

# Academic CME/CPD in the United States and Canada: The 2015 AAMC/SACME Harrison Survey

*Integration, Innovation, and Impact in the Academic Medical Center*

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Finally, the efforts of R. Van Harrison, PhD, University of Michigan Medical School, have provided a platform on which to build further analyses of activity and to track changes within the academic CME/CPD community. The naming of this survey pays tribute to his commitment to survey design and execution over many years and to the Society for Academic Continuing Medical Education.

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## Acronyms

<b>AHS</b> =	Academic health system. The complex of the hospital(s), medical school, regional clinicians, and other elements of a modern, integrated health care delivery network.
<b>AMC</b> =	Academic medical center. The teaching hospital-medical school complex.
<b>Can\$</b> =	Canadian dollar.
<b>CME/CPD</b> =	Continuing medical education/continuing professional development. The development and implementation of educational activities.
<b>CME/CPD unit</b> =	Continuing medical education/continuing professional development offices and programs. Includes variations in unit names such as continuing professional education, lifelong learning and professional development, and continuing education and improvement.
<b>GME/PGME</b> =	Graduate or residency education. In Canada, this is referred to as postgraduate education.
<b>IPE</b> =	Interprofessional education.
<b>QI/PS</b> =	Quality improvement and patient safety.

## Executive Summary

The seventh biennial Harrison Survey, jointly sponsored by the Association of American Medical Colleges (AAMC) and the Society for Academic Continuing Medical Education (SACME), documents an academic enterprise that displays three major characteristics, somewhat in opposition to its traditional image as an isolated, passive educational entity. First, continuing medical education/continuing professional development (CME/CPD) is increasingly integrated into the functions and missions of academic medical centers, 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 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.

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 survey notes 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.

- **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.
- **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. Examples of these are documented in this report and include 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).

## 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 reflected 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 education 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 both 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 patients they serve for further integration, innovation, and assessment of impact, including improving the most important outcome of all: patient care.

# Background and Methods

**This survey describes several elements in the transition of CME/CPD in academic medical centers from a passive resource (i.e., producing standard courses and lectures) to one that is dedicated to patient care, research, and education.**

## BACKGROUND

The seventh biennial Harrison Survey is jointly sponsored by the Association of American Medical Colleges (AAMC) and the Society for Academic Continuing Medical Education (SACME), in collaboration with the Association of Faculties of Medicine of Canada (AFMC). It is based on previous surveys of academic continuing medical education/continuing professional development (CME/CPD) providers conducted over the last two decades by SACME. Its name, the Harrison Survey, recognizes R. Van Harrison, PhD, of the University of Michigan Medical School, who led the society's CME/CPD survey efforts over this period.

The Harrison Survey reviews the organization of the CME/CPD unit in U.S. health care systems, U.S. and Canadian medical schools, and U.S. teaching hospital members of the Council of Teaching Hospitals (COTH). Additionally, the survey provides information about the structure and function of CME/CPD and the academic medical center (AMC) in which CME/CPD resides and reports on the impact of continuing education and professional development on patient care and innovation. This survey describes several elements in the journey of academic CME/CPD from a passive resource (i.e., producing standard courses and lectures) to one that is dedicated to patient care, research, and educational missions.

Many questions in the 2015 survey match those in the 2013 survey to provide a clear comparison from survey to survey. Questions were edited only for clarity, and a few additional questions were added to bring a deeper understanding of the data. The purpose of the survey is to help identify and understand the placement and alignment of the CME/CPD unit within the AMC. The scope of the survey and the subsequent report illustrate where the CME/CPD unit has, or can have, an impact within the institutional structure—on the internal and external audiences and the public community that it serves.

Several reporting and naming conventions are used in the Harrison Survey (see list of acronyms). In addition, the Canadian dollar was valued at roughly 0.72 of the U.S. dollar during the year in which this report was created. In 2013, the Canadian dollar was valued on average at roughly 0.96 of the U.S. dollar. Thus, where monetary amounts are represented, the figures are itemized separately. Where percentages are reported, they are rounded to the nearest full percentage point.

## METHODS

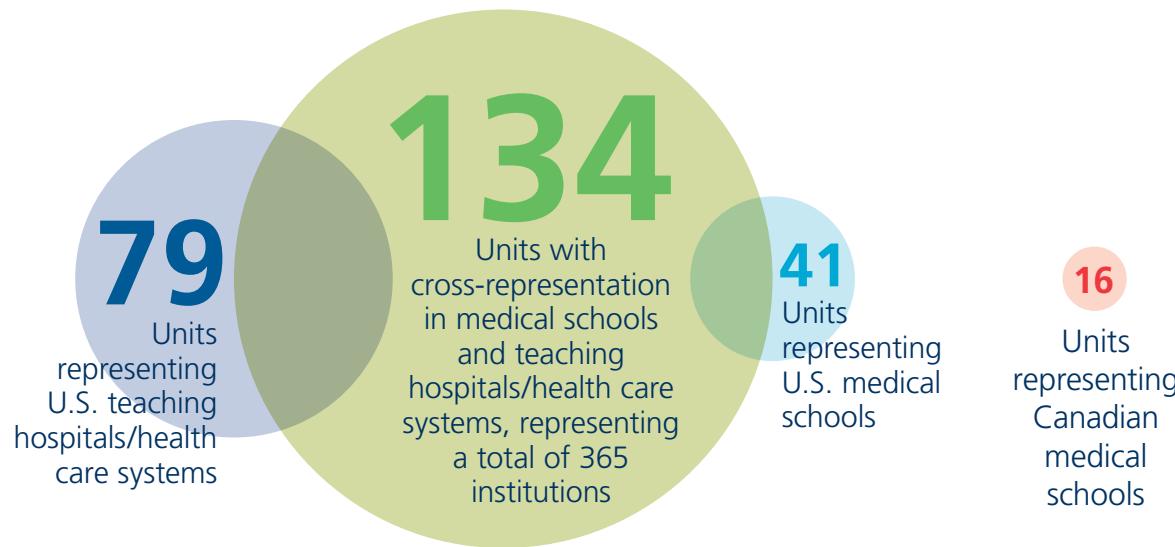
Questions from the 2013 survey were reviewed by the writing group named in this report. Some were edited or modified to improve clarity; others were added.

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 Accreditation Council for Continuing Medical Education (ACCME) ([www.accme.org](http://www.accme.org)) and the Royal College of Physicians and Surgeons of Canada ([www.royalcollege.ca](http://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 system (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. See Figure 1.

**Figure 1. Grand total of 270 academic CME/CPD units in the United States and Canada.**



In early August 2015, an email was sent to each director to ask for confirmation of his/her role and announce the upcoming survey. At the beginning of October, the survey was open for a ten-week period during which time three reminders were sent to nonresponders; it closed in mid-December. This report summarizes data from active, accredited CME/CPD units whose data were available at the time of reporting. Although organizationally located in medical schools or teaching hospitals, many CME/CPD units function in a manner that often encompasses activities across both institutions, making separate reporting problematic.

The 2015 Harrison Survey report comprises five major sections:

1. Survey response rate and characteristics of respondents
2. The structure of academic CME/CPD units and the AMCs in which the units are situated
3. The function and relationships of academic CME/CPD units
4. The reach, scope, and impact of the academic CME/CPD unit both internal and external to the AMC
5. Discussion, conclusions, and implications of the structure, function, impact, and direction of academic CME/CPD

## Section 1: Survey Response Rate and Responder Characteristics

Of the 269 eligible academic CME/CPD units, 155 (58%) responded to the survey. Of these, 90% were in the United States and 10% in Canada. Three-quarters (75%) reported national accreditation in the United States by the 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 a variety of 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
<b>Total</b>	<b>269</b>	<b>155</b>	<b>58%</b>	<b>13</b>	<b>139</b>		<b>54</b>	<b>170 (some with multiple responses)</b>		

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%).

Throughout this report, the data represent CME/CPD units that vary widely in their size, scope, and mission. This includes varying degrees of staff, financing, structure, and placement within the institution.

## Section 2: Structural Elements of CME/CPD in the Academic Medical Center



**A cohort of academic CME/CPD units displayed a moderate or greater degree of integration across teaching hospital and medical school functions, somewhat less than the integration with the institution's clinical enterprise itself.**

This section characterizes the settings in which academic CME/CPD units were situated in 2015 and the organization of the CME/CPD unit within that environment. The latter describes a variety of structural phenomena, including the degree of integration of academic and clinical CME/CPD enterprises, structure and role of the CME/CPD committee, and engagement and understanding of the system's leadership with regard to an active and integrated CME/CPD presence. Such considerations are important in understanding the context in which academic CME/CPD units plan and work.

### INTEGRATION OF THE AMC AND ITS CME/CPD UNIT

Respondents were asked, "How integrated is the medical school with the clinical enterprise (i.e., the teaching hospital, academic medical center, and/or health care system)?" This question led naturally to a discussion of those programs, offices, or units in the AMC with which the CME/CPD unit can meaningfully interact.

#### *Integration of the Medical School with the Clinical Enterprise*

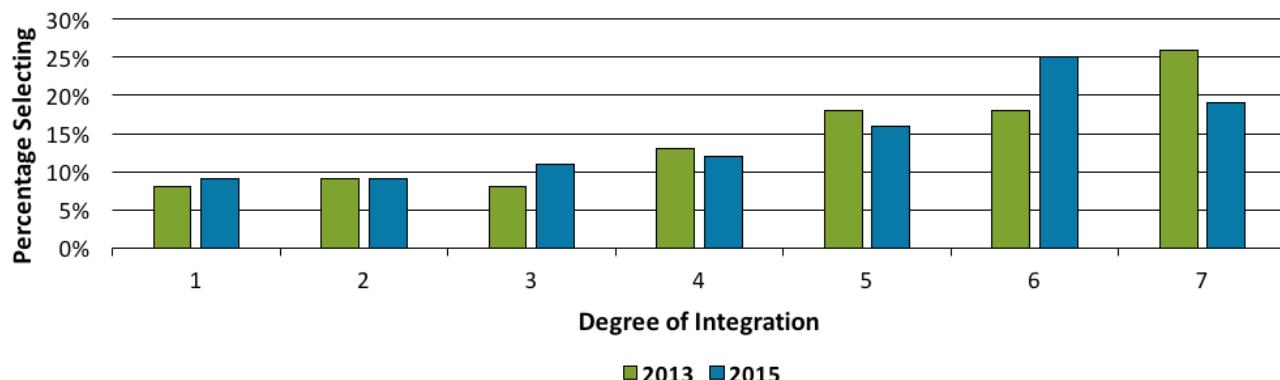
One hundred and forty units replied, indicating a spectrum of AMC and AHS integration along a continuum ranging from no integration (9% of respondents) to highly integrated (19%). The majority (60%) indicated that they were moderately to highly integrated, reporting integration with most programs and facilities. See Figure 2.

#### *Medical School CME/CPD Unit Integration with the Clinical Enterprise*

Equally important is the question of CME/CPD unit integration with the CME/CPD of the clinical enterprise. Respondents were asked about their degree of such integration. Here, a more binary response was noted: half of the units indicated moderate or greater integration with the institutional clinical enterprise itself, while a slightly smaller percentage reported lesser degrees of integration. See Figure 3.

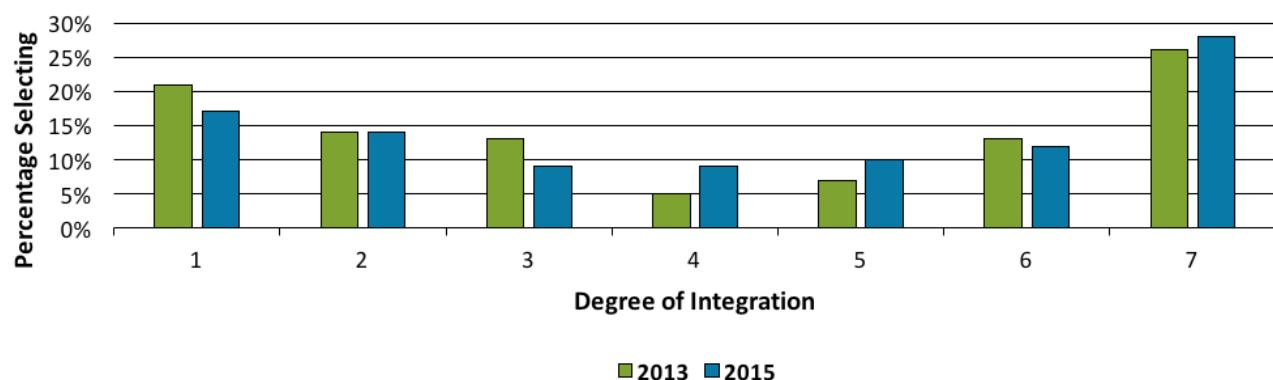
Comparing these data with those of 2013, there is a slight increase in the number of schools reporting integration of the CME/CPD unit with that of its clinical partner—a nonsignificant "shift to the right." Of note, those systems indicating the highest degree of integration reported a lesser number of CME/CPD units indicating integration. In contrast, those systems reporting more moderate or less integration indicated a stronger CME/CPD unit integration or alignment.

**Figure 2. Degree of integration of the medical school with the clinical enterprise (2013 = 137 respondents; 2015 = 140 respondents).**



1 = Low. Medical school is totally separate from clinical enterprise, with no/little cross-organizational structures or communication.  
7 = High. Medical school and clinical enterprise are under common governance.

**Figure 3. Degree of integration of the medical school CME/CPD unit with the clinical enterprise (2013 = 135 respondents; 2015 = 140 respondents).**

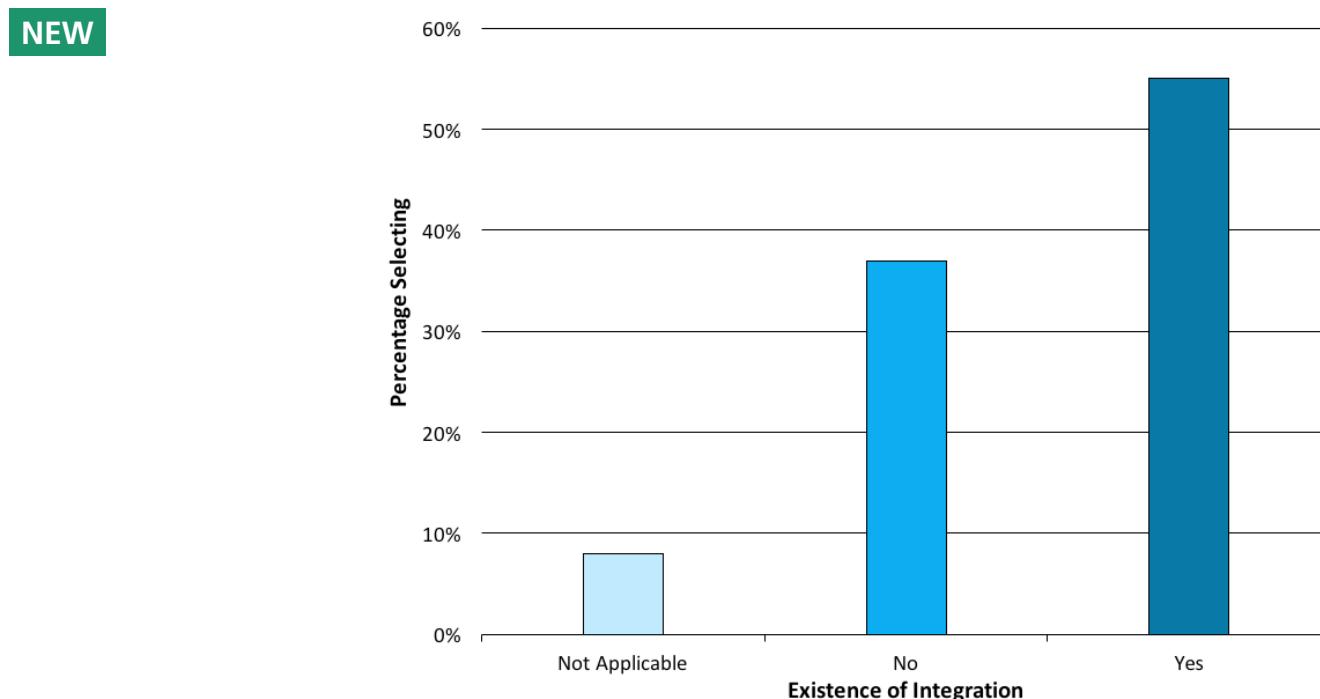


1 = Low. Medical school/university CME/CPD unit is totally separate from clinical enterprise CME/CPD unit.  
7 = High. Medical school/university CME/CPD unit and clinical enterprise CME/CPD program are totally integrated (i.e., there is only one CME/CPD unit operating in both the medical school and hospital environment).

### ***Institutional Organization and the CME/CPD Unit***

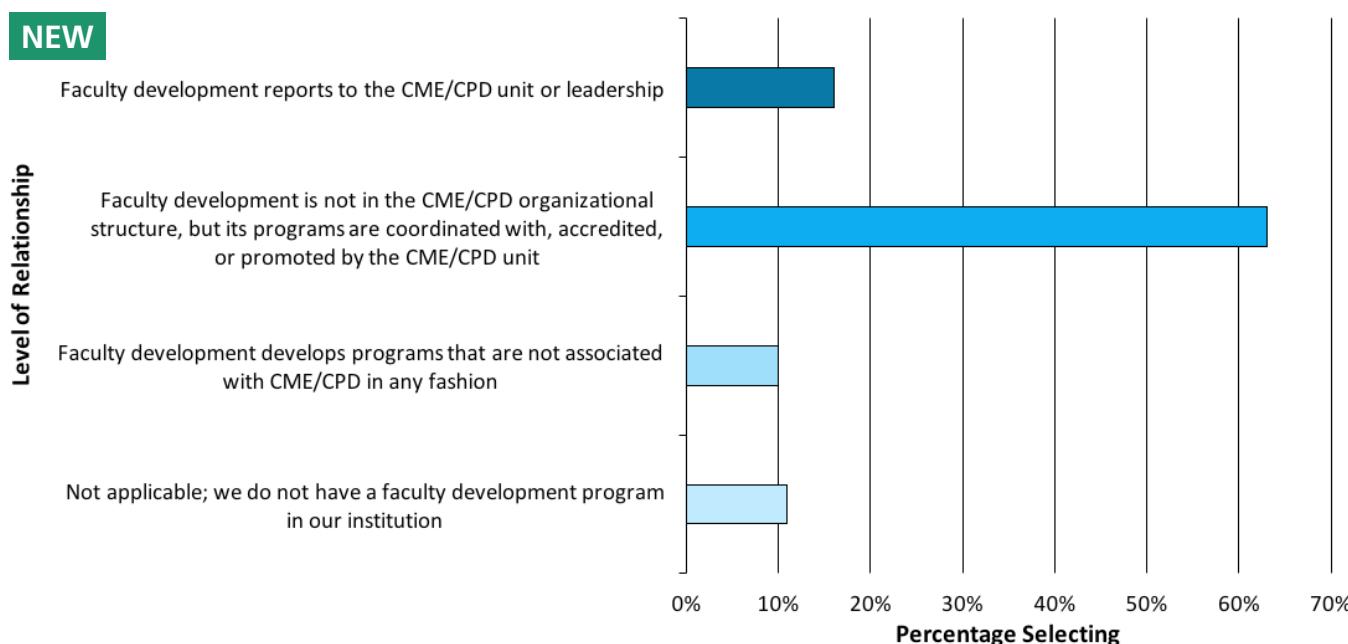
New to the 2015 survey was a query about the integration of the CME/CPD unit with the university at large (e.g., reporting to a provost or vice provost). The majority of the 153 respondents (55%) indicated an operational relationship with the larger university. See Figure 4.

**Figure 4. Relationship of the CME/CPD unit to the university at large (153 respondents).**



The 2015 survey also sought to better identify the organization of faculty development relative to the CME/CPD unit. Of the 150 total respondents, 11% indicated an absence of a faculty development program and 10% indicated no relationship with faculty development. However, the majority (63%) reported that faculty development programs are coordinated with, accredited by, or promoted by the CME/CPD unit. A further 16% stated that faculty development reports to the CME/CPD unit or leadership. See Figure 5.

**Figure 5. Relationship between the CME/CPD unit and the faculty development function (150 respondents).**



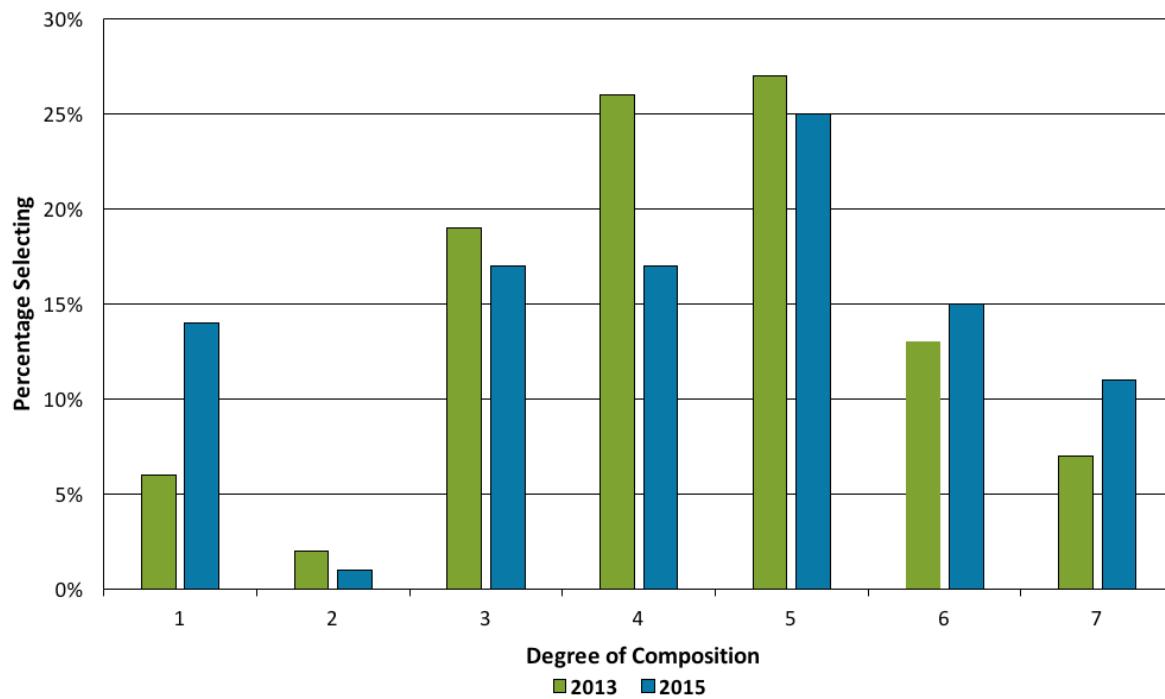


## THE CME/CPD COMMITTEE: COMPOSITION AND ROLE

One of the key structural components of the CME/CPD unit is an advisory committee that is of use in planning and evaluation, in policy setting, in advocacy, and in establishing a presence in the AMC.

The 2015 survey raised the question of the composition of the CME/CPD committee. Respondents were given a range of options, from a nominal CME/CPD committee (i.e., one in name only), to a number of increasingly engaged and active committee structures, to a committee that the survey described as highly representative and proactive—a category considered most desirable by the survey writing group. The seven-point scale details are listed in Figure 6. Roughly one-third (32%) identified a nominal committee, one with relatively narrow representation. Forty-two percent of the units indicated broadly representative membership, with individuals interested in and committed to CME/CPD improvements. Approximately one-quarter of the units (26%) represented the most highly evolved and committed category. Both ends of the spectrum showed trends toward increases compared with 2013 results; the middle range displayed a decrease. See Figure 6 for results.

**Figure 6. Representativeness of CME/CPD committee composition (2013 = 126 respondents; 2015 = 141 respondents).**



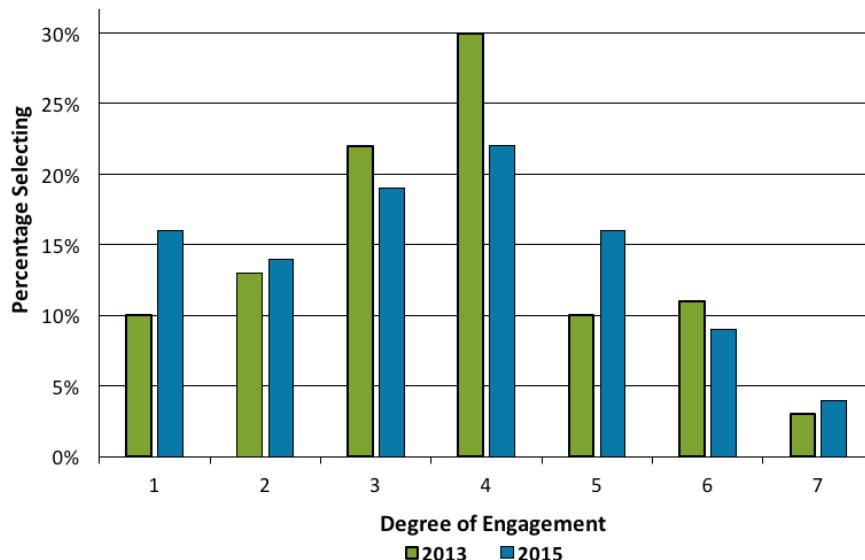
- 1 = Nonrepresentative. CME/CPD committee is nominal (in name only), or there is no committee.
- 2 = A small, ad hoc committee. Members have no/little interest or commitment to CME/CPD.
- 3 = Committee with narrow representation. Members have some interest or commitment to CME/CPD.
- 4 = Committee with broad representation. Members are interested in and committed to CME/CPD improvements.
- 5 = Committee with broad representation, plus other committee members representing the clinical and educational enterprise. Members are interested in and committed to CME/CPD improvements.
- 6 = Committee with broad representation, plus others representing quality improvement, educational expertise, electronic health records, and other elements of the clinical and educational enterprise. Members are interested in and committed to CME/CPD improvements.
- 7 = Highly representative. Committee with strong representation, plus leaders in quality improvement, educational expertise, electronic health records, and other elements of the clinical and educational enterprise. Faculty members are interested in and strongly committed to CME/CPD improvements.

**Just over half of academic CME/CPD units reported being guided by moderately or highly representative CME/CPD committees.**

The Harrison Survey also studied the role and level of engagement of the CME/CPD committee, something arguably more important than the committee's structure. Respondents were asked to select from options ranging from an inactive committee or nonexistent committee, to one focused superficially on some issues such as course approval, to those that concentrated more on the improvement of the CME/CPD in the AMC, to a scenario in which the committee was identified as highly engaged (i.e., active in recommending CME/CPD and integration with quality improvement, other clinical elements, and the community). The seven-point scale details are listed in Figure 7. A little less than one-third (30%) indicated a nominal or minimally functioning committee. Roughly one-fifth (19%) of committees had begun to focus on improvement activities relative to CME/CPD in course content or delivery. Just over one-third (38%) had begun to advance consideration of health care outcomes and the integration of CME/CPD into the clinical enterprise. Finally, 15% selected a scenario describing a more fully evolved and highly engaged CME/CPD committee. Such a committee had recommended, or had begun to recommend, CME/CPD integration into most quality and performance improvement programs, the integration of educational programs with other clinical elements, and the routine use of quality data to plan and assess CME/CPD programming.

These percentages are approximately the same as those reported in 2013. See Figure 7.

**Figure 7. CME/CPD committee role and level of engagement (2013 = 126 respondents; 2015 = 139 respondents).**



- 1 = Inactive. CME/CPD committee is nominal, with no/little role, or there is no committee.
- 2 = Committee is narrowly focused on administrative functions such as superficial approval of CME/CPD activities and policies.
- 3 = Committee is focused on administrative functions such as approval of CME/CPD activities and policies and has begun to develop strategies for improving the content, integration, or delivery of CME/CPD.
- 4 = Committee is initiating strategies to improve the content or delivery of CME/CPD and has begun to consider strategies for integrating CME/CPD with education and health care outcomes.
- 5 = Committee is active in recommending CME/CPD integration into some educational and clinical programs focused on health care outcomes.
- 6 = In addition to activities described in level 5 above, committee is active in requiring CME/CPD integration into most educational and clinical programs and has begun to consider other clinical elements such as education delivery methods (electronic health records, feedback from hospital data, etc.) and the use of quality data to develop educational activities.
- 7 = Highly engaged. Committee is highly engaged in recommending CME/CPD integration into most quality and performance improvement programs, has integrated educational programs with other clinical elements and the community (e.g., electronic health records, feedback from hospital data, etc.), and routinely uses quality data to plan and assess CME/CPD programming.

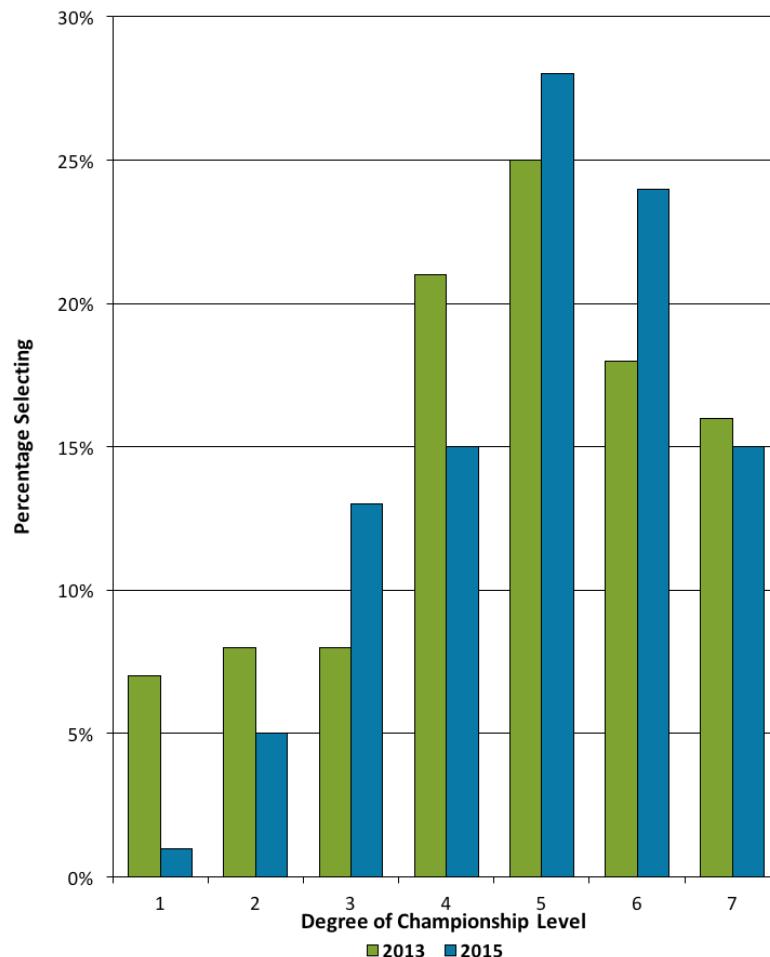


## LEADERSHIP ENGAGEMENT AND THE VALUE OF THE CME/CPD UNIT

The role of AMC leadership with regard to the potential of the CME/CPD unit in improving health care delivery is arguably among the most important considerations addressed by the Harrison Survey. Respondents were asked the question, "Which level best characterizes your institution's leadership (deans, associate deans, chief medical officers, quality improvement leaders, clinical and faculty leaders) as champions for CME/CPD alignment and improvement?" A range of possible answers were documented along a seven-point scale from little/no understanding of the potential for an integrated CME/CPD unit to a situation in which leaders demonstrate excellent understanding of and support for CME/CPD at all levels. The results, shown in Figure 8, indicate a slight but consistent skewing toward a more committed leadership from 2013 to 2015. Over two-thirds (67%) indicated present and active leadership support, meaning leadership that is moderately understanding and supportive of an effective and integrated academic CME/CPD unit. Roughly one-third (34%) indicated room for improvement in leadership engagement. See Figure 8.

**Figure 8. Leadership as champions for academic CME/CPD alignment and improvement (2013 = 131 respondents; 2015 = 144 respondents).**

CME/CPD units reported widespread—but not entirely complete—leadership support for an aligned CME/CPD unit, focused on clinical and academic improvements. This is accompanied by a sense of moderate or high value on the part of the majority of respondents.

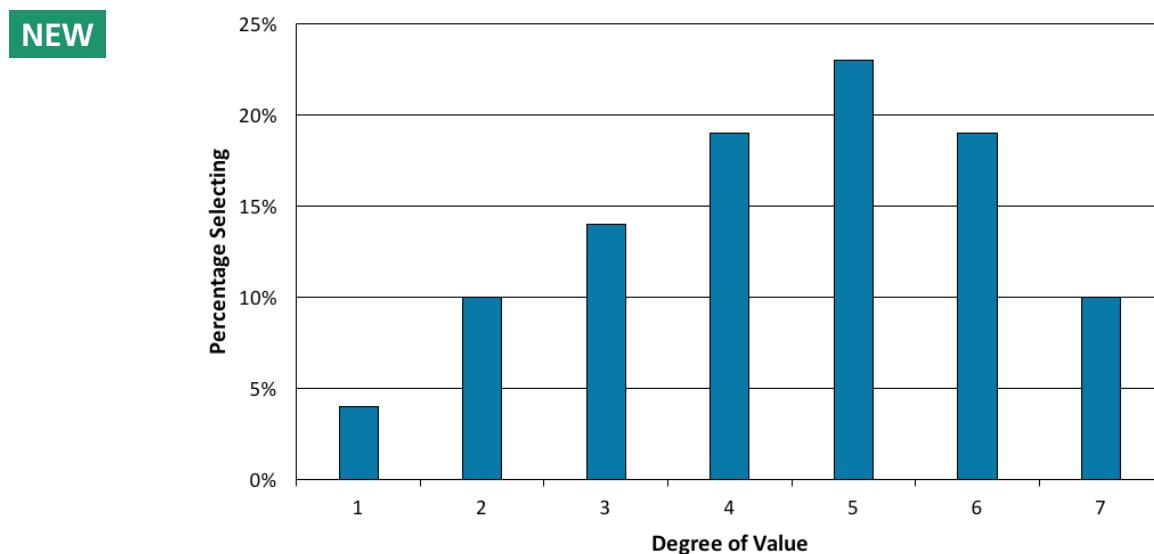


1 = Absent. Institution leaders have no/little understanding of the potential for an integrated CME/CPD unit.

7 = Present and active. Leaders demonstrate excellent understanding of and support for CME/CPD at all institution levels.

How the health system/institution values the role of CME/CPD in health system changes was a new question introduced in the 2015 survey. Similar to the question of leadership support, respondents were asked to select from a range of possible answers—from a position in which CME/CPD is not valued by the organization to the converse situation in which it is highly valued. The results, shown in Figure 9, indicate that just over half (53%) expressed a belief that the CME/CPD unit's role is moderately valued or highly valued, 33% described the unit's role as somewhat valued, and a small percentage (14%) indicated the perception of little or no value for CME/CPD. See Figure 9.

**Figure 9. Degree of value of CME/CPD role in all health system changes (144 respondents).**

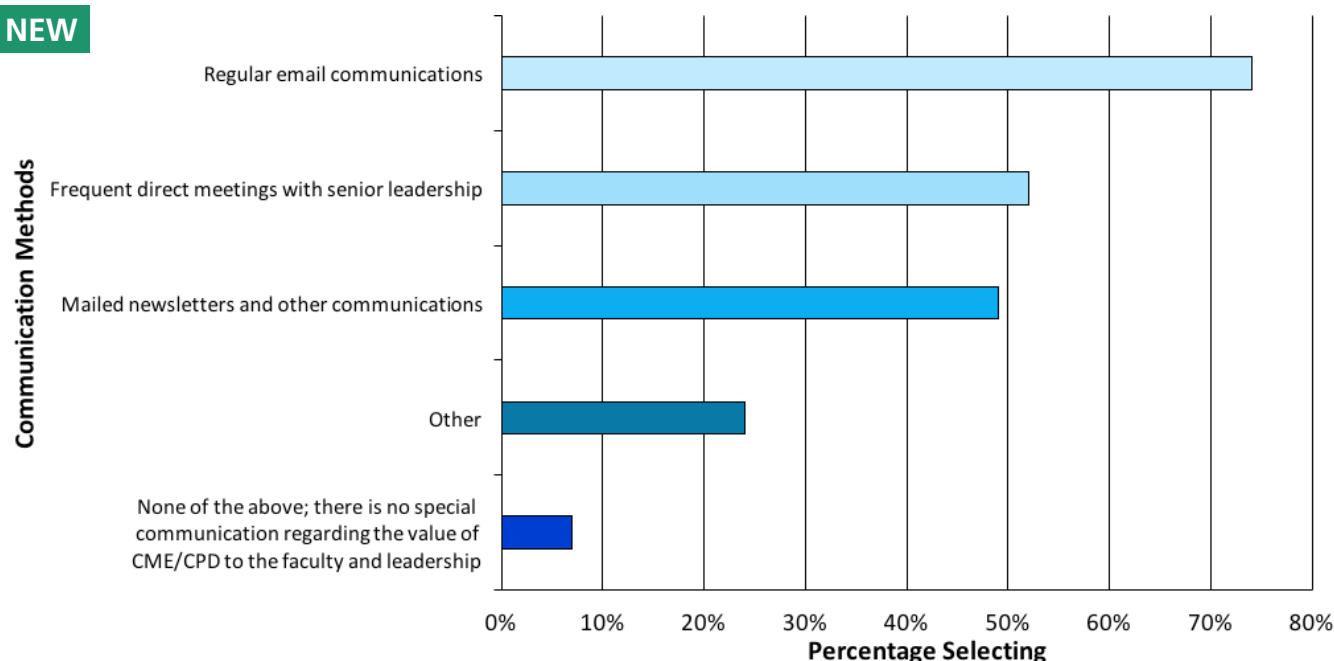


1 = Low. No value paid to CME/CPD unit.

7 = High. CME/CPD is highly valued.

Another question introduced in the 2015 survey determined the manner by which the CME/CPD unit communicates with faculty and with the institution. For each method listed, respondents were able to “select all that apply.” These methods included regular email (74%), frequent direct meetings with senior leadership (52%), and mailed newsletters or similar communications (49%). One-quarter (24%) used other methods, including presentations at clinical practice and faculty meetings, advisory meetings, CME/CPD committee meetings, surveys, a monthly blog, website postings, and other social media methods. See Figure 10.

**Figure 10. How the CME/CPD unit communicates with faculty and institution (144 respondents).**



## STAFFING AND FINANCING THE CME/CPD UNIT

The 2015 survey asked for the number of full-time equivalent staff members (FTEs) employed in the CME/CPD unit, with the goal of understanding the size of the CME/CPD unit within the AMC. One hundred and fourteen units responded, listing a staff complement ranging from 1 to 36 and generating a mean of 7 and a median of 5. See Table 2.

**Table 2. Total Number of Full-Time Equivalent Staff Members (FTEs) Employed in CME/CPD Units**

**NEW**

Number of respondents	<b>114</b>
Mean number of FTEs	<b>7</b>
Median number	<b>5</b>
Maximum number	<b>36</b>
Minimum number	<b>1</b>

### *Financing the CME/CPD Unit*

The Harrison Survey analyzed relevant funding structures, focusing on the CME/CPD unit's overall fixed operating budget and its support from institutional sources. CME/CPD units were queried about the degree to which their budgets were separate and identifiable. A large majority (86%) indicated this was the case. In contrast, the remainder (14%) indicated that their budgets were totally integrated with the institution or a subset and thus not suitable for analysis and reporting. These percentages are exactly equal to those from the 2013 Harrison Survey. Of the 116 positive responses, 104 respondents provided financial information.

### *Academic CME/CPD Budgets*

For the 2015 calendar year, CME/CPD units were asked about the size of their total fixed operating budgets, which produced a wide range of responses about budget sizes, especially among U.S. respondents. American institutions reported a median budget figure of \$522,000 but with wide variation, from a minimum of \$72,000 to a maximum of \$22 million. Less variability was noted among the 13 budget-reporting Canadian institutions, with a minimum of Can\$435,962 and a maximum of Can\$2.5 million. See Table 3.

**Table 3. Total CME/CPD Fixed Operating Budget and Total Revenue from Institution to CME/CPD Unit, by Institution Type**

Category	Canadian Dollars		U.S. Dollars	
	2013 N=8	2015 N=13	2013 N=94	2015 N=89
<b>Total Budget</b>				
<b>Mean</b>	\$1,310,905	\$1,055,623	\$860,454	\$1,071,228
<b>Median</b>	\$1,200,000	\$870,380	\$501,500	\$522,000
<b>Maximum</b>	\$2,000,000	\$2,500,000	\$23,000,000	\$22,000,000
<b>Minimum</b>	\$845,000	\$435,962	\$5,000	\$72,000
<b>Total Revenue</b>				
<b>Mean</b>	\$406,793	\$370,647	\$211,367	\$239,245
<b>Median</b>	\$357,500	\$350,000	\$163,864	\$163,970
<b>Maximum</b>	\$1,000,000	\$900,000	\$1,200,000	\$2,381,955
<b>Minimum</b>	\$0	\$35,000	\$0	\$0

**Institutional support for academic CME/CPD units appears to have increased slightly. While nearly two-thirds of respondents indicated similar year-to-year dollar amounts from this source for both 2013 and 2015, those reporting increased institutional support rose to 22% in 2015, compared with 13% in 2013.**

### *Revenue from Institutional Sources*

#### **2015 Data**

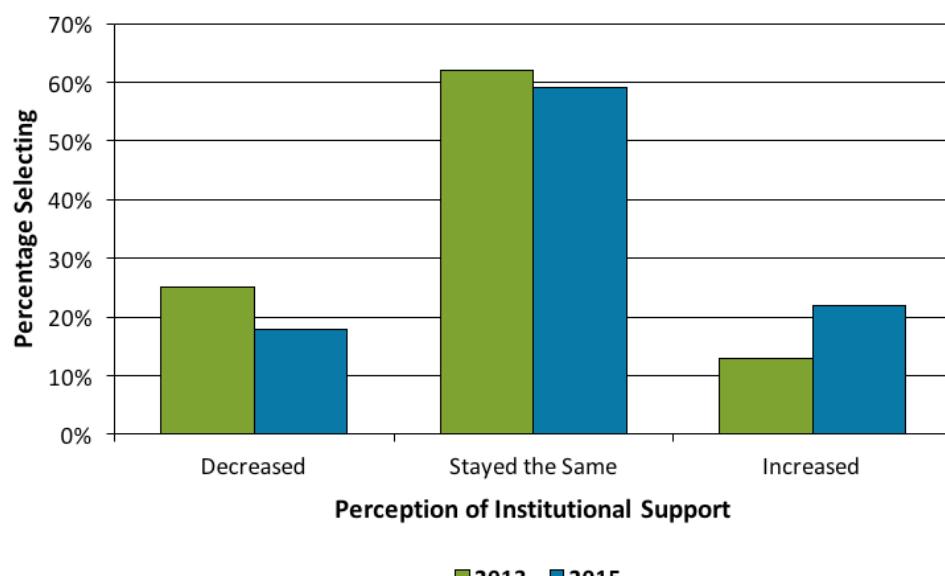
The 2015 Harrison Survey indicated a median of the total fixed operating budgets of Can\$870,380 for Canadian schools and \$522,000 for U.S. institutions. An important figure to consider within this total is the degree of institutional support (e.g., from the dean's office, hospital, or other central budgets). The median for this amount was Can\$350,000 for Canadian respondents and just over \$160,000 for U.S. respondents, with significant variation. Canadian institutions appear to have received a greater proportion of their income from the institution itself. See Table 3 for details.

#### **Comparison of budget and financial support, 2013 to 2015**

Overall, no significant differences were noted between reporting years for U.S. institutions. Comparing the two years for Canadian CME/CPD units, however, demonstrated a decrease in the total median budget for Canadian respondents, from Can\$1.2 million in 2013 to Can\$870,380 in 2015; the increased number of units responding may explain the change. Additionally, the median institutional support amounts decreased slightly from Can\$357,500 in 2013 to Can\$350,000 in 2015. For both Canadian and U.S. respondents, there was a 63% overlap (8 Canadian respondents and 59 U.S. respondents) of those who provided budget information for 2013 and again in 2015.

To validate the reported data, respondents were asked a more general question related to their perceptions of the increase or decrease of institutional support. When answering a request to describe what they viewed as a change in institutional support, 60% of respondents in 2015 indicated that year-to-year support remained the same, a percentage equal to that of 2013. A smaller yet significant percentage of respondents (22%) noted an increase in support in 2015, compared with 13% in 2013. Eighteen percent noted a decrease in support in 2015, less than the 25% of respondents reporting a decrease in 2013. See Figure 11.

**Figure 11. Percentage of institutional support compared over the past two years, as perceived by respondents (2013 = 110 respondents; 2015 = 116 respondents).**

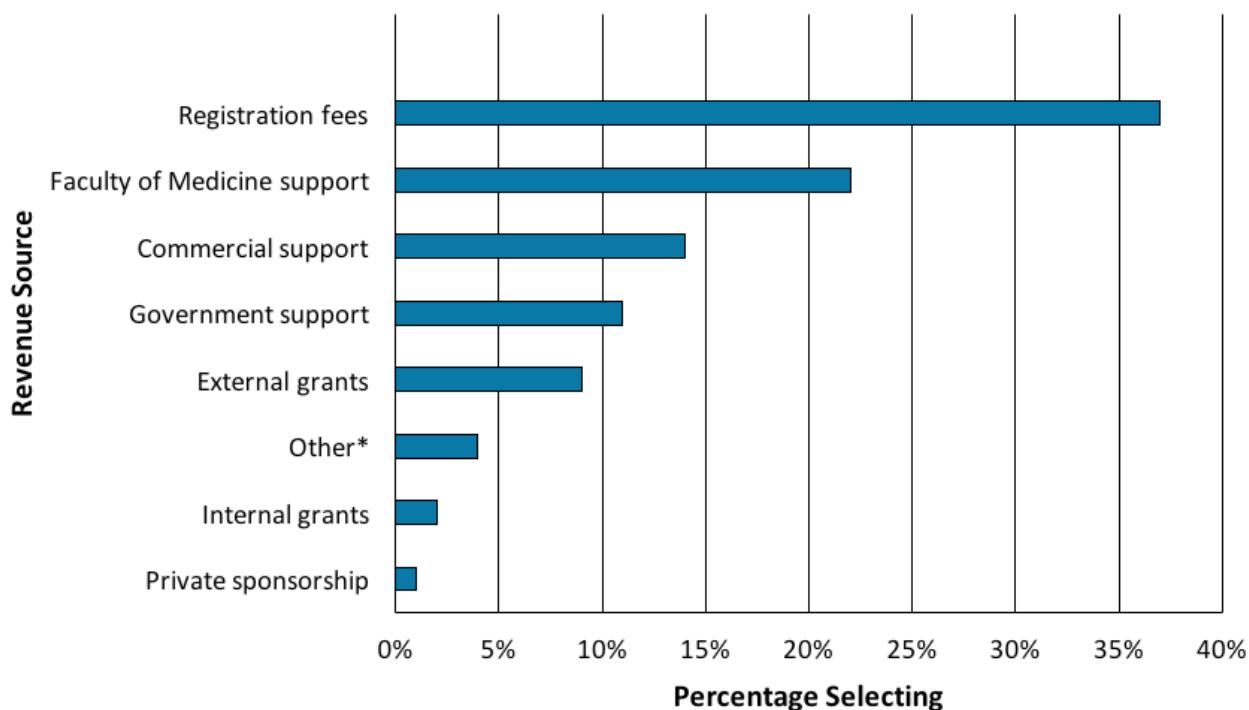


### ***Canadian Budgetary Data***

In 2012, the decision was made by the writing group to eliminate certain budget-specific questions collected by the ACCME. This process thus neglected the data provided by Canadian CME/CPD units—a situation corrected in the 2015 iteration of the survey.

Figure 12 outlines the percentage of revenue by source for those Canadian schools reporting. Registration fees and institutional, commercial, and government support accounted for the majority of funding sources. See Figure 12.

**Figure 12. Percentage of revenue to Canadian medical schools CME/CPD unit budget, by source (15 respondents).**



\* = other sources of funding that were noted and include items such as certification fees, administration fees, accreditation fees, and expense/cost recovery for departmental program planning.

## Section 3: Function of Academic CME/CPD in the Health Care System

This section describes the function of the AMC and the CME/CPD unit within it. While the CME/CPD unit has many functions, health care transformation was the particular focus of this section of the survey. The components involved included the following:

- *Integration with the Mission of the AMC.* Relative to the role that CME/CPD might play in helping prepare the system for change, the survey asked three questions about the degree to which
  1. quality improvement data were available and accessible to the CME/CPD unit for planning purposes,
  2. needs assessments were based on objective data from the system itself, and
  3. planning and executing CME/CPD activities engaged patients as partners.
- *Departmental or Intra-Institutional Relationships.* These relationships highlight areas in which CME/CPD can play a meaningful, collaborative role, including the degree to which the CME/CPD unit integrates functions with (post)graduate medical education.
- *Faculty Development.* Respondents indicated the degree to which academic CME/CPD units play a role in the training and professional development of faculty and staff and their areas of impact.
- *Use of Effective CME/CPD Methods.* This component of the survey reports the ability of the unit to deploy methods demonstrated to have an effect on health care professionals and thus system performance.

### INTEGRATION WITH THE MISSION OF THE AMC

Two areas exemplify the progress of CME/CPD unit integration with the mission of the AMC.

First, questions were asked in 2015 about the access to and the use of quality improvement and patient safety (QI/PS) data in planning CME/CPD activity. Second, the survey queried the degree to which needs assessments had moved from an entirely subjective determination to one that used objective information such as systems data. These questions were identical to those asked in 2013.



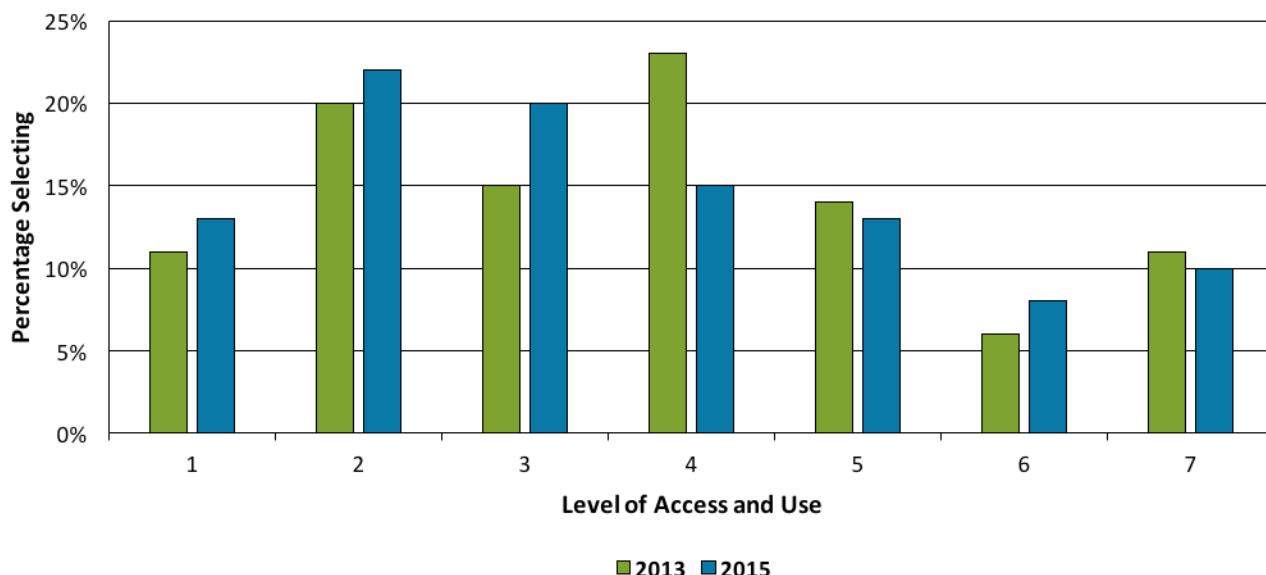
**In the journey toward full integration with the AAMC's mission, there appears to be a somewhat downward trajectory. Less than half of academic CME/CPD units had access to and employed QI/PS metrics to drive CME/CPD programming and interventions. However, nearly three-fourths reported use of more general objective needs assessment data in planning.**

### ***Access To and Use of Quality Metrics***

Respondents were asked a specific question about access to and use of quality metrics in planning, with available answers along a continuum of no or low access to a situation in which such data were readily available and used by the CME/CPD unit. The scale is detailed in Figure 13.

In 2015, less than half of the academic CME/CPD units (46%) had access to and employed QI/PS data to drive CME/CPD programming and interventions, with a majority (54%) selecting lower levels. In 2013, the reverse was apparent: 55% reported a higher level of access and 45% a lower level. See Figure 13.

**Figure 13. Quality metrics access and use (2013 = 132 respondents; 2015 = 143 respondents).**



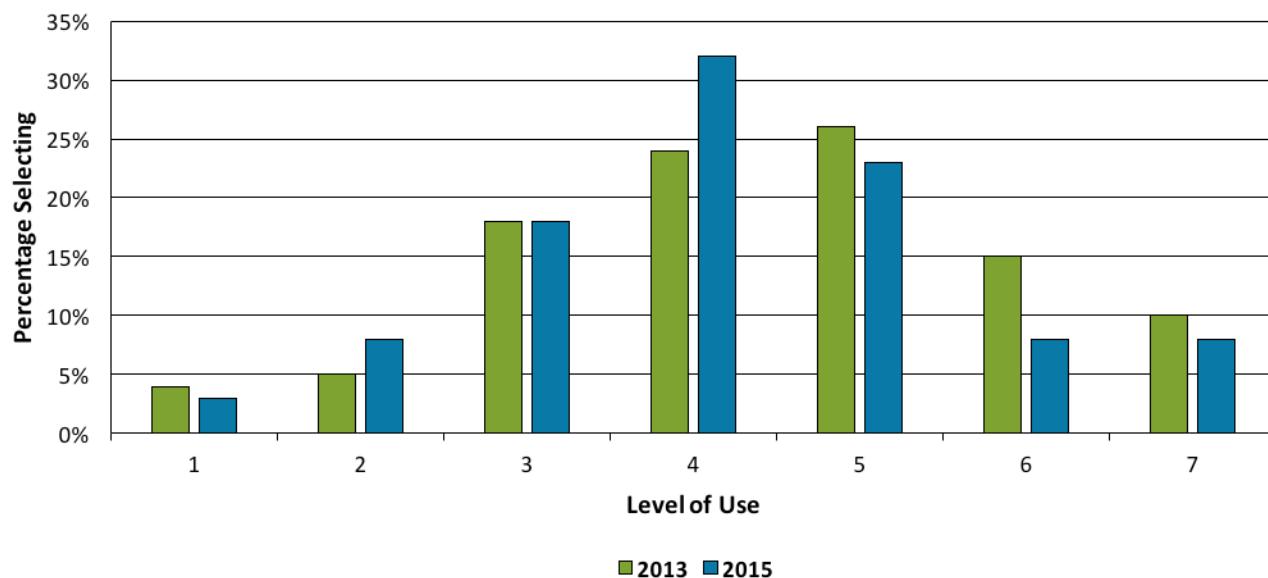
1 = Low. CME/CPD unit has no access to data acquired by the health system.

7 = High. Quality improvement and patient safety data are readily available and used by the CME/CPD unit.

### ***Use of Other Objective Data in Planning CME/CPD***

Respondents were also asked about the use of more general objective data in planning (quality and performance reports, for example), in addition to subjective needs expressed by participants or faculty. Responses were recorded on a similar seven-point scale, detailed in Figure 14. Here, 72% indicated moderate to high usage of such data for needs assessment, while fewer respondents (28%) indicated little or no objective data use. This was essentially unchanged since the 2013 report. See Figure 14.

**Figure 14. Use of objective data for needs assessment (2013 = 131 respondents; 2015 = 145 respondents).**



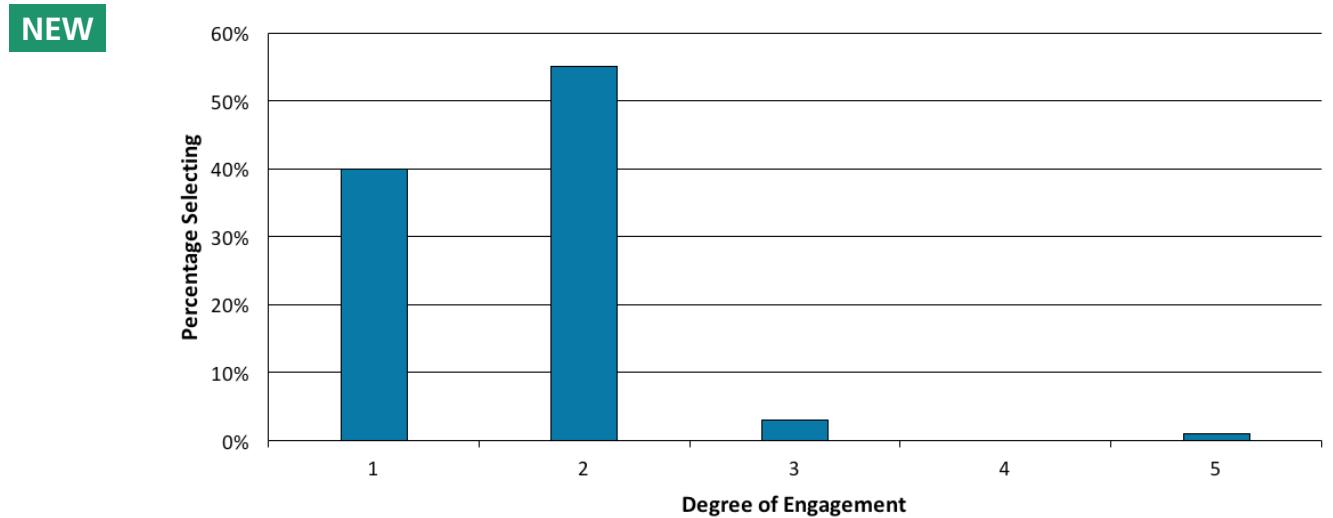
1 = Low. Score based entirely on subjective needs of participants or faculty.

7 = High. Score based entirely on objective metrics (e.g., quality data, performance, and other measures).

### ***Patients as Planning Partners***

To help understand the degree to which CME/CPD units engage patients as planners and partners in executing CME/CPD activities, a new question addressing this point was introduced in 2015. This question used a five-point scale, outlined in Figure 15, ranging from no involvement of patients to high—a situation in which patients have a seat on the CME/CPD committee and are included in most or all CME/CPD planning and activities. Only a small percentage (4%) included patients in CME/CPD planning and activities regularly, often, or always; the vast majority (96%) indicated absent or minimal patient participation. See Figure 15.

**Figure 15. Degree to which the CME/CPD unit engages patients as partners in planning and executing CME/CPD activities (141 respondents).**



1 = Absent/None/Low. Patients are never included in CME/CPD planning or activities.

2 = Occasionally patients are included in CME/CPD planning and activities.

3 = Regularly patients are included in CME/CPD planning and activities.

4 = In most or all CME/CPD planning and activities, patients are included.

5 = Present/Active/High. Patients have a seat on the CME committee and are included in most or all CME/CPD planning and activities.

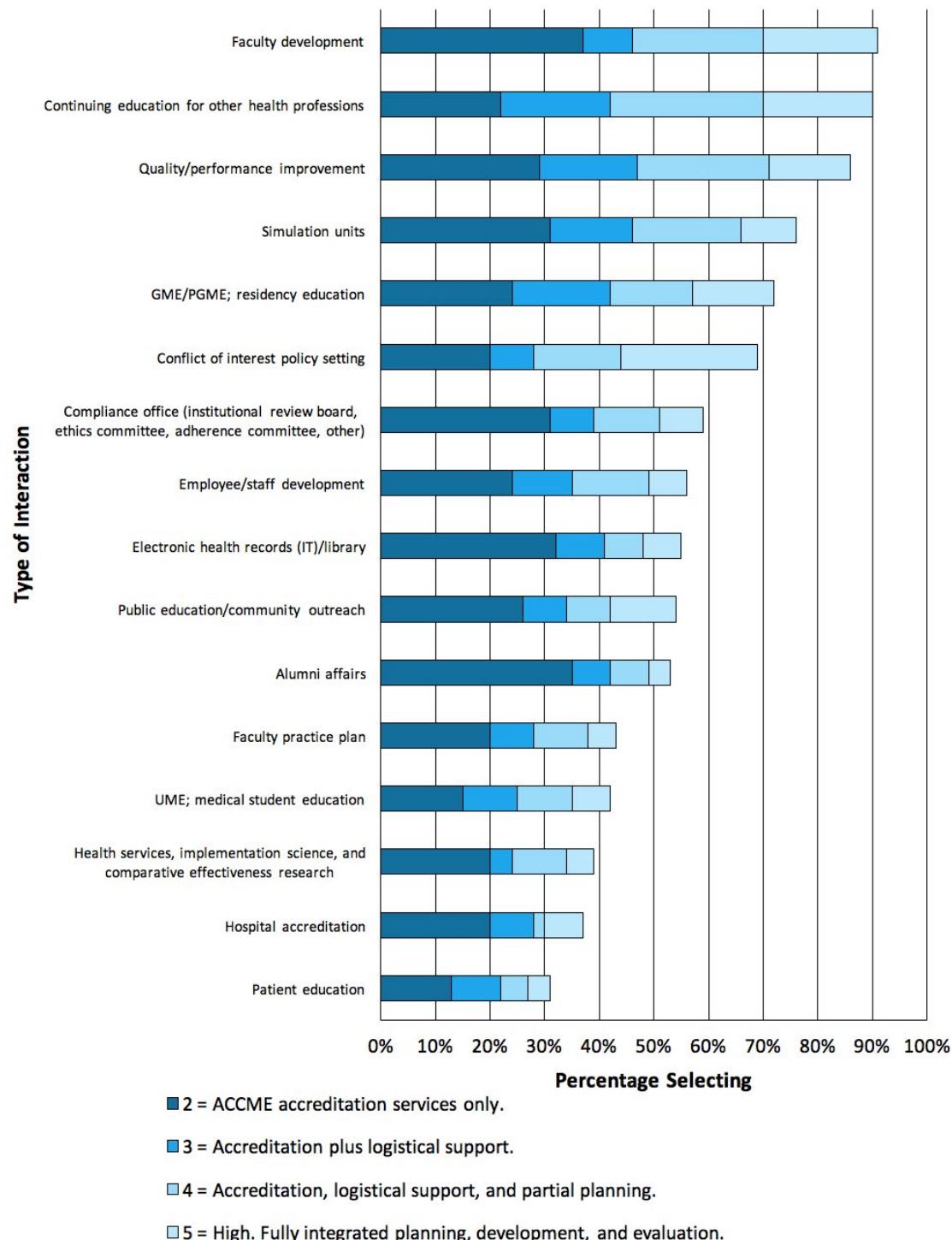


## DEPARTMENTAL AND INTRA-INSTITUTIONAL RELATIONSHIPS

To explore the question of relationships with other departments or divisions, the 2015 Harrison Survey asked about the degree of interaction with selected programs using a five-point scale. The scale ranged from no involvement, to the provision of accreditation services only, to accreditation plus logistical assistance, to all previous elements plus partial planning, to a high degree of involvement (i.e., all previous elements plus full assistance in planning, development, and evaluation of programs). See Figure 16.

As in past years, respondents indicated sizable interaction (90%) with continuing education programs for other health professionals and faculty development activities. Also included in the higher ranked areas were quality and performance improvement programs (87%), simulation units (76%), and relationships with GME/PGME/residency education (72%). Less degrees of involvement were noted with conflict of interest initiatives, compliance offices, and a host of other programs detailed in Figure 16. The figure also illustrates the degree and type of interaction. Particularly low levels of interaction were noted with undergraduate medical education (UME), patient or public education, faculty program plans, hospital accreditation, implementation, and similar research enterprises. See Figure 16.

Figure 16. Functional intra-institutional relationships with the CME/CPD unit and the AMC (131 to 136 respondents).

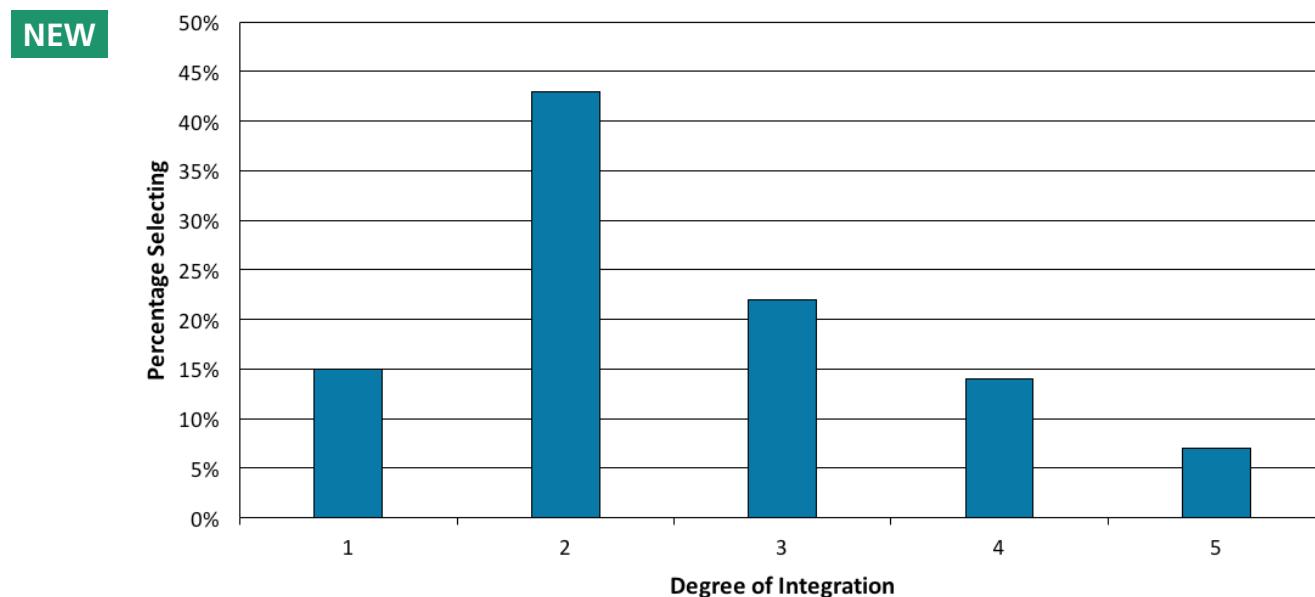


**Roughly 90% of academic CME/CPD units indicated a relatively high degree of interaction with residency education, faculty development, and allied health professional programs. There are strong showings of over 85% interaction with quality and performance improvement and over 50% with public education and community outreach, which is a significant increase from 2013.**

Most units reported relatively similar areas and levels of involvement between 2013 and 2015. Notable exceptions include employee and staff development (65% in 2013, 56% in 2015), electronic health records and other IT uses (60% in 2013, 55% in 2015), and public education and community outreach (41% in 2013, 54% in 2015).

In 2015, a new question addressed the increased national interest in (post) graduate medical education in both the United States and Canada, by asking about the degree of organizational integration of the CME/CPD unit with that of (P)GME. Respondents were asked to indicate the degree of integration, again using a five-point scale ranging from no relationship to the case in which the two operations function as one unit. Forty-two percent of units integrated the functions of CME/CPD with (P)GME regularly, often, or always; 58% indicated integration as absent, low, or only occasional. See Figure 17.

**Figure 17. Degree to which the CME/CPD unit is organizationally integrated and functions with (post)graduate medical education (138 respondents).**



1 = Absent/None/Low. The CME/CPD unit has no relationship to the (P)GME program.

2 = Occasionally the CME/CPD unit helps (P)GME by collaborating on programs, accrediting faculty development activities in (P)GME, etc.

3 = Often the CME/CPD unit helps (P)GME by collaborating on programs, accrediting faculty development activities in (P)GME, etc.

4 = On most occasions or in most program areas the CME/CPD unit helps (P)GME by collaborating on programs, accrediting faculty development activities in (P)GME, etc.

5 = Present/Active/High. The CME/CPD and (P)GME operations function essentially as one unit.

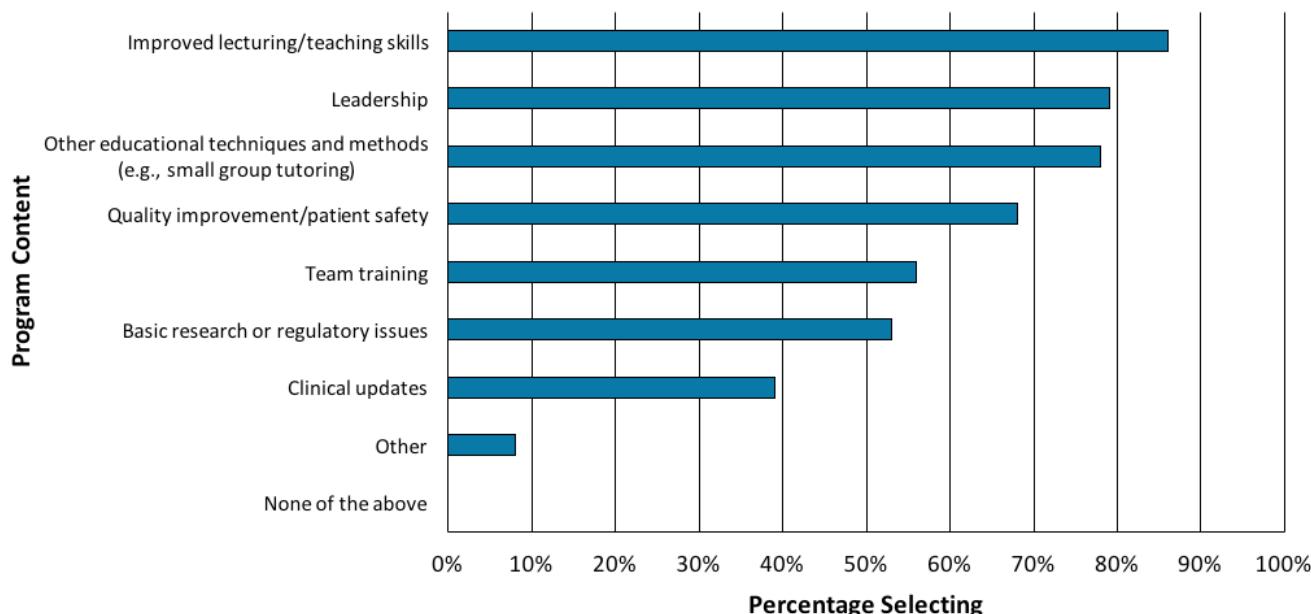


## FACULTY DEVELOPMENT AND CME/CPD

To explore the question of the extent and nature of CME/CPD unit interaction with and support of faculty development at the programmatic level, the Harrison Survey asked several questions related to the presence of interaction, the content of programming, and the beneficiaries or targets of faculty-oriented activities.

Over 90% of respondents indicated attention to aspects of faculty development. Detailed in Figure 18, these include improvement in lecturing/teaching skills (86%) and leadership skill development (79%). Less involvement was noted in the development of other educational methods (e.g., small group tutoring), team training, and regulatory issues, among others. See Figure 18.

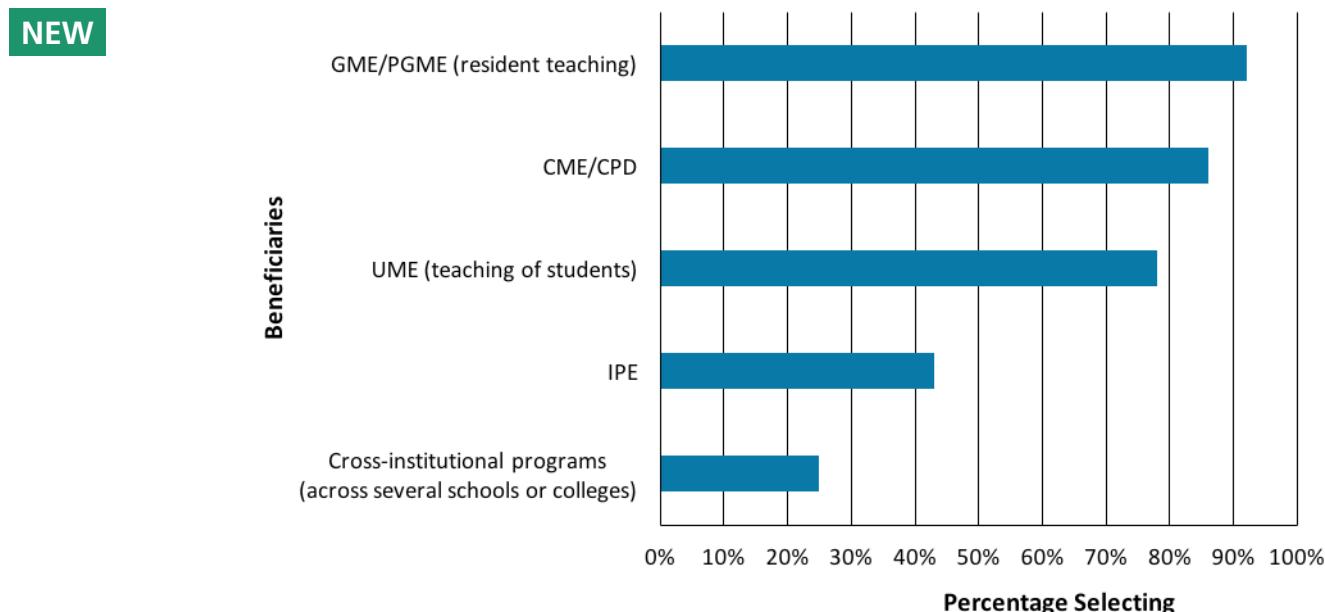
**Figure 18. Content areas addressed by faculty development CME/CPD activities (113 respondents).**



**Faculty development and CME/CPD interactions reported by almost all respondents covered a wide variety of content areas and have benefited UME, (P)GME, clinical, leadership, and research programs.**

In 2015, over two-thirds of respondents indicated that the CME/CPD program was involved in faculty development activities to improve faculty teaching. A question was developed for the 2015 survey asking respondents to identify the beneficiaries of such activity. Ninety-two percent of respondents indicated an impact on resident teaching, 86% on CME/CPD activity itself, 78% on the teaching of medical students, 43% on interprofessional education (IPE), and 25% on cross-institutional programs. See Figure 19.

Figure 19. Programs benefiting from faculty development CME/CPD activities (113 respondents).



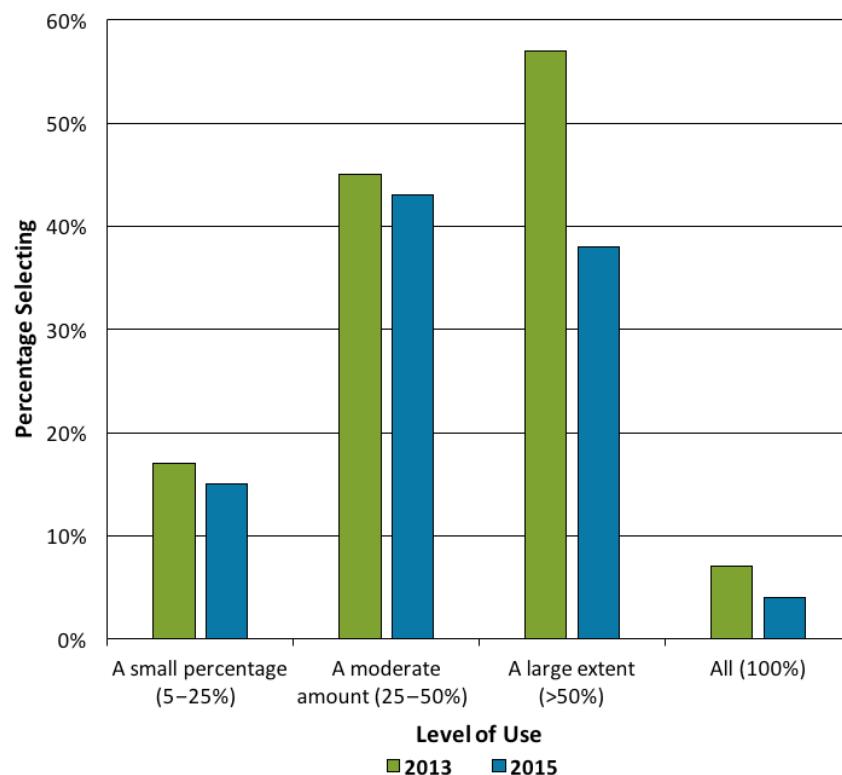
**One example of effective educational methodology—interactivity—is widely and increasingly used across most CME/CPD units and programs.**

### EFFECTIVE CME/CPD METHODS

The increase in the use of interactivity as an effective CME/CPD tool has been described extensively in the literature and past Harrison Surveys. This is defined as the use of methods and techniques such as case discussion, hands-on workshops, simulations, and other methods for 25% or more of a program (i.e., for each activity, at least one-quarter of that activity utilized an interactive method). Respondents were asked to what extent these methods were incorporated across all programs produced by the unit: a small percentage (less than one-quarter), a moderate amount (one-quarter to one-half), a large extent (more than one-half), or all programs. Responses were reported across a wide range. See Figure 20.

While the data comparing 2013 and 2015 are not directly comparable, the data are noted in Figure 20.

**Figure 20. Percentage of total CME/CPD offerings using interactive methods (2013 = 126 respondents; 2015 = 138 respondents).**



## Section 4: Reach, Scope, and Impact of CME/CPD Programming

This section focuses on the health professional and geographic reach of CME/CPD programming within and beyond the institution, as well as the programming's methods and measures of impact. It captures elements of three areas.

- *Location and types of health professionals* targeted by CME/CPD activities
- *Assessment and evaluation efforts* that CME/CPD units take to assess the impact of their programming endeavors
- *Scholarship* regarding the degree to which the CME/CPD units and their institutions are engaged in grant capture, research and scholarship, and impact assessment

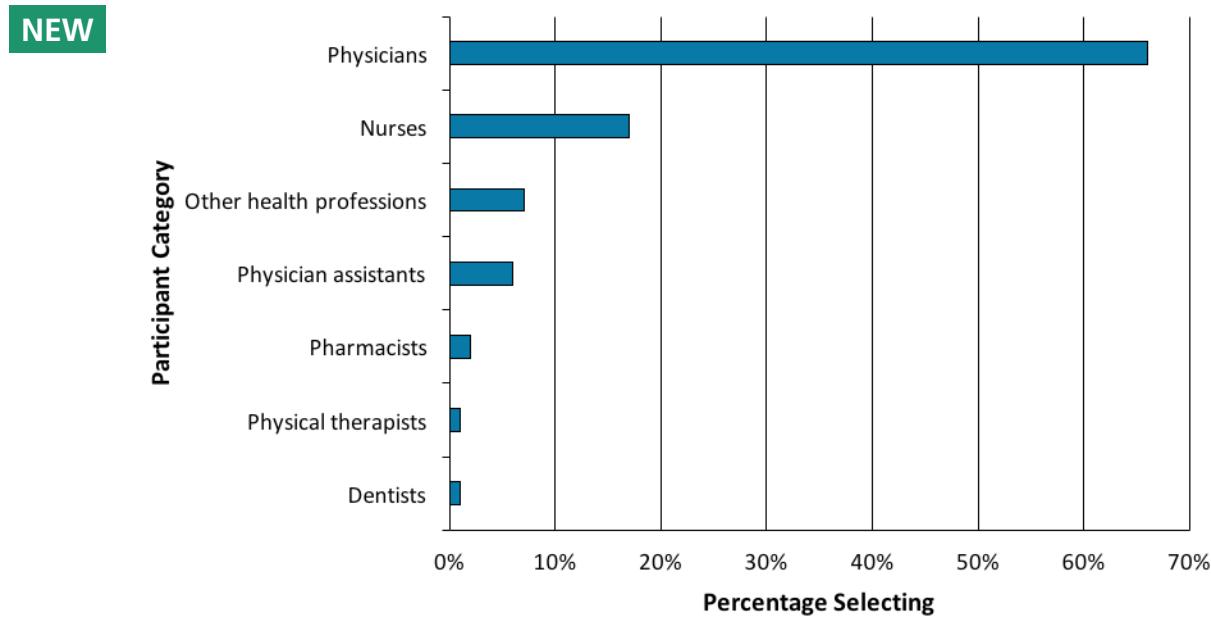


### PARTICIPATION BY HEALTH PROFESSIONALS IN CONTINUING EDUCATION

#### *Types of Health Professionals Participating in CME/CPD*

In 2015, a question was introduced asking respondents to identify the percentage of continuing education program audience by participant category. Physicians accounted for two-thirds of the program audience (66%), the highest percentage. The remaining audience members included nurses (17%), other health professions (7%), physician assistants (6%), pharmacists (2%), and physical therapists and dentists (1% each). The “other” option generated a long list of professional categories. See Figure 21.

**Figure 21. Percentage of continuing education program audience, by participant category (142 respondents).**



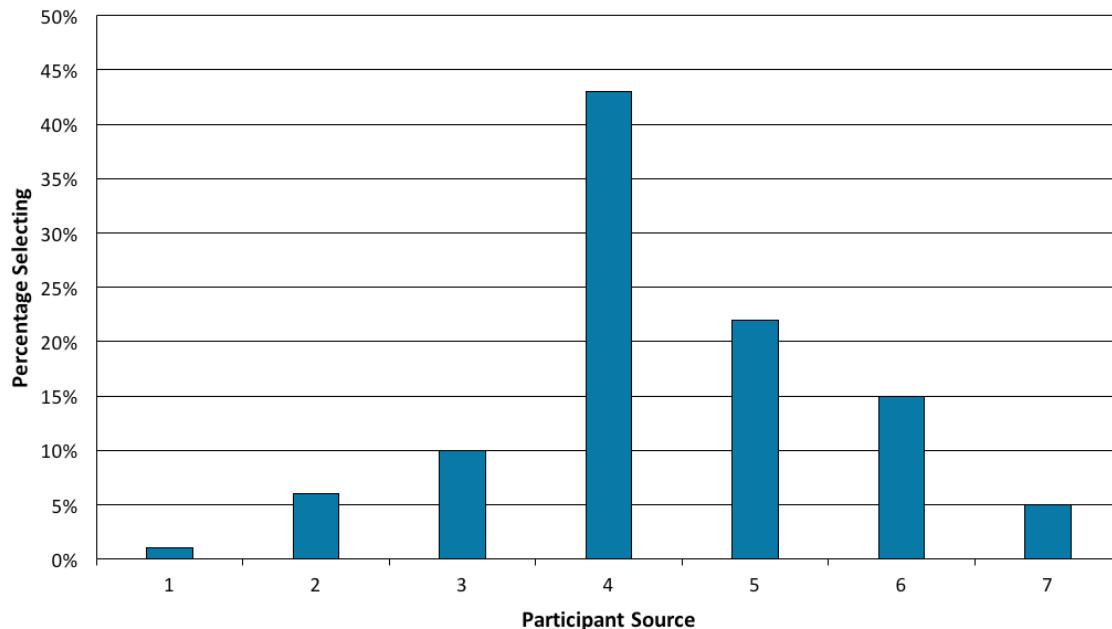
**Academic CME/CPD units engage a wide variety of health professionals in their programming and reach a professional population that consists of a slightly higher number of internal (faculty and staff) versus external (regional or national) participants.**

### ***Internal Versus External: Source of CME/CPD Participants***

Two questions asked about the CME/CPD programming participants at the unit's institution. The first related to the source, whether participants represented an internal audience (i.e., AMC staff and full-time faculty), an external audience (i.e., community based, outside the institution), or a combination of both.

Respondents were asked to use a seven-point scale ranging from an external-only audience to an entirely internal one (faculty and staff located in the CME/CPD unit's organization). A bell curve distribution was noted, with a heavier emphasis on an internal audience. One unit indicated that participants were derived entirely from an external population; six units reported that their participants were entirely internal. This shift to a more internal audience represents a trend first identified in 2013 and repeated here. See Figure 22.

**Figure 22. Source of participants in CME/CPD programming (136 respondents).**



1 = External. All participants are employed outside the health care system.

7 = Internal. All participants are employees of the health care system.

### **INTERNAL VERSUS EXTERNAL PROGRAMMING**

Reflecting the dichotomous nature of their participant sources, CME/CPD units were asked about program methods that targeted an internal population of health professionals versus those used for an external audience. CME/CPD units reported a wide variety of activities targeting both types of participants.

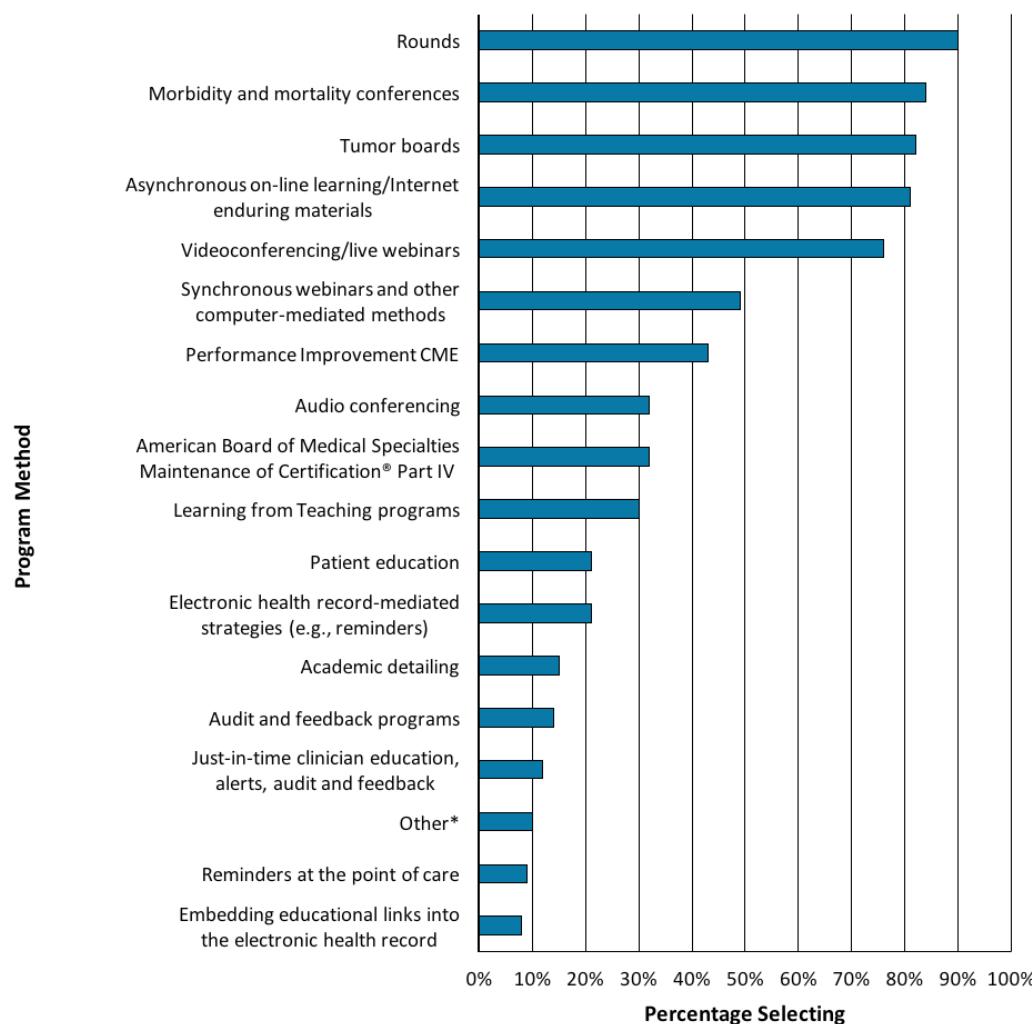


**Programming for internal participants employed educational methods that ranged from the historically traditional (rounds and M&M conferences, for example) to webinars, asynchronous learning, academic detailing, and EHR-linked learning. New data reported for 2015 includes measures of programming for PI-CME and ABMS MOC® Part IV.**

### *Internal Programming*

Answering the question about programming for an internal audience, 90% of respondents reported that conducting rounds (regularly scheduled meetings of staff and faculty in clinical departments or divisions) was the method most frequently used; the same percentage was reported in 2013. This was followed closely by morbidity and mortality conferences (M&Ms) reported by 84% and tumor boards (82%), comparable to the data from 2013. In contrast, asynchronous online learning increased significantly from 50% in 2013 to 81% in 2015. Videoconferencing and live webinars occupied the fifth most common position at 76%, similar to 2013. Less, but still appreciable, involvement was noted in synchronous webinars (49%, a marginal increase from 47% in 2013). New to the 2015 survey, PI-CME was reported at 43% and the American Board of Medical Specialties Maintenance of Certification® Part IV (ABMS MOC® Part IV) was reported at 32%. Fewer respondents reported using other methods. See Figure 23.

Figure 23. Methods included in CME/CPD programming for participants internal to the academic institution (136 respondents).



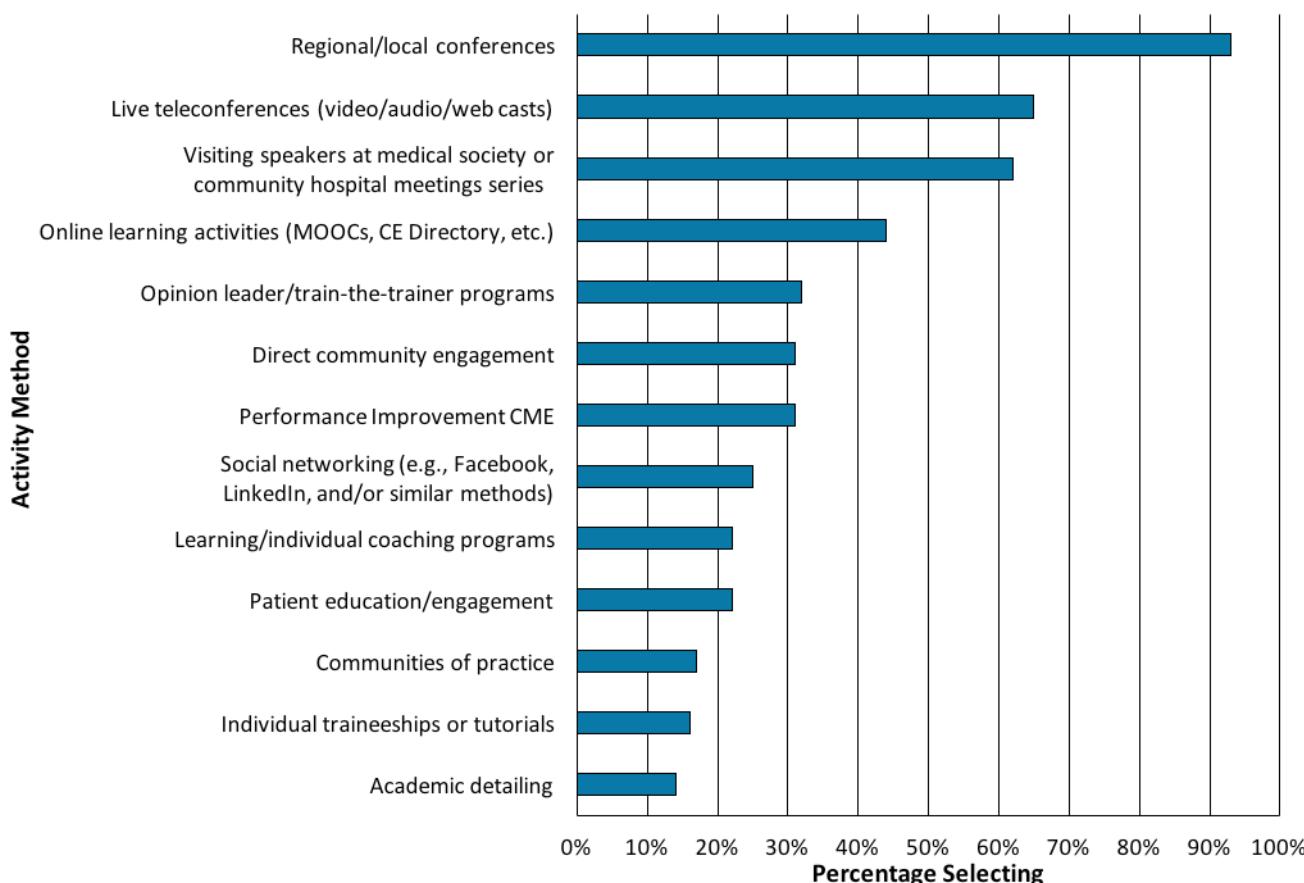
\*=other methods that included such activities as live programs, manuscript review CME, journal club and literature review, and hands-on cadaver labs.

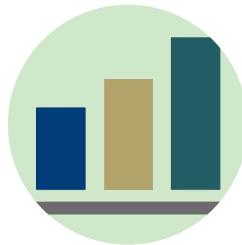
**Academic CME/CPD units demonstrated a strong commitment to external programming, using regional/local conferences, visiting speaker programs, and teleconferences, in large part, but also incorporating online learning activities, opinion leaders, train-the-trainer methods, and direct community engagement methods. Modest decreases in some methods were noted when comparing 2015 with 2013.**

### ***External Programming***

Respondents were also asked which outreach activities were planned and implemented to serve participants or learners outside the institution. This generated responses ranging from traditional activities, such as visiting speaker programs, to more current, nontraditional methods and activities, including coaching programs, communities of practice, and academic detailing. Regional or local conferences were most reported, by 93%, followed by live teleconferences (65%) and visiting speaker programs (62%). Online learning activities—including massive open online courses (MOOCs) and the CE Directory of the AAMC’s MedEdPORTAL®—garnered 44%. Fewer respondents reported other programs, such as opinion leader and train-the-trainer programs. See Figure 24. Notable differences with the 2013 survey include modest decreases in such programs as academic detailing, traineeships, train-the-trainer programs, visiting speakers, and live teleconferences and increases in online activities.

**Figure 24. Outreach activities planned for an audience of participants external to the academic institution (134 respondents).**



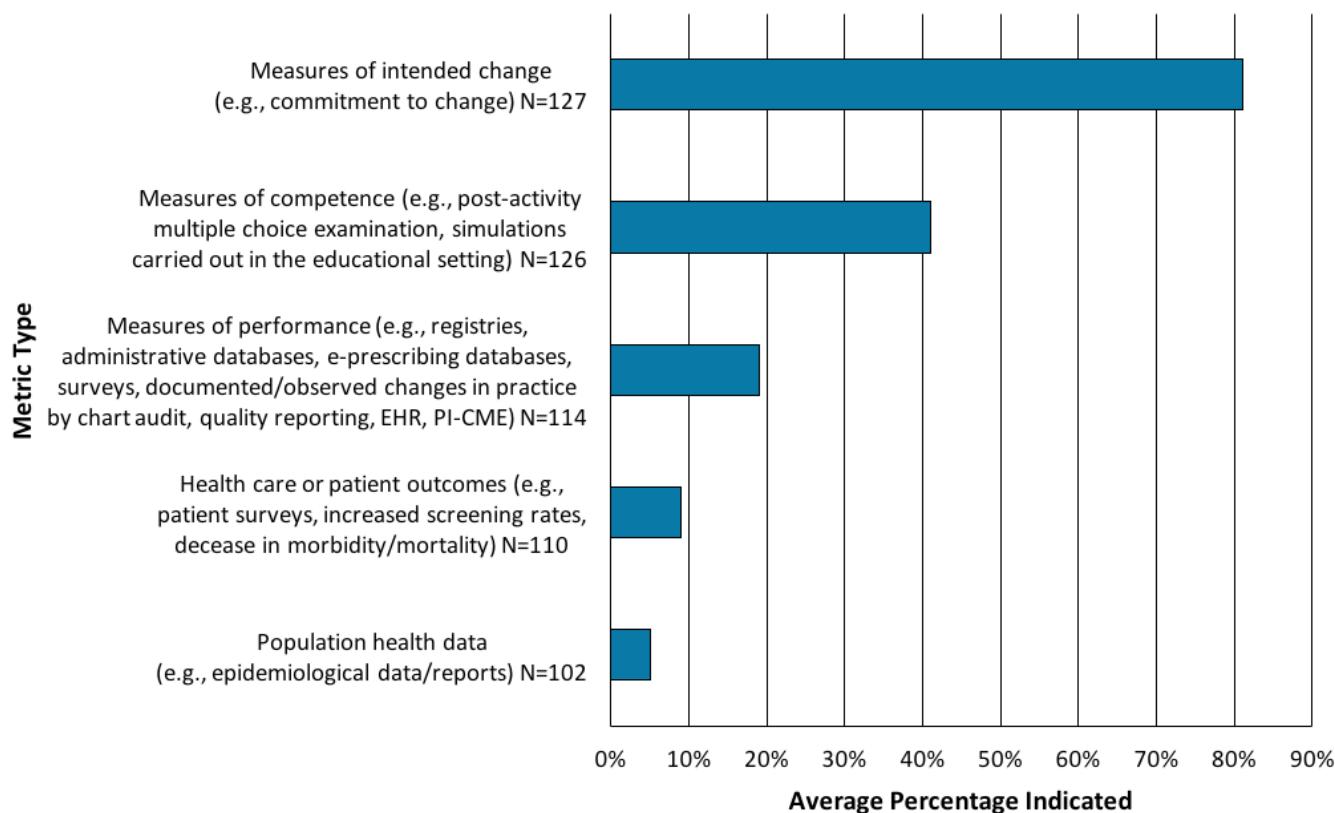


## OUTCOME MEASUREMENTS

A hallmark of an effective, integrated academic CME/CPD is the ability to track outcomes. In contrast to the more traditional view of CME/CPD as monitoring only learner perceptions (the so-called happiness index), academic CME/CPD units were asked to document the extent to which they employed metrics to track more advanced outcomes, such as competency-outcome or performance-outcome measurements. These included intention-to-change measures (commitment-to-change), competence measures (e.g., multiple choice exams, simulations), performance metrics (e.g., quality improvement, registry, or similar data), patient outcomes data as measured by patient surveys or health outcomes data, and population health information as tracked by epidemiologic data.

Not surprisingly, CME/CPD respondents reported they undertook those elements in closer proximity to the CME/CPD activity, such as documenting commitments to change more frequently, and undertook tracking health care or population health data less often. Nonetheless, respondents reported activity at all levels. A large majority (81%) reported that their programs used commitment-to-change measurements. In contrast, fewer units reported that all their activities used competency measures (41%), performance data (19%), patient outcomes data (9%), or population health data (5%). While all percentages decreased slightly from the 2013 data, the response order remained the same. See Figure 25.

**Figure 25. Outcome measures employed by academic CME/CPD units (102 to 127 respondents).**





## RESEARCH AND DEVELOPMENT: SCHOLARSHIP IN ACADEMIC CME/CPD

### *Research Activity*

Respondents were asked to what extent they engaged in research activities studying the processes or outcomes of CME/CPD. They were also asked to document the total of all new CME/CPD-related research studies by their institutions, including those that were sponsored and carried out by the CME/CPD unit. This represents a new item for the 2015 survey.

**The report reveals a concentration of research interests in a smaller number of institutions committed to scholarship in 2015, contributing to the research enterprise in health professional learning and practice. These AMCs have conducted a larger number of research studies compared with 2013, reflecting what appears to be collaboration both within and across institutions that is frequently supported by internal funding sources.**

In 2015, 45 units responded to the survey question of total grant support for all studies and 36 units reported CME/CPD-related research studies, with 23 numbering greater than zero (i.e., requiring financial support). Because U.S. and Canadian dollars are different, these figures are presented separately. Also, new in 2015, 20 units chose "I don't know" as their response to this inquiry.

In the United States, 27 units reported CME/CPD-related research activity in 2015 compared with 32 units in 2013. While the mean of reported studies increased (5.9 in 2015, 2.6 in 2013), the median was one study in 2015, half the number reported in 2013.

In Canada, nine units reported CME/CPD-related research activity in 2015 compared with seven units in 2013. For all of these reported studies in 2015, the mean, maximum, and median all increased slightly.

In the United States, the number of those reporting these activities as grant-supported decreased by 25%, from 22 in 2013 to 17 in 2015. The dollar amount of that grant support also decreased significantly, from a median grant support of \$225,000 in 2013 to a median income of \$61,000 for 2015. In Canada, the number of those reporting these activities as grant-supported decreased slightly, from seven in 2013 to six in 2015. However, the dollar amount of that grant support increased, from a median grant support of Can\$130,000 in 2013 to a median of Can\$150,000 for 2015.

Those studies in which the CME/CPD unit was involved garnered a large majority of the available financial or grant support (6 out of 6 for Canadian studies and 16 out of 17 for U.S. studies). The mean, maximum, and minimum numbers of studies and financial support are captured in Table 4.

Table 4. Research and Development Activities Reported by CME/CPD Unit

Total New CME/CPD-Related Research Studies by Institution (Including CME/CPD Unit-Sponsored Research Studies)					CME/CPD Unit-Sponsored Research Studies	
	Canadian 2013 N=7	Canadian 2015 N=9	U.S. 2013 N=32	U.S. 2015 N=27	Canadian 2015 N=9	U.S. 2015 N=26
<b>Maximum reported number of studies*</b>	15	20	10	100	19	10
<b>Minimum reported number of studies*</b>	1	2	1	1	2	1
<b>Mean reported number of studies*</b>	4	6.3	2.6	5.9	6.2	2.3
<b>Median reported number of studies*</b>	2	4	2	1	4	1
<b>Total Grant Support of All Studies (New Grants Plus All Other Ongoing Grants and Studies)</b>					<b>CME/CPD Unit Research Studies</b>	
	Canadian 2013 N=7	Canadian 2015 N=11	U.S. 2013 N=44	U.S. 2015 N=34	Canadian 2015 N=45	U.S. 2015 N=34
<b>Number reporting no grant support</b>	0	5	22	17	2	18
<b>Number reporting support &gt;\$0**</b>	7	6	22	17	6	16
<b>Maximum reported grant dollars for those with support &gt;\$0</b>	\$400,000	\$400,000	\$15,000,000	\$4,045,412	\$400,000	\$3,670,593
<b>Minimum reported grant dollars for those with support &gt;\$0</b>	\$1	\$10,000	\$10,000	\$2,000	\$10,000	\$10,000
<b>Mean reported grant dollars for those with support &gt;\$0</b>	\$142,429	\$198,000	\$1,002,587	\$507,285	\$185,500	\$502,603
<b>Median reported grant dollars for those with support &gt;\$0</b>	\$130,000	\$150,000	\$225,000	\$61,000	\$150,000	\$55,500

Note: \* = per institution; \*\* = those requiring some financial support.

To understand the funding for (1) all CME/CPD-related research studies conducted by the institution and (2) studies conducted by the CME/CPD unit, a question was added to the 2015 survey asking respondents to identify internal versus external sources. Funding sources were similar in both cases. See Table 5.

**Table 5. Mean Reported Percentage of Funding Sources of All CME/CPD-Related Research Studies and CME/CPD-Related Research Studies Involving the CME/CPD Unit**

NEW	Funding, by Research Activity	Internally Funded by Own Unit or Institution	Externally Funded by Commercial Interests	Externally Funded by Peer-Reviewed Granting Sources	Supported by Other Funding Sources
<b>Funding sources of all CME/CPD-related research studies (22 respondents)</b>	15%	29%	33%	23%	
<b>Funding sources of CME/CPD-related research studies involving the CME/CPD unit (23 respondents)</b>	9%	31%	32%	29%	

#### *Collaboration Within and Across CME/CPD Units*

Those units reporting research activity were asked to what extent these studies were intra-institutional (collaborative within the institution) or multi-institutional. The response number indicates that, while CME/CPD units themselves may not take part in research, other departments or faculty members—and even other institutions—may be so engaged. In 2015, of the 54 units responding, 83% reported undertaking cross-institutional studies, while half (50%) reported multi-institutional studies. Table 6 also includes 2013 comparative data.

**Table 6. CME/CPD Engagement in Intra- and Multi-Institutional Research**

Type of Research Engagement	2013 N=65			2015 N=54		
	Yes	No	Total	Yes	No	Total
<b>Intra-institutional (i.e., collaborative within own institution)</b>	54	11	65	45	9	54
	83%	17%	100%	83%	17%	100%
<b>Multi-institutional (i.e., collaborative with other institutions)</b>	35	29	64	25	25	50
	55%	45%	100%	50%	50%	100%

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## Section 5: Discussion— Structure, Function, Impact, and Direction of Academic CME

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, or at least aligned with, the functions and mission of the academic medical centers and medical schools of the United States and Canada. Second, it demonstrates numerous examples of innovation in educational design and operation. Third, it has begun to move beyond the measurement of participant numbers and satisfaction to assess its impact in competence, performance, and health care outcomes.

### INTEGRATION AND SUPPORT

AMCs and AHSs continue to integrate their services and structures and, along with them, their CME/CPD services and programs. In some cases, the role of the CME/CPD unit appears to mirror—and even be ahead of—that of the larger institution, and in most instances, robust relationships exist with many institutional programs. To some extent, this relationship building is reflected by the existence of highly representative, system-integrating CME/CPD advisory committees and the increasing institutional support at leadership and budgetary levels for CME/CPD. The relationships are particularly strong in three areas—faculty development, residency training, and allied health professional education—and have sizable but as yet unrealized potential in a fourth, quality improvement and patient safety.

The 2015 survey notes a decrease in access to and use of quality data for CME/CPD planning purposes when compared with 2013. The finding, contrary to expectations and current thinking regarding the creation of system-based, meaningful CME/CPD, may reflect several trends. First, respondents may be demonstrating an increased understanding of the nature, complexity, and granularity of meaningful, actionable quality data. Second, quality and safety leaders at some institutions may not understand that CME/CPD units need access to such data to prepare needs assessments and prioritize institutional educational offerings, as well as meet accreditation goals. Third, some CME/CPD unit personnel may not be aligned with AMC quality and safety leaders and committees, or they may be perceived as lacking the performance improvement skills, training, and education (e.g., LEAN, SIX Sigma, DAMAIC) necessary to interpret and apply such data properly. Fourth, institutional and system quality and safety data, generally housed in the hospital setting, play important roles in the era of the Affordable Care Act (ACA), when reporting can result in institutional and system financial penalties or rewards and when professional development assumes a less important role. 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.

Finally, significant missed opportunities remain for the academic CME/CPD unit and the AMC in building collaborations with faculty practice plans, UME, health services research, hospital accreditation, and the patient community itself.

## IMPROVING THE METHODS OF CME/CPD

Academic CME/CPD units display widespread use of many methods described here in two contexts: (1) those targeted to an external audience, including teleconferencing, webcasting, social media, outreach programs, and online, asynchronous activities, live streaming of and tweeting from meetings, online journal clubs and webcasting, and massive open online courses (MOOCs) and (2) those for an internal audience, such as M&M conferences, tumor boards, refresher programs, grand rounds, etc. Numerous examples of innovation exist across and within these methods—interactivity as a well-established means of effecting change is one of them documented as occurring more frequently in this survey. A new method represented in the 2015 data reflects the ABMS MOC® Part IV program and PI-CME. Both are based on anchoring CME/CPD activities in the context and needs identified by practice.

## TARGETING THE CME/CPD LEARNER

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 themselves are a mix of health professionals, as reflected in increased numbers of providers accredited by nursing, pharmacy, and other health professional bodies. In addition, CME/CPD programs are increasingly engaged in the organization, accreditation, and delivery of educational activities for faculty. These efforts span improved teaching and educational skills across the educational continuum, in addition to research and clinical skills. Faculty development programs—increasing in number and 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, leadership, and educational skills, with a strong emphasis on QI/PS.

## OUTCOMES OF CME/CPD: MEASUREMENT AND SCHOLARSHIP

Academic CME/CPD providers have moved beyond standard evaluation methods, many by including the use of commitment-to-change assessment methods. The survey notes smaller but important efforts dedicated to competence and performance measurements and even to patient and population health outcomes. Challenges may exist in the area of access to quality data but, once overcome, the linkage between access and assessment displays enormous potential for the integration and impact of CME/CPD in AMCs.

Finally, related to research and scholarship, the report reveals a concentration of research interests in a smaller number of institutions committed to scholarship that contributes to the research enterprise in—and the body of knowledge about—health professional learning and change. These AMCs have conducted many research studies compared with 2013, reflecting what appears to be collaboration both within and across AMCs, supported by funding sources internal and external to the institution. New data in the 2015 report illustrate that funding for all CME/CPD-focused research 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).

## SUMMARY

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 its *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 their 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.



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