Council of Medical Specialty Societies

MEETING SUMMARY

CPD DIRECTORS COMPONENT GROUP

Date	May 11, 2018
Time	9:15 – 10:00 AM; 1:00 - 4:00 PM
Location	Blackstone Hotel, Chicago, IL

Attendees

Tirza Lofgreen	AAO-HNSF
Johnnie White	AAO-HNSF
Devoren Chick	ACP
Kimberly Kretzer	ASRM
Julie Bruno	AAHPM
Shelby Englert	AUA
Lynn Brown	ASTRO
Anne Grupe	ASCO
Vanita Murray	ACOG
Elizabeth Lepkowski	ASA
Suzanne Ziemnik	ASCP
Deborah Samuel	AAP
Beth Wilson	AAO
Rebecca DeVivo	AAPMR
Devon Catright	ASCP
Vince Loffredo	AAFP
Amanda Morrone	ACS
Alisa Nagler	ACS
Candice Gillett	ACS

Meeting Minutes/Summary

9:15 AM – 12:30 PM Component Group Meeting/Elections

Steve Folstein opened the meeting with a welcome to participants. Introductions were shared.

Component Group Chair Breakfast

Steve reported on the first time component group chair breakfast held this morning. They are seeking to give the collaborative group meetings more focus and structure. There is consideration about some groups merging and/or meeting together. There is a new Report-Out process with each group reporting on the same three questions which were shared with the group.

Registry Summit Update

Attendees debriefed the Registries Summit. Relatively few CPD representatives were present at the Registries Summit that had significant attendance. The group discussed reasons that educators not present. In the content of the day, there was no discussion about integrating education into registries. CPD was not invited to contribute to the agenda. There was discussion about MOC and QI but these are not linked to education. The focus of registries is on quality measures. Registries are developed without input from education and there is not a recognition of the connection. The focus is externally on MIPS, MACRA. Registry work and QI are focused on how to operationalize their programs and processes and on how to get clinicians engaged. The opportunity to utilize data to identify practice gaps and link those to education and practice improvement is not yet recognized.

It is important to convey the importance of CPD involvement with QI; we add value by providing CME and MOC which allows physicians to meet multiple requirements and reduces the burden on them.

Ideas and Opportunities

- Create a cadre of QI coaches that go out into the field to assess and educate on use of registries, opportunities for QI. Could this be an “other” type of education activity?
- Providing CME for educational activities related to QI meets the ACCME commendation criteria. The CPD Component Group seeks to be more integrated into the QI process.
- Help QI people understand what is CME and what is education. CPD seeks to impact the organizational culture so that CME is not one more external requirement. It is part of the continuing learning and improvement of practice.

ACCME Meeting in April

Discussion followed on the ACCME meeting held in April. There was a lot of it focused on delivery of education. Changing the format of education will require training the faculty/members. If someone's practice involves teaching, then they can do QI project that develops teaching skills and qualify for MOC (Part IV). Point of care training is critical.

Innovative strategies for education will be more challenging to implement for those presenting science and research. They are delivering content on their research in didactic fashion; this is what's expected and rewarded. People are teaching because they are good researchers. There is no consequence for being a bad teacher. There is consequence for being bad researcher. Feedback from teaching needs to be part of their recognition.

The ACCME meeting utilized a homeroom concept that brought attendees together with peers practicing in same type of organization. (Parallels our experience as a CPD group at CMSS.)

One take-away from the meeting was that we all learn differently. We need to recognize this and provide environments where it's safe to share different opinions and learning styles.

There seemed to be buy-in to the 70/20/10 rule of retention. It holds that individuals obtain 70 percent of their knowledge from job-related experiences, 20 percent from interactions with others, and 10 percent from formal educational events.

ACCME started to bring in education and learning science people (not just medical educators). Modeled what they were teaching. No one is translating the wonderfully creative online activities into live activities. Instructional designers go to different meetings.

The session on behavioral economics was powerful. It is the psychology of why people make the choices they do; why people participate or change behaviors. This has implications for how we're communicating with our members and delivering education.

Faculty development resources: case references were about training academic faculty in hospital settings. There was limited acknowledgement of other arenas. MSS are a smaller component of the types of educators accredited by ACCME. Some noted that the commendation criteria are aimed at academic health care centers. The criteria are aspirational but not necessarily well aligned for MSS and what our members want and need.

Physicians practicing in hospitals feel isolated and see MSS as a home. Is there an opportunity to market CME activities to health systems setting where physicians are employed?

The discussion evolved to the ACCME self-study. The self-study is now available in PARS. All narrative goes in as plain text and has been simplified significantly. There is no place for images.

The COI chart is simplified and some fields are pre-populated from PARS data. The self-study still requires reflection.

The group shared concerns about meeting the thresholds for commendation and discussed value of commendation. It means six versus four years of accreditation and is a sign of excellence; it may improve access to grant funding. Commendation criteria does require significant change in practice for CME programs.

There was a question regarding changed performance. While it can be self-reported, what about validation of what they already know?

Accredited programs need to show that the experience of the activity has educational value. Each can find the assessment model that is meaningful and relevant to our learners.

ACCME staff have been open to answering questions.

"Other" criteria. What is anybody doing?

- Anesthesiology: Online community to set up closed SIGs to allow members to discuss specific cases, articles. Fits into POC learning. Links to LMS and fill out self-reflective questions. Offer .25 or .5 credits. Provide a few times each year when members can do the reflection to learn. Content is generated by peer-to-peer. Request to share the messaging used to engage members. Want it to be organic.

Other innovations that programs are engage in:

- Simulation to teach communication.
- More discussion about patient engagement and patient stories. How to share stories?
- Health literacy – communication in plain language training for staff when developing content for patients and families.
- Medical Improv
  Role plays; marketed with MOC credits. Standardized patients.
  Broke into small groups and practiced with patient/case role plays.
  Some are collaborating with nursing schools that tend to have strong simulation programs

10:45 AM – ACCME: Kate Regnier

The CPD Component Group welcomed Kate Regnier to the meeting who provided updates and engaged the group in various topic areas.

CME for MOC
ABIM, ABP, ABA, ABPath are currently using PARS for MOC activities. Upcoming: Otolaryngology, Ophthalmology. ACCME is steering the Boards toward using requirements already in place. They would like to create a single program guide for all Boards. Currently, there are about 350-370 ACCME accredited providers who have registered activities (of 1700) so there is room to grow.

Visioning Commission
ACCME is actively involved to make sure commission gets the perspective of the education providers. Education and life-long learning should stay strong and be an important part of the continuing certification.

PARS changes
Efforts are underway to make PARS better and more streamlined. Starting roll out with the November 2018 cohort. The CPD asked if, with the streamlining of content, if there a chance that the reflection and honoring of the quality of work being done could be lost. Kate suggests that we link the activities reports and data into the self-study. There are ways that we can pull data reports across years or types of activities that will help us tell our stories.

CMEFinder.org
This has been developed to provide clinicians access to variety of activities. ACCME has been tracking visits to website but will begin to track what they are clicking on. Kate reported that some providers have asked if activities that do not provide MOC can be listed on CME Finder. This is being considered by ACCME. They are looking at CME Finder as a national repository of CME activities.
Concern was expressed about ACCME encroaching on MSS's providing the member benefit of tracking learner activities and the MSS having a relationship with their Boards. Is there a way to think about this as interoperability versus the value of a national repository?

ACCME is doing a pilot with the state of TN; 11 of 12 providers in TN will report learner data into PARS. TN did not want to track CME of licensed providers. The state then has access to the learner data when license renewal is due. This parallels what ACPE does for pharmacists.

"Free to member" language in CME Finder needs changed. It is not transparent to learner or easily identifiable. (ACCME is looking into changing to free, free to members, no.) The members

of the Component Group have mixed responses to members utilizing CME Finder. On the one hand, members are losing direct contact with MSS when they go to ACCME. On the other hand, MSS activities are visible to much broader audience.

ACCME is collecting learner level data. The challenge is reporting when clinicians need to report to multiple boards. ACCME is looking at ways to pull data by learner and have the boards listed that need to see reports.

Commendation Criteria
Feedback was provided to Kate on the concerns regarding thresholds. She noted that every type of provider has complained that the criteria is set up against them. Recognized that providers are watching numbers due to impact on size.
ACCME will be sharing samples. Programs are having success.
The accrediting bodies are also looking at commendation criteria for joint accreditation.

Tom Granatir: ABMS

Tom Granatir was welcomed to the meeting. He provided updates on the Visioning Commission.

While acknowledging the firewall between certifying boards, diplomates want to feel the benefit of continuing certification which puts Boards in the position of educating. Boards (generally speaking) know they need to work collaboratively with societies. He noted that not all of the diplomates are fully represented by their membership societies; some are, but some are not.

From the perspective of the learner, do we have a system that supports the continuing certification? Physician agency is important. Boards ought to have a point of view about what physicians need to learn. Why aren't we talking about what the learning priorities are together?

The ABA is connecting the MOCA minute data at learner level and providing the learner a scorecard that links to the relevant education activities. This is a good model that honors the firewall. ABR is going in this same direction. AUA is also collaborating with their board. Board determines the gaps at the individual level; AUA links activities to blueprint so diplomates who receive a provisional pass get linked to activities that they can complete to get out of that status.

The Visioning Commission is coalescing around 3 pathways

1. Longitudinal assessment (more than half of the boards; several using CertLink); frequency variable but most either weekly or quarterly.
2. Annual assessments based on current research and practice (8 boards incorporate this into their programs; four currently use this as an alternative to the high stakes exam); items are not secure; content is defined by both the Board and MSS
3. ABIM and ABS two year check-ins; only ABIM's is a secure exam.

- Two boards use a conventional exam format, but content is customized and the process is designed to remediate
- Three boards have announced that they will have alternatives to the high-stakes exam but haven't declared which model they are going to use. I expect it to be some form of longitudinal assessment.
- We expect all the boards to have an alternative to the high stakes exam

There is a clear need to move away from continuing certification based on one activity. Efforts to be learner focused.

Philosophically, the Commission is asking, "What is the core job of certification?"

ABA – once certified, the board's job is to determine if the diplomate deserves to lose the certificate. (As opposed to having to earn the certification again and again.)

The Commission is supposed to develop a report by November. Everything is on the table except that there needs to be ongoing validation. How to develop a system that supports the physician in practice and is part of their practice? Physicians want activities that count for multiple things.

The phrase "quality improvement" is volatile. Perhaps we should be talking about how to support and enhance practice – how to help physicians to do a good job. ACCME and ABMS are in compliance boxes; QI is in compliance box. We need to tap into things that are targeted toward reinforcing what physicians enjoy (providing high quality care).

How to develop an expanded definition of CPD? See handout provided. Tom will provide the recent article out of England.

Tom's summary of what's needed.

Revalidation system needs to make people better.Needs to be decentralized.
Portfolio based on observations, not one event.
Proportionate regulation. Focus more on people that are higher risk.

MSS are only one of the types of educators. We need to figure out our role in the system of continuing professional development.

3:00 pm

PCORI partnership on education activities with Erica Sarnes and Bill Lawrence

At the physician round table earlier in 2018 with PCORI it was requested that PCORI not compete with MSS; is there opportunity to collaborate?

Overview of PCORI – legislative mandate to fund comparative effectiveness studies; include patients as part of the research team. Patients help determine subject topics, help recruit subjects, and are involved in data analysis and findings. PCORI's goal is to improve decisions around health care.

PCORI has five national priorities:

1. Assessment of prevention, diagnosis, and treatment options
2. Communication and dissemination research
3. Improving health systems
4. Addressing disparities
5. Methods in comparative effectiveness research

Their specialty is engaging patients in research. PCORI uses CME as a dissemination vehicle and is looking at ways to share findings.

The group engaged in discussion with our guests about the potential value of collaboration and barriers to collaboration with PCORI. PCORI has a small and growing CME program with Prime and Baylor as their contracted CME partners. CME has to go through Baylor or Prime. They are the ones who work with stakeholders to design the activity. They could be live, online, include patient education, etc. MSS can provide input and subject matter experts. PCORI would look to MSS to define what goes into the task orders. Task orders can be prescriptive or more open. All CME are free. Baylor or Prime would pay the MSS for expertise that we provide. Is co-branding of interest?

For several MSS, co-branding or working with external providers (Prime or Baylor) is not of interest.

PCORI wants to have evidence coming out of their projects of the influence on the patient/provider. They do have results coming in. PCORI is identifying gaps. PCORI has dissemination awards that disseminates findings. MSS could apply for funding to disseminate creatively. They want to get findings out to people who need them. With engagement awards, PCORI can play the role of the funder. PCORI.org is where they list their projects. Search by topic or investigators. (search "engagement awards")

Next steps:

- PCORI to share with colleagues what they have learned today and to consider further what they can they do as a funder? It was helpful for them to know that there is interest.
- Some of their PIs have indicated that they will be moving forward with CME so they don't want to create competition with dissemination.
- All agreed to continue the conversation. Is there an opportunity for us to talk with CMSS about having a Summit day that engages PCORI, patient advocates, and various component groups of CMSS to discuss PCORI (topics, funding, dissemination strategies) and opportunities for CMSS to help address the complexities of dissemination and shared decision making. CMSS has a Patient Engagement Component Group. Not sure of status of that group.

Reporting out on our meeting today:

- PCORI funded Shared Decision Making Summit. Ask about Patient Engagement Component Group.
- AAFP purchased licenses to provide access for cross discipline burnout survey. Could CMSS purchase access? Mayo created tool that is free for physicians. For small fee, can access reports. Could CMSS assist with this?
- There is a need for QI and Registry work to include CPD and recognize the role of education in improving practice/performance.
- We want to get away from CME as one more thing. We are about learning and improvement.

Successes:

- ACCME sees the MSSs as united; example – listened to need for how activities are labeled as free; not as successful when one MSS identifies the issue.
- CPD Component Group listserv
- Using AMA simplification as opportunity.

Agenda for next time:

- Individual successes; share the innovative strategies we are implementing.

With gratitude to members and guests, the Meeting was adjourned at 4:30 p.m. to allow the group to attend the CMSS general session.