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Academic CME/CPD in the United States and Canada

Results of the 2018 AAMC-SACME Harrison Survey

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Results of the 2018 AAMC-SACME Harrison Survey

Association of American Medical Colleges
Washington, D.C.

Contents

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Foreword

The results of the 2018 AAMC-SACME Harrison Survey show that CME/CPD unit leaders and staff have many opportunities to advance improvements in how they practice and respond to the many ongoing changes in health care.

Although CME/CPD units have historically focused on approving courses for credit, the survey data reflect structures and functions that are more integrated and robust than before. The CME/CPD units affiliated with our medical schools are in a unique position to advance the education of physicians and other health professionals. High priorities for these units, as reported in the survey, included not only clinical knowledge and skills, but quality improvement and interprofessional practice. Going forward, I encourage embracing these priorities as well as expanding efforts to work even more collaboratively across our academic institutions. We must all work across the education continuum and across professions to increase evidence-based approaches to continuous learning and development, especially as they relate to the delivery of high-quality, safe care that is informed by our patients and their family members.

I appreciate all those who worked on this report and those of you who took the time to respond to the survey. Your ongoing commitment to advancing health care through education is vital to the mission of our academic institutions. Patients, families, and communities benefit from your time and talent.

Alison J. Whelan, MD
AAMC Chief Medical Education Officer

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Acknowledgments

The Association of American Medical Colleges (AAMC) and the Society for Academic Continuing Medical Education (SACME) acknowledge the work of the members who served on the advisory committee:

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Acronyms

ABMS   American Board of Medical Specialties

ACCME   Accreditation Council for Continuing Medical Education

AMC   academic medical center, the teaching hospital-medical school complex

CA$ Canadian dollar

CACME   Council on Accreditation for Continuing Medical Education

CBME   competency-based medical education

CME/CPD   continuing medical education and continuing professional development

CME/CPD unit   continuing medical education and continuing professional development offices and programs, including variations in unit names, such as continuing professional education, lifelong learning and professional development, and continuing education and improvement

CQI   continuous quality improvement

FTE   full-time equivalent

GME   graduate medical education or residency education; in Canada, this is referred to as postgraduate medical education (PGME)

IPCE   interprofessional continuing education

MOC   Maintenance of Certification

QI   quality improvement

QI/PS   quality improvement and patient safety

Executive Summary

This eighth biennial survey about continuing medical education and continuing professional development (CME/CPD) at Liaison Committee for Medical Education (LCME)-accredited U.S. and Canadian medical schools is jointly sponsored by the Association of American Medical Colleges (AAMC) and the Society for Academic Continuing Medical Education (SACME). Both organizations have similar goals: to promote high-quality education across the continuum of physician development. This survey of CME/CPD units at LCME-accredited U.S. and Canadian medical schools generates several broad and important findings for discussion. The response rate (73%) of all 161 eligible schools signifies its importance to academic medical center (AMC) leaders.

Integration of CME/CPD Into the Broader Academic Medical Center

While approving educational activities for CME credit, meeting planning, and marketing remained the highest operations of CME/CPD units, nearly all (84%) units were also developing educational curricula and 39% were engaged in the institution's annual strategic planning.

Many respondents indicated that their office was located independently on the academic campus. The office of faculty development was the most commonly reported shared office. Medical school leaders with whom the CME/CPD unit leader met regularly were the senior associate dean for education or equivalent, clinical department chairs, and the medical school dean.

Many departments or offices interacted with the staff of the CME/CPD unit. Most people came from the following departments or offices: graduate medical education (GME), faculty development, continuing education in other health professions schools, simulation center, and quality improvement and patient safety (QI/PS). Individual meetings between the CME/CPD and GME leadership occurred regularly.

Educational Offerings

Respondents indicated that the teaching method used most frequently was lecture. Clinical case conferences and panel discussions were also frequently used. Methods used less frequently in CME/CPD activities included patient-led activities, flipped classrooms, debates, peer observations and feedback, and coaching or mentoring.

The six core competencies developed by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) are essential components of teaching and assessment across the continuum of medical education. According to respondents, the two competencies most frequently addressed within their offerings were medical knowledge and patient care. Fewer offerings incorporated the remaining four competencies: practice-based learning and improvement, professionalism, systems-based practice, and interpersonal and communication skills.

Assessment of the impacts of CME/CPD educational offerings principally involved knowledge gained (e.g., post-activity examination, simulation for skills development assessment, teamwork, situational awareness) and declaration of an intent-to-change by the learner. Impacts of CME/CPD offerings on patient outcomes were less frequently measured.

Budget and Personnel in CME/CPD Units

Most CME/CPD units had budgets that were separate from rather than combined with other offices in the institution. Budgets ranged widely. In the most recent completed budget year, the median reported annual operational expenditures per CME/CPD unit was $578,767 for the U.S. medical schools and CA$950,000 for the Canadian medical schools. Median financial support from the institution offset 30% of total expenses in U.S. CME/CPD units and 40% in Canada's.

A senior leader for CME/CPD was identified by nearly all respondents. The most common reported title was associate dean of CME, CPD, or CME/CPD. The dedicated time (full-time equivalent, or FTE) of this leader was wide, ranging from 0.05 to 1.0, with a median of 0.3. Thirty-nine percent of responding institutions had a senior leader with an FTE equal to or greater than 0.5 (interquartile range 0.2-0.6). The staff in most units consisted of program managers, event planners, accounting and financial support personnel, and administrative assistants. The number of staff ranged widely with a median response of 5.5 FTEs.

Current and Future Priorities of the CME/CPD Unit

Respondents reported that priorities of CME/CPD units included incorporating ACCME or Council on Accreditation for Continuing Medical Education (CACME) accreditation criteria, encouraging more interprofessional continuing education (IPCE), promoting the value of CME/CPD, and attending to faculty Maintenance of Certification (MOC).

Access to institutional-specific quality data is essential to better inform educational activities that enhance both clinician competencies and patient outcomes. These clinical quality data were reported as available at just over half (52%) of the CME/CPD units.

Faculty support was reportedly provided by 50% or more of CME/CPD units in the areas of program evaluation, Maintenance of Certification, instructional methodology, learner assessment methods, and curriculum design. Less than half of the 114 respondents reported supporting faculty in the areas of leadership development (49%), wellness (32%), and research skills (27%).

The majority of the 83 respondents reported being involved in scholarship by presenting findings at local or regional meetings (71%) and national or international conferences (76%). Less than half (40%) of CME/CPD staff reported having authored (sole or joint) a peer-reviewed publication. Most CME/CPD leaders reported having authored (alone or jointly) a journal publication or book chapter.

Discussion

This eighth Harrison Survey since 2008 was marked by a high response rate (73%). It is the 20th survey documenting characteristics of the CME/CPD community since 1982. Before 2008, the survey was conducted independently by SACME. Results document an academic enterprise displaying several characteristics in addition to its past image of a separate, transactional, credit-granting entity. First, the CME/CPD unit appears to be increasingly integrated into, or at least aligned with, the functions of its institution. Second, varied and evidence-based educational methods of instruction are increasing, although at a slow pace. Third, support for faculty's role as educators is provided by the majority of CME/CPD units.

As each CME/CPD unit moves toward being reorganized as an educational home for faculty of medical schools and other health professions schools, many opportunities will exist to innovate and assess impact, including improving the most important outcome: quality care for every patient.

Section 1
Background, Methods, and Respondent Characteristics

Background

The eighth Harrison Survey, administered in 2018, was jointly sponsored by the Association of American Medical Colleges (AAMC) and the Society for Academic Continuing Medical Education (SACME). This is the 20th survey documenting characteristics of the continuing medical education and continuing professional development (CME/CPD) community and the eighth that has been jointly administered by the two organizations since 2008. Its name recognizes R. Van Harrison, PhD, from the University of Michigan Medical School, who provided the principal platform in 1985 on which to analyze educational activities and track changes within the academic CME/CPD community.

This biennial survey provides a snapshot of the current structure and function of CME/CPD units at medical schools in the United States and Canada. It describes several elements in the transition of academic CME/CPD from a passive resource (i.e., producing standard courses and lectures) to one that is dedicated to improving patient care through education and scholarly missions. In preparing this survey, we were constantly reminded of our readers and prepared questions that better reflected more recent transformations in continuing education and professional development.

Methods

All questions from the 2015 survey were reviewed by members of the AAMC/SACME advisory committee. Some items were removed for lack of relevance and others were added to reflect new trends in CME and CPD. An expert in survey design and administration was added to the advisory committee to ensure that items were constructed with appropriate clarity and brevity. Six SACME members agreed to proofread the survey to ensure the clarity and relevance of the questions and responses.

The potential survey participants were the CME/CPD unit leaders at 144 U.S. and 17 Canadian medical schools. The few schools without a CME/CPD unit were not included. An email was sent to all CME/CPD unit leaders to confirm their role and announce the upcoming survey. The unit leaders were encouraged to complete the survey over six weeks with the CME/CPD program manager. Four email reminders were sent to nonrespondents during this period.

Respondent Characteristics

The 161 eligible medical schools with academic CME/CPD units were contacted, of which 118 (73%) responded to the survey. Of these, 104 responses (88%) came from the United States and 14 (12%) from Canada. Overall response rates were 72% for medical schools in the United States (private schools: 77%; public schools: 69%) and 82% in Canada. According to the respondents, accreditation of CME/CPD activities was provided for 87% of the U.S. medical schools by the ACCME, 8% by state accrediting agencies, and 7% by the Joint Accreditation for Interprofessional Continuing Education. Of the 14 responding Canadian schools, 13 were accredited by the Committee on Accreditation of Continuing Medical Education (CACME).

Section 2
Integration of CME/CPD in the Academic Medical Center

This section characterizes how the academic CME/CPD units were structured in the academic institution in 2018. Organization of the CME/CPD unit was reflected by where the CME/CPD unit resided, its operations, the presence of a CME/CPD committee, and people with whom the CME/CPD unit leader met regularly.

Location of the CME/CPD Unit

Many of the survey's 118 respondents indicated that their CME/CPD unit resided within, or had a primary affiliation with, more than one department or area (Figure 1). The offices of faculty development and faculty practice plan were the second and third most commonly reported affiliations.
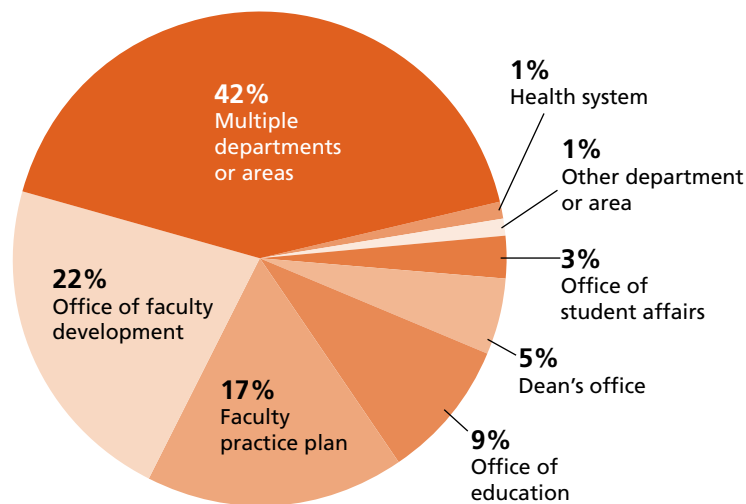

Figure 1. Location of the CME/CPD unit at the academic medical center (N = 118). Respondents could select only one response, so percent values sum to 100%.

Operations of CME/CPD Units

The most frequently reported operation of the CME/CPD unit was approving activities for credit. Other commonly reported operations included meeting and conference planning, developing content for CME/CPD activities, and marketing CME/CPD activities (Figure 2). Maintenance of Certification (MOC) Part II, as directed by the American Board of Medical Specialties (ABMS), was identified by more than half of the 116 respondents who answered this question as another operation. Less frequent operations included annual strategic planning for the institution, education research, MOC Part IV, the MOC Portfolio Program of the ABMS, and Ongoing Professional Practice Evaluation (OPPE).
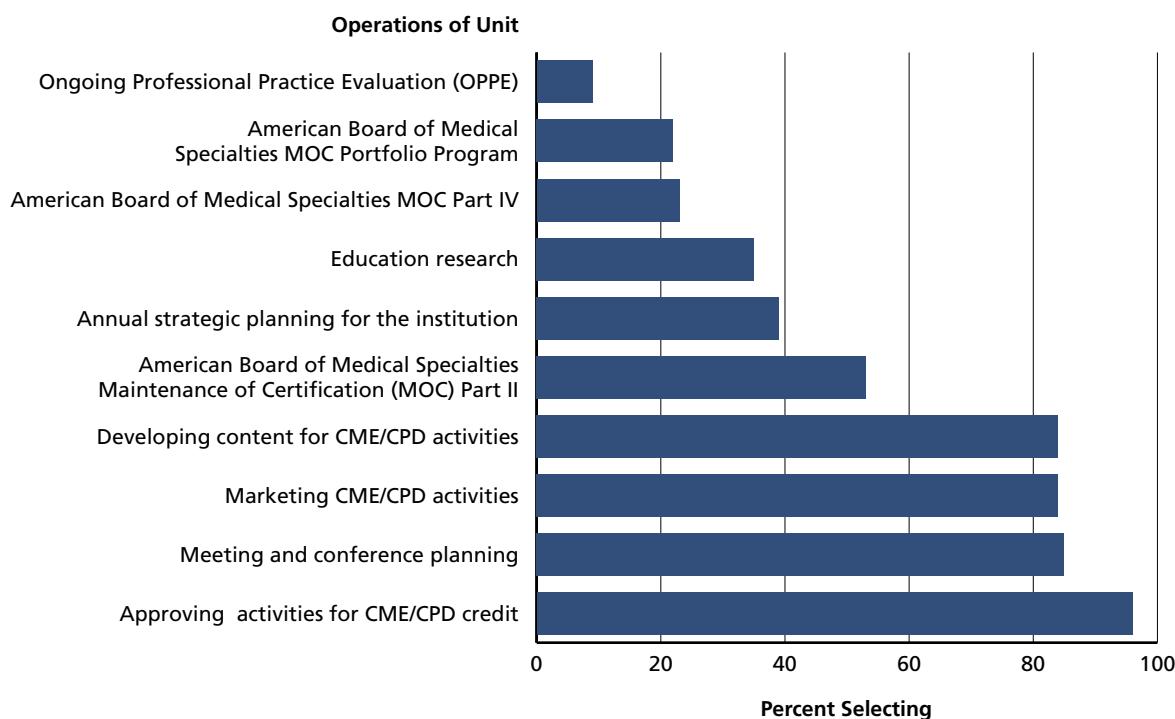
Operations of Unit

Figure 2. Operations of the CME/CPD unit (N = 116). Total percentage exceeds 100% because respondents could select multiple responses.

Institution-wide CME/CPD Committee

Respondents were asked whether an institution-wide CME/CPD committee existed and, if so, how often the committee met. About three-fourths of the 118 respondents (77%) responded that there was a committee. The committee met most often on one to four occasions (65%) each year, and less commonly on either five to eight (12%) or nine or more occasions (15%). A small number of schools (8%) reported that the committee had not met.

Institutional Leaders With Whom the CME/CPD Unit Leader Meets Regularly

Respondents were asked to whom the CME/CPD leader reported. The most frequent title to whom the CME/CPD leader reported was the medical school dean (35%). The title second most frequently reported to was senior associate dean for education or equivalent (27%).

Respondents were also asked, How many times a year did the CME/CPD unit leader meet in person with different institutional leaders? A list of institutional leaders and frequencies of formal meetings held annually is shown in Table 1. The most frequent in-person meetings were with the associate or assistant dean of education. Separate meetings with clinical department chairs, chief quality and safety officer, medical school dean, and designated institutional officer were usually on one to four occasions annually. Other institutional leaders who met at least annually with CME/CPD unit leaders included the associate provost for faculty, other medical school deans (diversity, research, faculty affairs), chief nursing officer, deans of other health professions schools, and chief financial officer.

Table 1. Frequencies of Meetings per Year Between the CME/CPD Unit Leader and Institutional Leaders

Unit leader indicated meeting with:	Number of respondents	Percentage selecting each category				
		0 meetings	1–4 meetings	5–8 meetings	9–12 meetings	More than 12 meetings
Associate/assistant dean(s) of education	108	5%	21%	8%	24%	42%
Designated institutional officer	102	44%	25%	5%	11%	16%
Medical school dean	110	15%	39%	16%	15%	15%
Clinical department chairs	112	8%	43%	25%	14%	10%
Chief learning officer	92	74%	11%	5%	7%	3%
Chief medical officer	101	50%	36%	4%	8%	3%
Chief executive officer, hospital	104	58%	32%	3%	5%	3%
Chief operating officer	100	62%	26%	6%	4%	2%
Chief quality and safety officer	102	36%	39%	12%	11%	2%
Chief information officer	101	69%	22%	4%	4%	1%

Note: Each row reflects the percentage of responding units that selected the response and category. For example, 42% of 108 units selected the category "More than 12" for the response item "Associate or assistant dean(s) of education."

Offices or Departments Working With the CME/CPD Unit

Respondents were asked, During the past year, which of the following departments or offices had one or more individuals work with your CME/CPD unit? People working with the CME/CPD unit came from several different departments or offices (Figure 3). More than 75% of 114 respondents indicated that they worked with one or more of the following five departments: faculty development, continuing education in other health professions schools, simulation centers, QI/PS, and resident and fellow education.

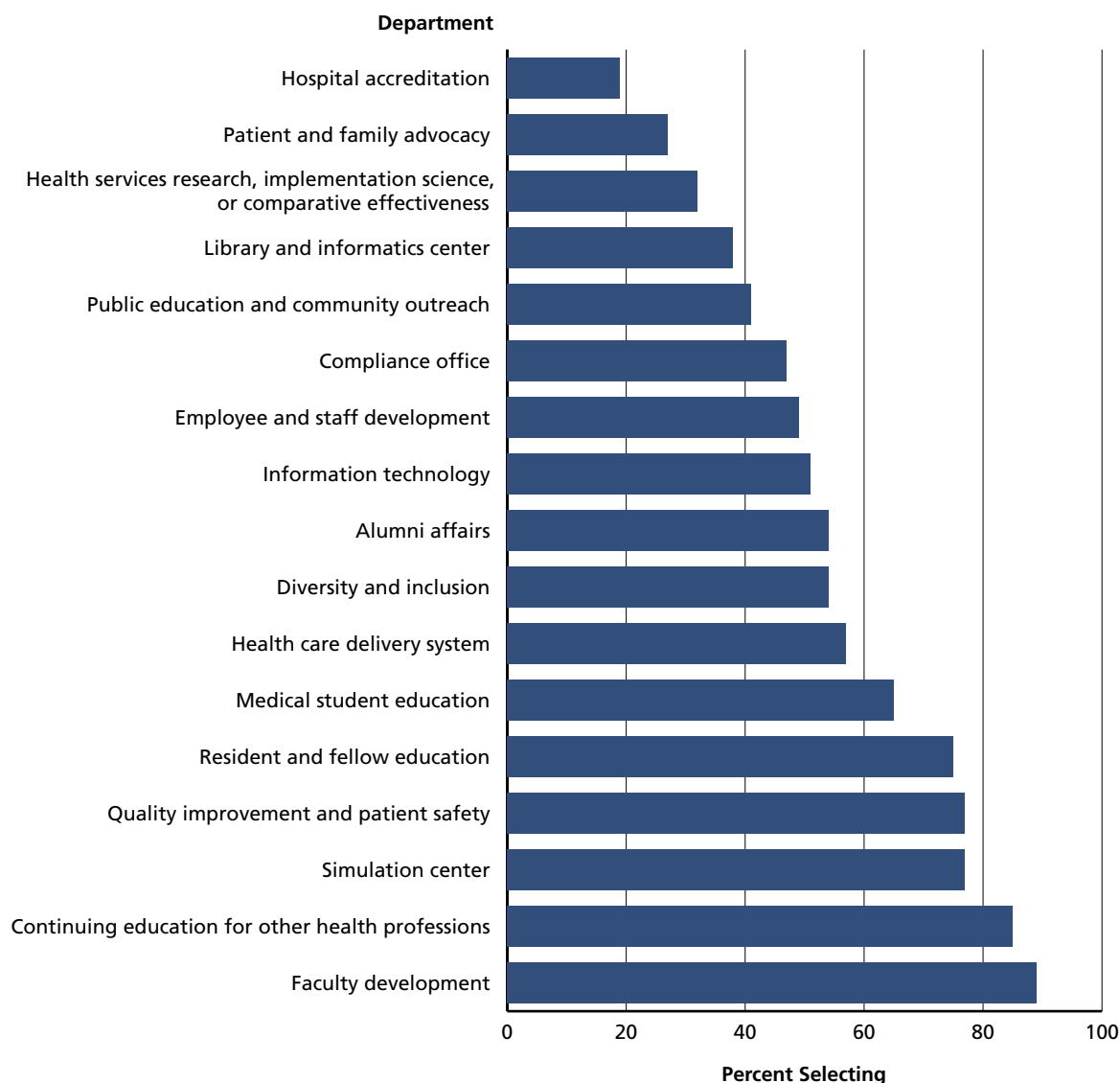Association of
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Department

Figure 3. Departments or offices at the institution that work with the CME/CPD unit (N = 114).
Total percentage exceeds 100% because respondents could select multiple responses.

Slightly more than half (51%) of the respondents reported that meetings between the CME/CPD unit and the GME office occurred from one to eight times annually. Twelve percent of respondents stated that they did not meet with GME leaders, and 20% reported that they met 12 or more times annually.

About half of all respondents said that individuals who worked with the CME/CPD unit came from the following departments or offices: health care delivery system, diversity and inclusion, information technology, alumni affairs, employee and staff development, compliance (e.g., institutional review board, ethics committee), and public education and community outreach. Between one-fifth and one-third of CME/CPD units engaged with colleagues from the library and informatics center or from offices of health services research implementation science or comparative effectiveness, patient and family advocacy, and hospital accreditation.

Section 3
Educational Offerings of the CME/CPD Unit

Academic CME/CPD units reported delivering a wide variety of teaching and learning offerings. To understand the value of these educational activities, it is important to find out about the aims of health care offered, whether core competencies were included, what methods of teaching were used, and how impact was measured.

Aims of Educational Offerings

Many aims of health care were reported as a high priority in the educational offerings from the CME/CPD unit. Each respondent was asked to select up to four aims that represented the highest priority for the unit. The aim most frequently reported by 115 respondents was to get clinical knowledge updates (Figure 4). Aims given less priority in the educational programming of the units included health care disparities, population health, and working in teams. The lowest priorities in educational offerings from CME/CPE units were provider wellness and burnout, diversity and inclusion, value-based delivery (including cost reduction), and patient experience.
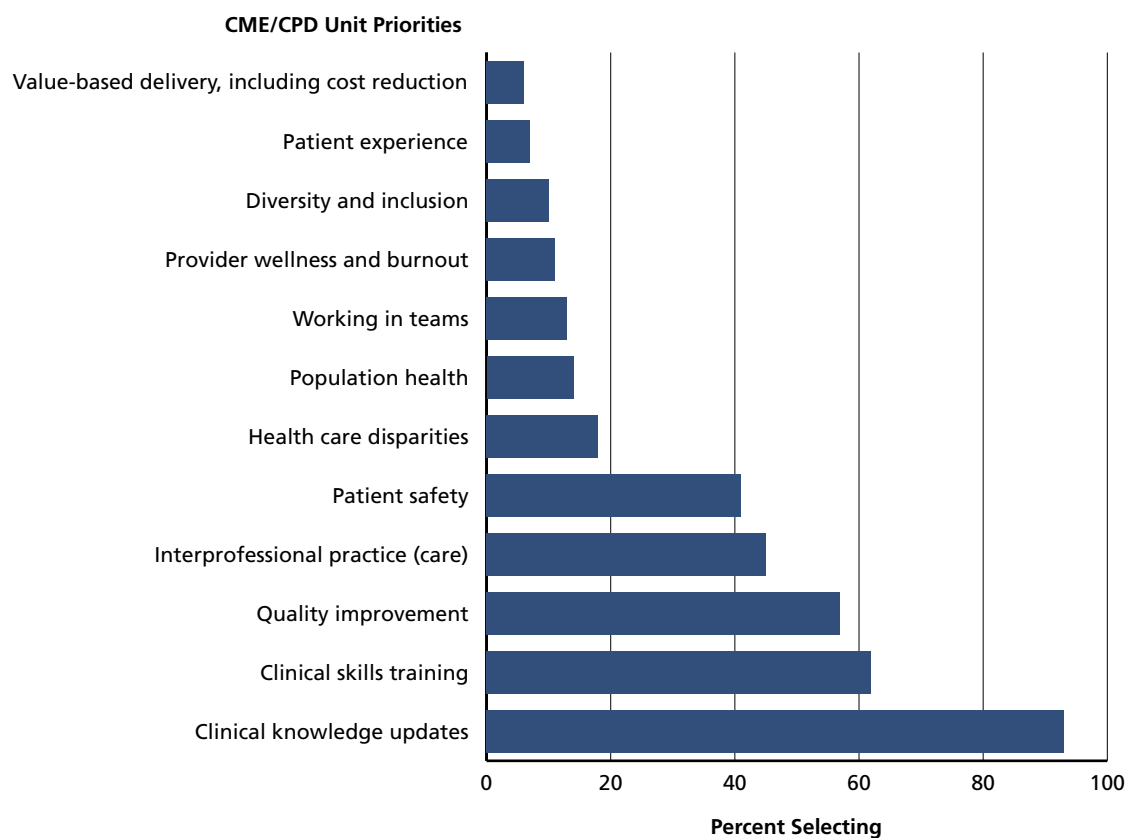
CME/CPD Unit Priorities

Figure 4. Priorities of educational offerings by CME/CPD units (N = 115). Participants could select up to four priorities.

Core Competencies in Educational Programming

Core competencies developed by the ACGME and the ABMS are essential components of educational programming. Respondents were asked the question, What percent of the educational programming from your CME/CPD unit addresses the following core competencies? Medical knowledge and patient care received the highest percentage of educational programming as reported by most respondents (Table 2). The remaining four competencies were less frequently addressed in the educational programming of the CME/CPD unit.

Table 2. Core Competency Coverage in CME/CPD Unit Educational Offerings

Core competency	Number of respondents	Percentage selecting each category			
		0%–25% of programming	26%–50% of programming	51%–75% of programming	76%–100% of programming
Medical knowledge	112	2%	11%	16%	71%
Patient care	111	5%	24%	23%	47%
Practice-based learning and improvement	109	22%	32%	30%	16%
Professionalism	111	36%	34%	21%	9%
Systems-based practice	112	31%	41%	21%	6%
Interpersonal and communication skills	110	40%	32%	20%	8%

Note: Each row reflects the percentage of responding units that selected the response and category. For example, 71% of 112 responding units reported that "Medical knowledge" was covered in 76%–100% of their programming.

Educational Methods Used in CME/CPD Activities

We combined a wide variety of methods or tools for teaching and learning in asking the question, In the last year, how often were the following methods used in your CME/CPD activities? Lectures remained the principal method, yet clinical case conferences, morbidity and mortality conferences, and panel discussions were also used by nearly all units (Table 3). Tools used on at least three occasions in the past year included audience response systems, team-based learning, video or digital presentations, small group or paired interactions, online learning, and simulations. Methods that were used less frequently included flipped classrooms, debates, peer observations and feedback, and coaching and mentoring. Patient-led educational activities were used the least, being only on a few occasions or none at all each year. In addition, several respondents mentioned use of rapid-fire didactics to enhance communication in crisis scenarios, scripted video vignettes, role-playing, cadaver labs for hands-on clinical skills training, academic detailing, student-led education, and educational games to test critical thinking skills and medical knowledge. Respondents also reported using technology-based methods such as scripted video vignettes, virtual reality, educational games, and skills-lab break-out sections.

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Table 3. Teaching and Learning Method Coverage in CME/CPD Offerings in the Last Year

Method, used within the last year	Number of respondents	Percentage selecting each category			
		0 times	1–2 times	3–4 times	5 or more times
Audience response system (e.g., "clickers")	112	6%	25%	25%	44%
Clinical case conference	113	6%	4%	14%	75%
Coaching and mentoring	110	24%	34%	22%	21%
Debate format	106	32%	26%	25%	16%
Flipped classroom	111	32%	30%	21%	17%
Lecture	113	0%	0%	3%	97%
Morbidity and mortality conference	112	13%	7%	2%	78%
Online learning	112	7%	14%	12%	67%
Panel discussion	113	0%	12%	17%	71%
Patient-led activity	108	51%	38%	7%	4%
Peer observation and feedback	111	34%	32%	17%	17%
Self-reflection	111	23%	23%	19%	35%
Simulation	112	8%	23%	24%	45%
Small group or paired interactions	112	5%	26%	21%	47%
Team-based learning	112	14%	21%	26%	39%
Video or digital presentation	110	7%	18%	15%	59%

Note: Each row reflects the percentage of responding units that selected the response and category. For example, 44% of 112 responding units reported that "Audience response system (e.g. "clickers")" was used 5 or more times.

Measuring Impact of Educational Offerings

Respondents were asked to select outcomes that their CME/CPD unit tracked to measure the impact of their educational offerings during the past year. The two most common outcomes reported by 115 respondents who answered this question were knowledge gained (usually measured by simulations and post-activity examinations) and the intent-to-change as expressed by the participant (Figure 5). Improvements in actual performance were measured by nearly two-thirds of the CME/CPD units. Impacts on patient outcomes and especially on population health were less frequently measured.

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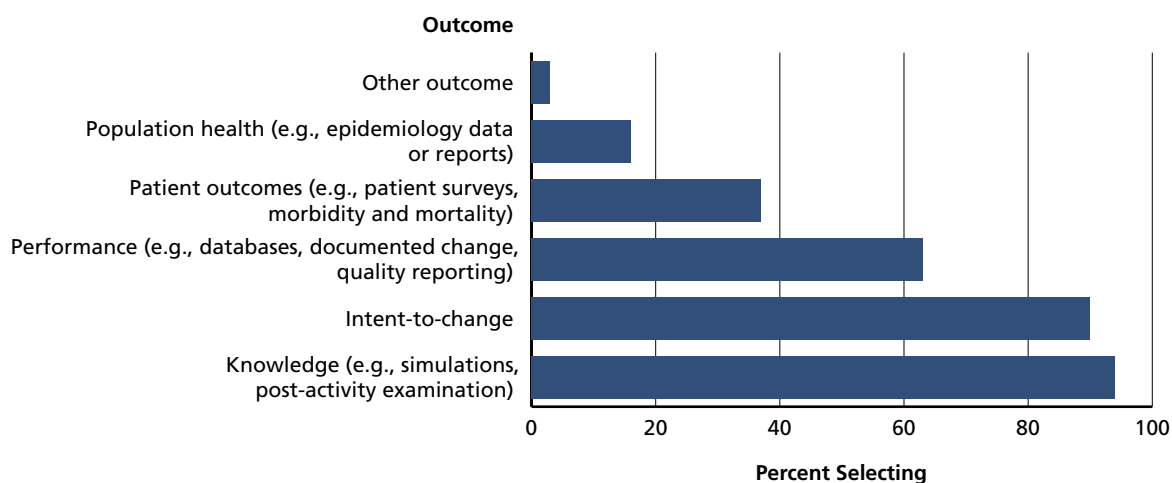American Medical Colleges

Outcome

Figure 5. Outcomes tracked to measure the impact of CME/CPD offerings (N = 115). Total percentage exceeds 100% because respondents could select multiple responses.

Section 4
Personnel of the CME/CPD Unit

Understanding responses to questions pertaining to personnel adds clarity to what is expected to recruit and retain the best CME/CPD team. The typical unit consists of a senior leader and staff members who serve in a variety of roles.

The CME/CPD Leader

Responses of 101 participants indicated that a senior leader for CME/CPD was identified at nearly all medical schools. The most common title of the leader was associate dean of CME, CPD, or CME/CPD (Figure 6). Less often, the senior leader was identified as being an assistant dean, director or medical director, or vice dean. Infrequent titles included being an assistant or associate dean for academic affairs, business development, in GME and CME, continuing competency and assessment, faculty, or education strategy.
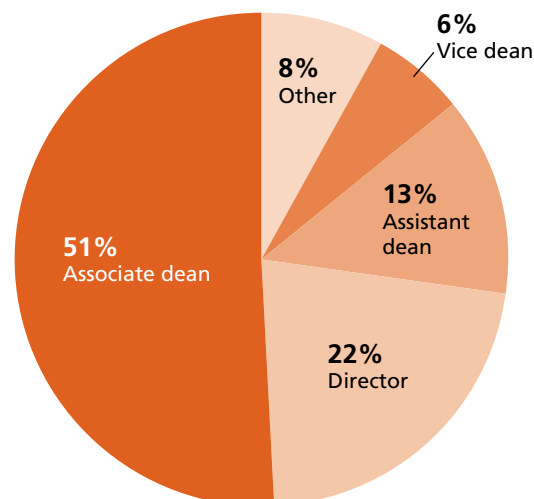

Figure 6. Titles of CME/CPD senior leaders (N = 101).

Respondents were asked the FTE of the senior leader whose job description stipulates that a percentage of his or her time be dedicated to CME/CPD. Of the 98 participants who answered this question, the FTE was wide-ranging, from 0.05 to 1.0 (Figure 7). The median FTE was 0.3 with an interquartile range of 0.2 to 0.6 FTE. The mode FTE was 1.0. Of 98 respondents, 39% indicated a leader with an FTE equal to or greater than 0.5.
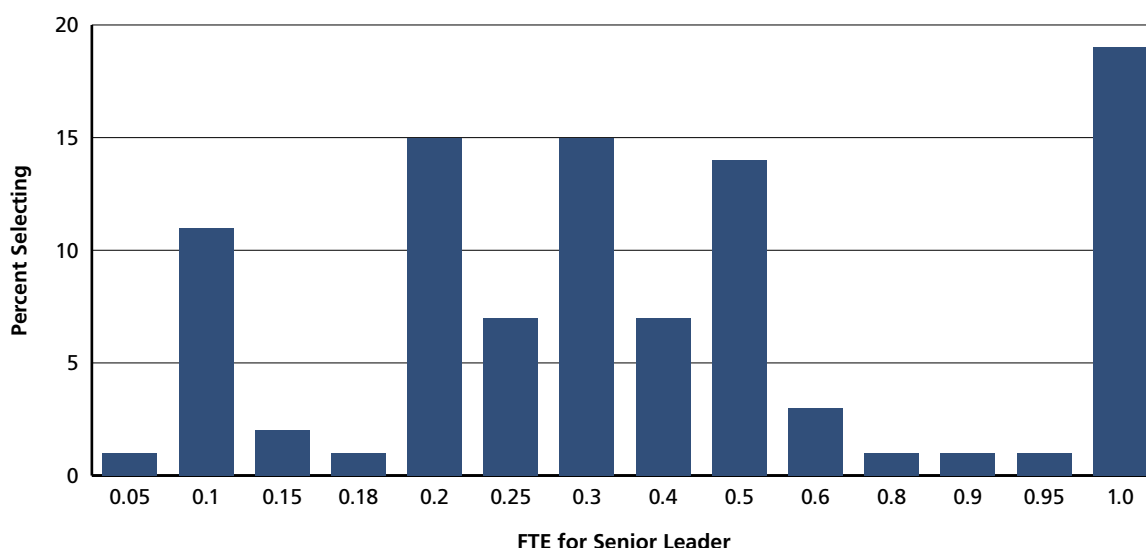
Figure 7. Full-time equivalent (FTE) of the senior leader whose job stipulates a percentage of time dedicated to CME/CPD (N = 98).

Staff

In addition to the CME/CPD senior leader, staff in the unit consisted of program managers, event planners, accounting and financial support personnel, and administrative assistants. The total number of FTEs for staff members employed in each CME/CPD unit during the most recent budget year ranged widely for the 110 respondents (Figure 8). The median number of staff was 5.5 FTEs with an interquartile range of 3.0 to 9.1 FTEs. The results for CME/CPD units that participated in 2018 were similar to the results for the same units that also participated in 2015 (Table 4).
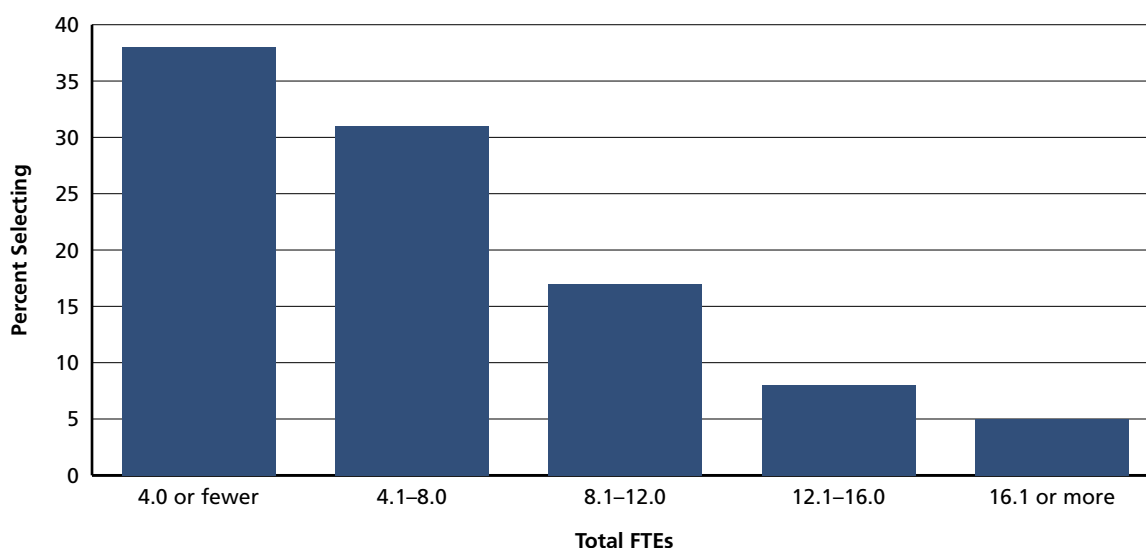

Figure 8. Range of staff full-time equivalent (FTE) per CME/CPD unit (N = 110).

Table 4. Total Staff Full-Time Equivalents (FTEs) for CME/CPD Units Responding in Both 2015 and 2018

Percentile	2015	2018
25th percentile	4	3.5
50th percentile	6	6.0
75th percentile	10	10.0
Number of respondents	71	71

Note: Data include only responses of units that responded in both 2015 and 2018. Respondents in 2018 could enter decimals; 2015 respondents were instructed to round answers to the nearest whole number. Respondents in 2018 were instructed to exclude the FTE of the senior leader; 2015 respondents were not so instructed.

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Section 5
Budgets of the CME/CPD Unit

Respondents were asked to share details about the overall fixed operating budget of the CME/CPD unit and its support from institutional sources. Revenues come from a variety of sources such as fees for meeting registrations and educational grants. Total expenses were related to outputs such as salaries and benefits, information technology, telephones, office rent, and expendable supplies.

Separate Versus Integrated Budgets

CME/CPD units were queried about the degree to which their budgets were separate and identifiable rather than combined with another office in the institution. A large majority (82%) indicated the budget was separate. The remainders (18%) indicated that their budgets were integrated with the institution both fully or partially and thus not suitable for analysis and reporting. These percentages are nearly equal to those from the 2015 survey results.

Total Expenses for CME/CPD Units

Respondents were asked what the total expenses of their CME/CPD unit were in the most recently completed budget year. Examples of expenses included salaries of staff and benefits, information technology, phones, and rent for the CME/CPD unit. The median total expenses for each CME/CPD unit in the past budget year was $578,767 for U.S. and CA$950,000 for Canadian medical schools. Total budget expenses per CME/CPD unit were similar for the 52 U.S. medical schools that responded in 2018 and 2015.

Financial Support From the Institution

Institutional support came from the university, hospital, faculty practice plan, or medical school.
The respondents were asked the following question: Over the past two years, what was the general change within your CME/CPD unit in terms of the amount of institutional support as a percentage of your fixed budget? In most circumstances, the institutional support that respondents perceived either stayed the same (65%) or decreased (22%). Approximately 13% of CME/CPD units stated that financial support seemed to have increased. These responses were similar for survey years 2015 and 2018 (Figure 9). The range of support per CME/CPD unit were compared between U.S. and Canadian medical schools in Table 5. Median financial support from the institution offset 30% of total expenses of U.S. CME/CPD units and 40% of Canada's.
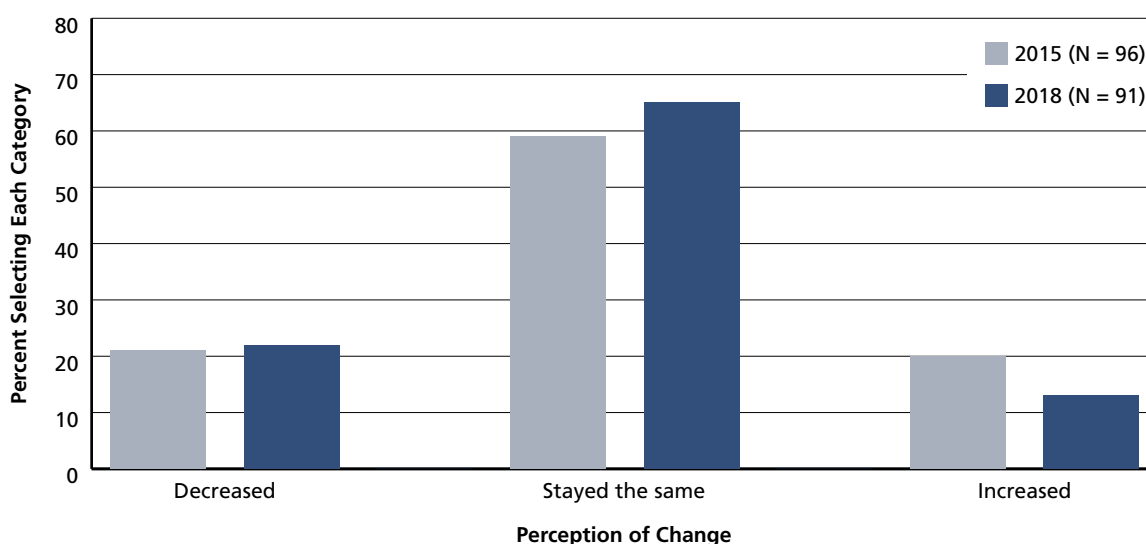
Figure 9. Perceptions of change in institutional financial support for the CME/CPD budget, 2015 and 2018. To enable comparison, the data include medical school CME/CPD units only.

Table 5. Institutional Financial Support Provided per CME/CPD Unit at U.S. and Canadian Medical Schools During the Past Budget Year

Statistic	Canada	United States
Median	CA$378,900	$176,402
Mean	CA$450,562	$260,126
Maximum	CA$1,150,000	$1,900,000
Minimum	CA$80,000	$50
Standard deviation	CA$331,684	$302,487
Number of respondents	11	53

Note: The data reflect verbatim entries of respondents. Canadian respondents entered Canadian dollar amounts, and U.S. respondents entered U.S. dollar amounts.

CME/CPD Unit Identified as a Revenue Source

Respondents were asked, During the past two years has your CME/CPD unit been identified by your AMC leadership as either a value source or revenue source? Approximately two-thirds (65%) of the 118 responding CME/CPD unit leaders indicated that they perceived their unit as being primarily a revenue source by their institutional leaders.

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Section 6
Priorities of the CME/CPD Unit

Respondents indicated that priorities of CME/CPD units included QI/PS, faculty support, and education-related scholarly activity and research.

Quality Improvement

When queried about accessibility to clinical quality improvement (QI) data, only 58 of the 111 respondents (52%) stated that data were available at their institutions. When available, the clinical data were used by CME/CPD units for assessment of needs, education activity content development, and assessment of outcomes (Figure 10). Other uses were for crediting MOC projects (part IV), measuring the impact of regularly scheduled series (especially morbidity and mortality conferences), acknowledging portfolio program projects, and auditing and providing feedback to better understand system-related problems. Of institutions with access to QI data, 91% reported using the data for content development, needs or outcomes assessment, or other purposes.
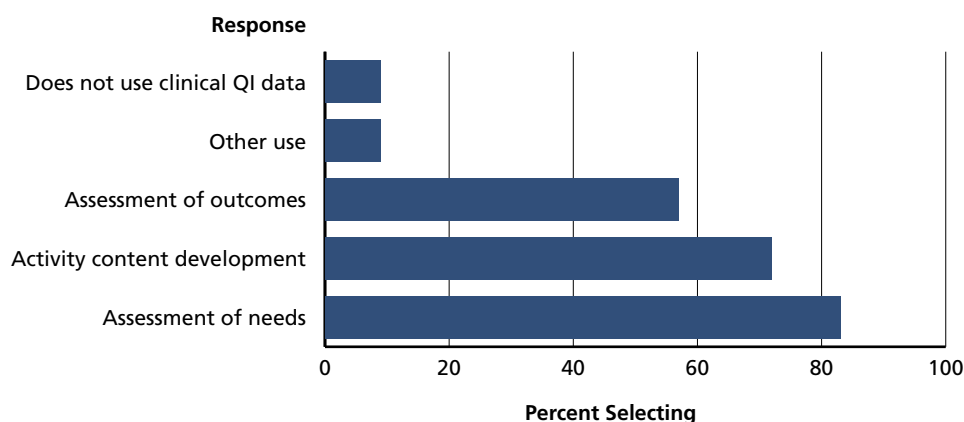

Response

(bar chart, x-axis: Percent Selecting, 0 to 100)

- Does not use clinical QI data
- Other use
- Assessment of outcomes
- Activity content development
- Assessment of needs

Figure 10. Uses of institutional quality improvement data available to CME/CPD units (N = 58).

Faculty Support and Leadership Development

Faculty support remains essential for enhancing teachers' skills in the continuum of medical education. For this reason, the following question was asked: In which of the following content areas does your CME/CPD unit provide support for faculty? All 114 responding units indicated having been involved in some manner. More than half of the respondents stated that their faculty were supported in the following educational content areas: program evaluation, maintenance of (or continued) certification, instructional methodology, learner assessment methods, and curriculum design (Figure 11). Respondents reported that they provided less support for developing faculty in the following areas: leadership development, medical knowledge content in individual medical or surgical specialties, competency-based education (e.g., CBME), physician wellness, and research skill preparation.
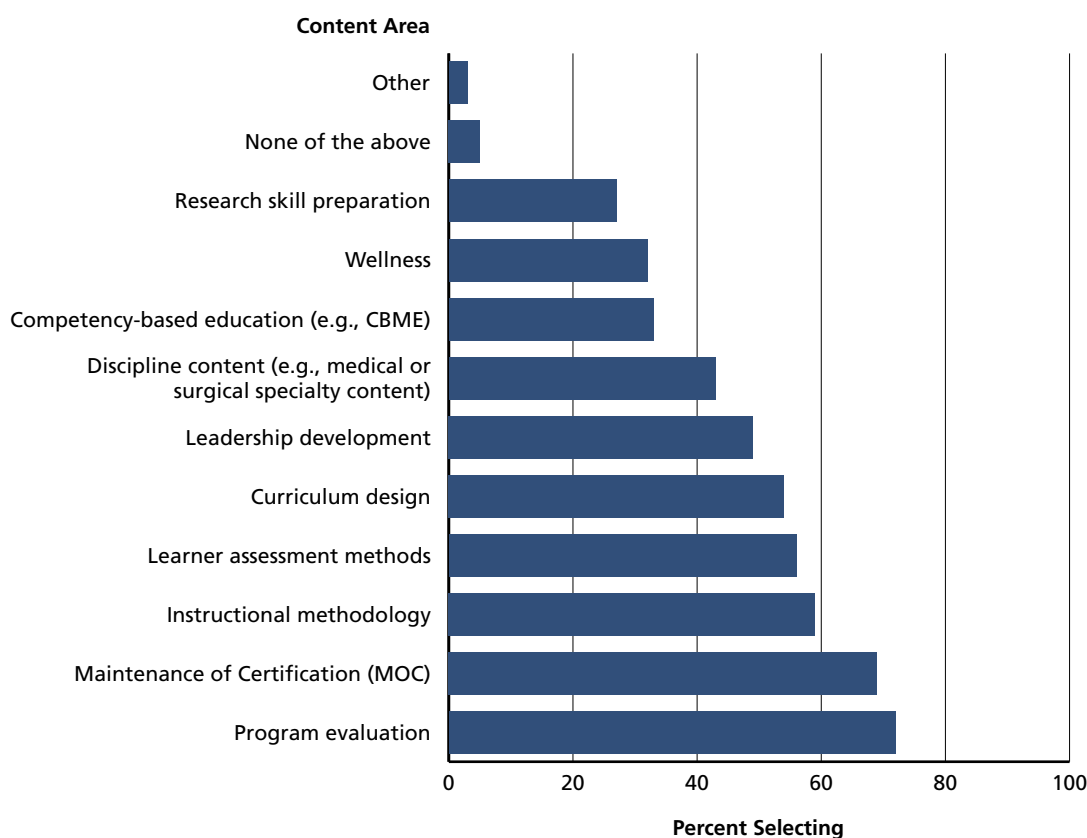
Content Area

Figure 11. CME/CPD unit content support for faculty (N = 114).

Scholarly Activity and Research

The majority of 83 responding CME/CPD units were involved in a variety of education-related scholarly activities (Figure 12). During the past two years, members in these units participated with CME/CPD-related scholarly presentations at conferences locally, regionally, nationally, or internationally. Either sole or joint authorship of journal articles or book chapters was reported by many CME/CPD leaders. It is noteworthy that the CME/CPD unit at every Canadian medical school was expected to be engaged in some form of scholarly activity.
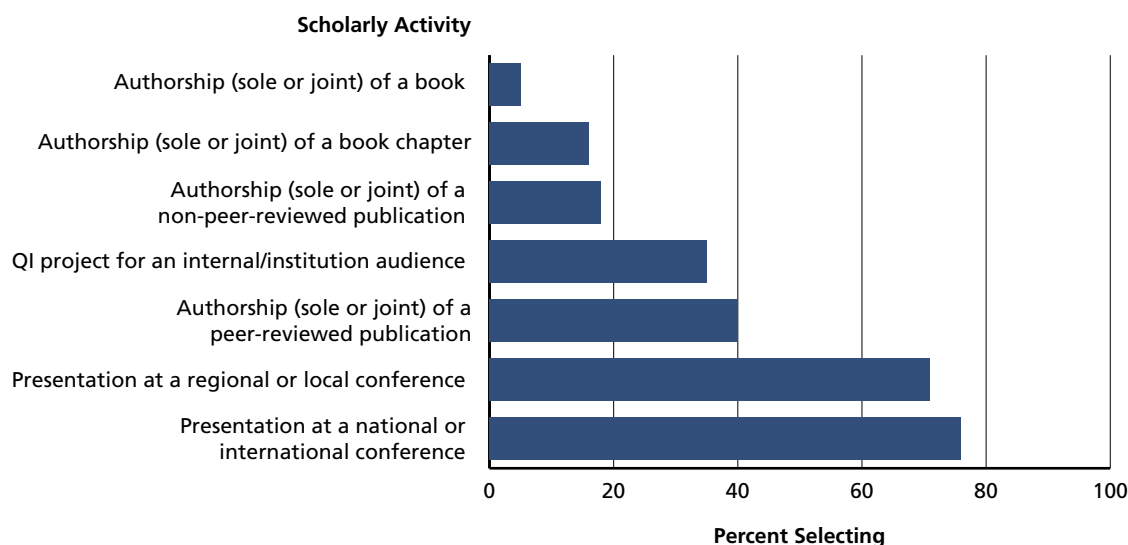
Scholarly Activity

Figure 12. Education-related scholarly activities of CME/CPD units (N = 83). Total percentage exceeds 100% because respondents could select multiple responses.

From 2016 to 2018, only a small percentage (12%) of the 110 respondents received any grant funding for educational research. Examples of research topics related to education are academic detailing, physician assessment and feedback, continuous quality improvement (CQI) in rural health care, and interprofessional continuing education. Units' sources of funding outside their organization for these specific education grants were difficult to generalize from the survey responses.

Priorities in the Next Year

Respondents were asked to select up to four areas considered to be their highest priorities in the next two years, 2018-20. The top four areas among the 111 respondents were incorporating ACCME (or CACME) new accreditation criteria, encouraging more IPCE, promoting the value of CME/CPD, and attending to faculty MOC (Figure 13). Fewer respondents included the following in their list of top four priorities: education strategies, development of clinician educators, and competency-based education. Training in conflicts of interest and education research were given the lowest-priority consideration.
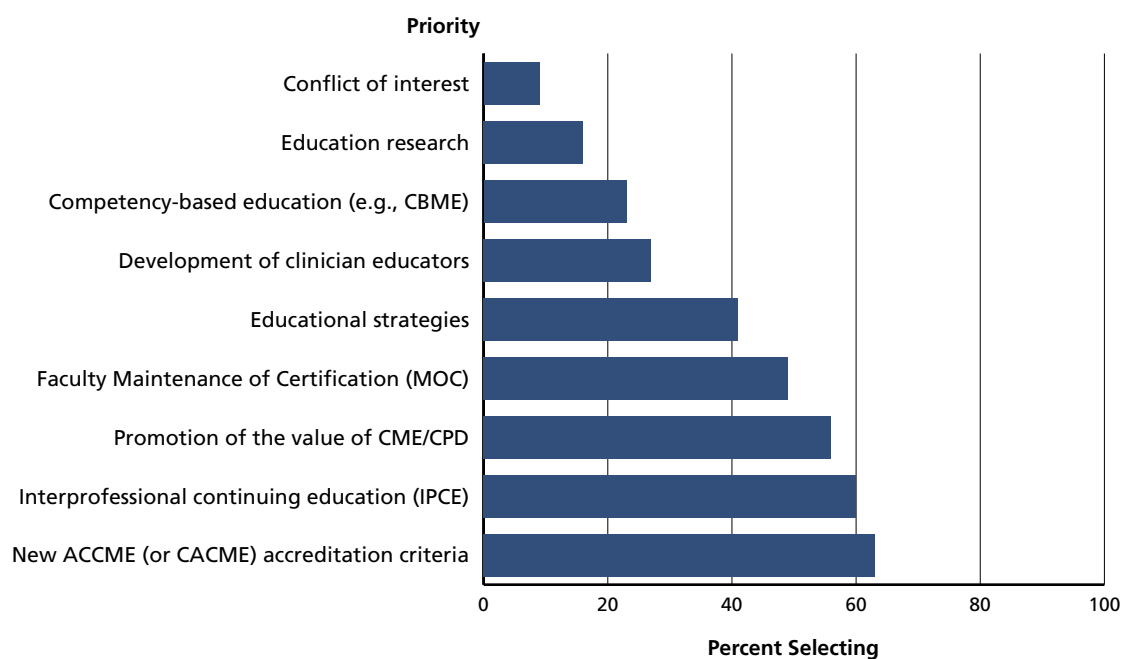
Priority

Figure 13. Priorities of CME/CPD units in the next year (N = 111). Total percentage exceeds 100% because up to four responses were permitted.

Section 7
Discussion: Implications and Future Directions

This eighth Harrison Survey was marked by a high response rate (73%). It is the 20th survey of the CME/CPD community since 1982. Results document an academic enterprise displaying several characteristics in addition to its past image of a separate, transactional, credit-granting entity. First, the CME/CPD unit appears to be increasingly integrated into, or at least aligned with, the functions of its institution. Second, varied and evidence-based educational methods of instruction are increasing, although at a slow pace. Third, support for faculty's role as educators is provided by the majority of CME/CPD units.

Relationship Between the CME/CPD Unit and the Broader Academic Medical Center

Medical schools, and the CME/CPD units that reside within them, are becoming increasingly integrated; several findings in this report provide evidence to support this trend. Although approving educational activities for CME credit, meeting planning, and marketing remained the highest operations of CME/CPD units, 84% of units were also developing educational curricula and 39% were engaged in annual strategic planning of the institution.

Nearly one-fourth (22%) of CME/CPD units were located within an office of faculty development. Just over half (52%) of respondents reported having access to clinical quality data. CME/CPD that is informed by clinical QI data can help identify and fill practice gaps. Education or ongoing professional development is an important driver of change and should be included in action planning for quality and patient safety. Collaboration between QI coaches and medical educators has the potential to create unique synergies for performance improvement. At a minimum, these findings should inspire a dialogue about the transparency and use of such data with CME/CPD activity planning and execution.

Educational Offerings of CME/CPD Units

Nearly all respondents cited clinical knowledge updates as a high priority for their educational offerings (93%), followed by clinical skills training (62%) and QI (57%). Aims of health care that were reported as a priority by less than half of the respondents included interprofessional practice (45%), patient safety (41%), health care disparities (18%), population health (14%), provider wellness and burnout (11%), patient experience (7%), and value-based delivery (6%). Increasing offerings in these areas should be considered a growth opportunity for CME/CPD units going forward.

Lectures continued to be the most common method of instruction indicated by respondents, yet there is ample evidence demonstrating that this is a weak method for increasing knowledge and changing practice behaviors. Lectures and panel discussions can be modified to be more interactive and complement other educational methods such as clinical case discussions, simulations, and reflective exercises. Numerous CME/CPD units also integrated online learning and video presentations into their programs. Small group learning or paired interactions and flipped classroom methods were reported to be used infrequently by CME/CPD units.

Some CME/CPD units used innovative methods of teaching and incorporated technology as a means to enhance interactivity in their educational offerings. Some units reported the following additional strategies: rapid-fire simulations to enhance communication in crisis scenarios as a method for team-based learning, scripted video vignettes, role-playing, cadaver labs for hands-on clinical skills training, and educational gaming to test critical thinking skills and medical knowledge.

Developing Faculty and Leadership in CME/CPD

The respondents reported that they collaborated with those working in faculty development more than any other group. AMCs have the unique opportunity and responsibility to prepare their faculty for roles in the tripartite missions of the institution (educators, scientists, and clinicians). Meeting these needs is a growth area for CME/CPD units.

The majority of the CME/CPD units reported that their staff had participated in some form of educational scholarship, often as presenters at local, regional, national, and international conferences. However, funding for educational research was very limited, with only 12% of responding units having received grant funds over the prior two years. It is noteworthy that the CME/CPD unit at every Canadian medial school is expected to be engaged in some scholarly activity.

Survey findings demonstrated variation in time allocation for the CME/CPD leadership role (interquartile range 0.2 to 0.6 FTE). Advancing leadership in CPD/CME will require the commitment of academic and clinical partners. CME/CPD leaders must possess a fundamental knowledge of the field, be able to garner institutional credibility and resources, and view this role as a valuable and viable career path. More consideration should be given to identifying the optimal time allocation and competencies for a CME/CPD leader, as well as what programs are necessary for recruiting, developing, and retaining these leaders.

Moving Forward

AMCs, and the CME/CPD units that reside within them, face rapid changes in health care delivery, expansions of clinical knowledge, and advances in technologies. Pressures to provide high-quality care to differing patient populations, to become more relevant learning organizations, and to do so in an economically viable manner are major challenges at all AMCs.

The results of the Harrison Survey presented here point toward opportunities for CME/CPD units in the coming years. We can provide learning experiences and expertise that support the strategic goals of the AMC. We can grow in our connections and relationships with other relevant units connected to the AMC. We can increase our access to quality data and have it inform our educational activities to enhance both clinician performance and patient outcomes. As CME/CPD units continue to incorporate innovative educational strategies into their activities, it will become increasingly important to study these advances in a scholarly manner to ensure a higher value education for our learners. These advances will allow the contemporary CME/CPD unit to become the educational home for physicians and other health professionals, assisting them in determining their educational needs across all the domains of competence.

Association of
American Medical Colleges