profession!) The conclusions drawn from the data must be those that would be reasonably drawn from those data. This does not mean that every clinician in the country accepts the recommendation. It does not mean that the recommendation is part of FDA-labeling. However, it does mean that our teachers and authors, of CME that counts for maintenance of licensure, need to assure us all, implicitly or explicitly, that what they are recommending is valid for use in the care of patients.

"All scientific research referred to, reported or used in CME in support or justification of a patient care recommendation must conform to the generally accepted standards of experimental design, data collection and analysis."

Adopted by ACCME July 2002

Statement 2

An important part of validity is the scientific integrity of the data from which the conclusions are drawn and the clinical recommendations crafted.

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The last statement adopted by ACCME in July 2002 outlines those providers that are **NOT** eligible for ACCME accreditation. Ultimately, it was necessary to explicitly state that we already know some content cannot meet the expectation of the ACCME member organizations, and others, and that ACCME requirements assure the accuracy and reliability of the information disseminated in continuing medical education that is used to maintain licensure, credentials and competence in the United States.
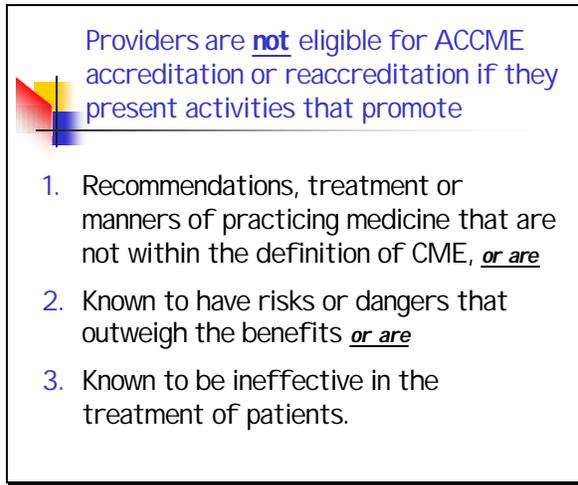
Providers are **not** eligible for ACCME accreditation or reaccreditation if they present activities that promote

1. Recommendations, treatment or manners of practicing medicine that are not within the definition of CME, *or are*
2. Known to have risks or dangers that outweigh the benefits *or are*
3. Known to be ineffective in the treatment of patients.

Statement 3

End Result: Our Outcome

The end result, the ACCME hopes and intends, is for the accreditation system and its providers to be reflective of these values and accountable – with respect to clinical content -- so that the CME presented meets the definition of CME, any clinical suggestions for patient care are valid, recommendations known to be ineffective or that are associated with dangers that outweigh any benefits, are not part of certified CME by an accredited provider, and there is a foundation for the integrity of the recommendations for patient care.

With the assistance and concurrence of accredited providers, CME will be seen as facilitating life-long learning, thereby contributing to physicians' maintenance of competence.

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