The Accreditation Council for Continuing Medical Education at Work

Accreditation  Recognition  Education  Operations  Governance
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Welcome to The Accreditation Council for Continuing Medical Education at Work. We have produced this detailed report of our accreditation system and services as part of the ACCME's ongoing efforts to facilitate dialogue, increase transparency, and promote understanding about the ACCME and accredited CME.

During the past few years, the ACCME has experienced significant growth, expanding in staff, services, and even our office space. We have undergone this transformation because the government, the public, and the profession of medicine called on accredited CME to increase its accountability. In 2006, we released the Accreditation Criteria to answer that call. The Criteria, which incorporate the updated 2004 Standards for Commercial Support: Standards to Ensure Independence in CME Activities, are designed to reposition accredited CME as a strategic partner in health care quality initiatives, providing physicians with relevant, practice-based education that is independent, based on valid content, and free of commercial influence.

We have completed accreditation and reaccreditation reviews based on the 2006 Accreditation Criteria for more than half of ACCME-accredited providers. We are pleased to report that our data demonstrate that accredited providers are successfully managing the transition to the Accreditation Criteria. Accredited CME is now strongly positioned to support U.S. health care quality improvement efforts and to align with emerging continuing professional development systems such as the American Board of Medical Specialties Maintenance of Certification® (MOC) and the Federation of State Medical Boards Maintenance of Licensure (MOL) initiatives. We believe that we have the right requirements in the right place at the right time. We also believe that our system has a head start in implementing “CME for MOL” and “CME for MOC” because we began our transformation almost a decade ago.

Throughout our ongoing transformation, we have aimed to support accredited providers in meeting the ACCME's higher standards and to demonstrate accredited CME's value to stakeholders. We have focused on opening doors—at our offices, by hosting events that foster open, face-to-face dialogue between the ACCME, accredited providers, and other stakeholders; and throughout the community, by expanding our collaboration, communications, outreach, and education efforts. Here are a few examples from the past few years. We think that these efforts, explained in more detail in the report, illustrate our commitment to following the continuous improvement model embo-
died in the Accreditation Criteria. We expect physician learners and accredited providers to engage in ongoing learning, change, and improvement—and we hold ourselves to the same expectations.

**Strengthening collaboration.**
From roundtables bringing together the ACCME Board of Directors, member organizations, and a spectrum of CME leaders, to a series of town hall–style meetings for specific accredited provider groups, we have convened events to foster high-level interchange with our stakeholders about the challenges and opportunities facing accredited CME. These events have laid the foundation for an ongoing dialogue about how to advance CME's contributions to health care quality initiatives.

**Expanding education to meet measured needs.**
To assist accredited providers in attaining and maintaining accreditation, we produced an Education and Training section of our Web site, which offers a range of multimedia resources, including interviews with CME leaders about innovative approaches. We updated our compendium of accreditation case examples to offer a more user-friendly resource. We initiated phone calls with accredited providers experiencing accreditation challenges to offer them additional assistance in their improvement efforts. We continue to provide face-to-face educational opportunities through our accreditation workshops, newcomers conferences, and town hall meetings at the ACCME offices. We have increased our educational and professional development support for the state medical society system. There are now six ACCME staff who travel to conduct educational sessions in support of the ACCME accreditation system.

**Supporting the intrastate accreditation system.**
In response to a 2006 call from Recognized Accreditors (state medical societies), the ACCME revised its recognition system and created the Markers of Equivalency, an updated set of requirements designed to ensure the consistency of accreditation decision-making across the national and state system. Also in collaboration with ACCME Recognized Accreditors, the ACCME has taken a number of additional steps to strengthen the integration of the state and national systems. Several representatives from the intrastate system now serve on the national-level Accreditation Review Committee and the ACCME Board of Directors. We've also continued to enhance the support and resources we provide for the intrastate accreditation system, including regional face-to-face forums, monthly webinars, an annual conference, and professional development training for new CME staff members at state medical societies.

**Supporting interprofessional education.**
National organizations, such as the Institute of Medicine, have identified team-based care as a critical component of health care improvement. To reward organizations for offering team-focused education that improves patient care, we partnered with the Accreditation Council for Pharmacy Education and the American Nurses Credentialing Center to develop a joint accreditation initiative. In 2010, we were proud to announce that two continuing health care education providers became the first organizations to achieve joint accreditation.
Supporting international continuing medical education.
As we have done throughout the years, we continue to support global CME initiatives. In 2010, ACCME executive staff welcomed visitors from the Jordanian Medical Council, who are seeking assistance for the development of accreditation standards; made two presentations at the First China International Continuing Medical Education Conference in Beijing; and received an invitation to assist in the development of a CME system in Ethiopia. The ACCME recognized the Association of Faculties of Medicine of Canada as substantially equivalent to the ACCME’s accreditation system; the Royal College of Physicians and Surgeons of Canada received this recognition in 2008.

Increasing transparency and accountability.
To further transparency, we published more information about accredited providers, accreditation decisions, and compliance findings. To strengthen accountability, we accelerated the improvement process for providers found in noncompliance. We expanded the definition of a commercial interest to further safeguard the separation of promotion from education. Because of these improvements, we were honored to testify before the U.S. Senate Committee on Aging in July 2009, stating that the ACCME is an effective firewall between industry marketing and accredited CME. We continue to advance transparency and accountability; in 2010, we revised our complaints process to include providers’ responsibilities to inform learners if an activity is found in noncompliance.

Increasing Interactions with government.
Through our interactions with government, we seek to inform public officials about the value of accredited CME, and to provide support for national health care quality and safety initiatives. We have continued our long-standing collaboration with the White House Office of National Drug Control Policy and made a presentation to a Food and Drug Administration Center for Drug Evaluation and Research Advisory Committee about how accredited CME could be a strategic asset to Risk Evaluation and Mitigation Strategies (REMS) initiatives. We were invited to several meetings with the senior staff of the Office of Health Information Technology, Department of Health and Human Services, to discuss proposals for better integrating health IT and professional medical education, including CME.

Supporting our volunteers.
The ACCME is successful in its mission only because of its dedicated volunteers. Taking into account national-level volunteers, intrastate accreditation volunteers, and CME committee volunteers, approximately 20,000 people across the country support the system. We deeply appreciate their expertise and efforts, and we continue to enhance our volunteer education resources, which include a new Surveyor Resources Web page, a newsletter, and ongoing training.

The next 100 years
One hundred years ago, the Flexner Report generated a complete restructuring of medical education, elevating standards and professionalism. Now, the continuing medical education enterprise is undergoing a time of profound reflection and improvement, raising CME to a higher level of effectiveness and relevancy. Accredited providers are facilitating self-directed, practice-based education that supports physicians’ commitment to lifelong learning. Technological advances enable providers to offer education through simulations and just-in-time learning, and to utilize electronic records to evaluate physicians’ changes in practice and patient care. Accredited CME providers are implementing educational strategies to help physicians overcome barriers to change and they are part-
nering with quality initiatives within their institutions, health systems, and communities. Accredited providers have successfully demonstrated that CME is a Bridge to Quality™.

Now in its 30th year, the ACCME remains dedicated to maintaining a voluntary, self-regulated accreditation system and to supporting accredited CME providers and other stakeholders in their efforts to close health care quality gaps, address emerging public health concerns, and produce CME that matters to patient care. We hope that this report shows you that the ACCME accreditation system is your accreditation system, and we look forward to working with you to build CME’s future.

Richard B. Reiling, MD  
2011 Chair  
ACCME Board of Directors

Sandra B. Norris, MBA  
2011 Vice-Chair  
ACCME Board of Directors

Murray Kopelow, MD  
MS(Comm), FRCPC  
ACCME Chief Executive and Secretary
The Accreditation Council for Continuing Medical Education (ACCME®), a nonprofit corporation based in Chicago, is responsible for accrediting US institutions that offer continuing medical education (CME) to physicians and other health care professionals. The ACCME’s mission is to identify, develop, and promote rigorous national standards for quality CME that improves physician performance and medical care for patients and their communities.

The ACCME was founded in 1981 in order to create a national accreditation system. It is the successor to the Liaison Committee on Continuing Medical Education and the American Medical Association’s Committee on Accreditation of Continuing Medical Education. The ACCME’s founding and current member organizations are the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, the Association for Hospital Medical Education, the Council of Medical Specialty Societies, and the Federation of State Medical Boards of the United States. The ACCME is supported solely by accredited provider fees and workshop registration fees.

The ACCME has long-standing collaborative relationships with the other institutions that oversee national CME accreditation and credit systems, including the American Academy of Family Physicians, the American Medical Association, and the American Osteopathic Association. (In this report, the terms “accredited CME” and “accredited provider” refer to programs and organizations within the ACCME accreditation system.) The ACCME also works in collaboration with other health care regulatory bodies.

ACCME accreditation is a voluntary self-regulatory system that assures the public and the medical community that accredited CME is a strategic partner in health care quality and safety initiatives, providing physicians with relevant, effective education that meets their learning and practice needs. Accreditation standards ensure that CME is designed to be independent, free of commercial bias, and based on valid content. The ACCME accreditation system is recognized as a national model by federal and state government agencies, other health care accrediting bodies, and the profession of medicine. Committed to continuous improvement, the ACCME is responsive to the evolving medical education and health care environments.

There are approximately 700 ACCME-accredited organizations, known as CME providers, including medical schools; nonprofit physician membership organizations, such as medical specialty and state medical societies; hospitals/health care delivery systems; publishing and education companies; government and military organizations; and insurance and managed-care companies. The ACCME also recognizes 45 state and territory medical societies as accreditors for approximately 1,450 local organizations, such as community hospitals and county medical societies, offering CME. In total, there are approximately 2,100 accredited CME providers, including organizations accredited by the ACCME and by ACCME Recognized Accreditors.

Accredited educational activities draw more than 17 million health care professionals annually. These activities are offered through a variety of channels, including live meetings and courses, medical
journals, and the Internet. Physicians participate in accredited CME activities in support of their own practice-based learning and improvement. Participation also helps them meet requirements for maintenance of licensure, maintenance of specialty board certification, credentialing, membership in professional societies, and other professional privileges.

FOR MORE INFORMATION
The following resources are available on our Web site, www.accme.org.

Accreditation Council for Continuing Medical Education
American Medical Association’s Committee on Accreditation of Continuing Medical Education
American Board of Medical Specialties
American Hospital Association
American Medical Association
Association of American Medical Colleges
Association for Hospital Medical Education
Council of Medical Specialty Societies
Federation of State Medical Boards of the United States
American Academy of Family Physicians
American Osteopathic Association
The Accreditation Council for Continuing Medical Education’s (ACCME®) primary responsibility, as defined by its mission, is to identify, develop, and promote standards for quality continuing medical education. Since its founding in 1981, the ACCME has focused on creating accreditation requirements that are relevant to physicians’ lifelong learning needs and responsive to changes in the health care environment. The purpose of the ACCME accreditation requirements is to ensure that CME is independent, based on valid content, and contributes to health care improvement for patients and their communities.

The ACCME develops and updates its accreditation requirements through a deliberative process that includes reviewing and analyzing relevant research and obtaining feedback from multiple constituents, including accredited providers. (For more about the ACCME’s standard-setting process, see “Governance, Leadership, and Collaboration.”)

There are three parts to ACCME accreditation requirements: the Accreditation Criteria, the ACCME Standards for Commercial Support®, and the ACCME Policies.

The Accreditation Criteria

Released in 2006, the Accreditation Criteria are based on a learner-centered, continuous improvement model of CME. The 22 Accreditation Criteria call on accredited providers to offer educational activities that address physicians’ real-world practice needs, whether their scope of practice is in clinical care, research, health care administration, or other areas of medicine. The Criteria state that CME programs should be designed to change either physicians’ competence, by teaching them strategies for translating new knowledge into action, or physicians’ performance (what they actually do in practice), or patient outcomes. Accredited providers must also evaluate their programs’ effectiveness in achieving these goals.

The Accreditation Criteria are divided into three levels. To achieve Provisional Accreditation, a two-year term, providers must comply with all Level I Criteria (1, 2, 3, and 7–12). Providers seeking full Accreditation or reaccreditation for a four-year term must comply with Level 2 Criteria (1–15). To achieve Accreditation with Commendation, Level 3, a six-year term, providers must comply with all 22 Criteria. (For information about the accreditation decision-making process, see the chapter “The National Accreditation System.”)

The 2006 Accreditation Criteria build on two earlier sets of accreditation guidelines. The first set, called the Seven Essentials and established in 1982, laid the foundation for an accreditation system. They required providers to create CME mission statements, use a needs assessment process to plan educational activities, develop educational objectives for each activity, and evaluate the effectiveness of their overall CME programs.
In 1998, the ACCME updated the guidelines, releasing the Essential Areas and Their Elements, or System98. The revised model encouraged accredited providers to focus on CME that linked educational needs with desired results, and to evaluate the effectiveness of their CME activities in meeting those educational needs. The ACCME continued to expect accredited providers to implement processes for reviewing and improving their overall CME programs.

The ACCME developed the 2006 Accreditation Criteria in response to changes in the health care environment. The government, the public, and organized medicine called on the CME system to be even more accountable in facilitating and demonstrating physician practice improvement. The ACCME was asked by its member organizations and others to assist in repositioning the CME enterprise as a strategic asset to the quality improvement and patient safety imperatives of the US health care system, such as addressing health care disparities, reducing medical errors, and preventing and treating chronic disease. The Institute of Medicine reports “To Err Is Human: Building a Safer Health System, Crossing the Quality Chasm” and “Health Professions Education: A Bridge to Quality” identified critical factors for improving the quality of care.

The ACCME Board of Directors Task Force on Competency and the Continuum of Medical Education received oral and written testimony from a wide representation of organizations within the CME enterprise, as well as other organizations interested in physician education. Its final report, released in April 2004, stated, “To meet the needs of the 21st-century physician, CME will provide support for the physicians’ professional development based on continuous improvement in the knowledge, strategies, and performance of practice necessary to provide optimal patient care.” The Accreditation Criteria were created to fulfill those goals and are designed to align with the American Board of Medical Specialties Maintenance of Certification® initiative and the Federation of State Medical Boards Maintenance of Licensure Initiative.

Learning and change are the goals of the Accreditation Criteria, both for the learners and providers, as described in the article “Accreditation for Learning and Change: Quality and Improvement as the Outcome,” by ACCME Deputy Chief Executive Kate Regnier, et al., Journal of Continuing Education in the Health Professions, September 2005. Under the 2006 Accreditation Criteria, all providers must not only analyze changes in learners, they must also analyze their own effectiveness at meeting their CME program’s mission and identify plans for improvement.

The 2006 Accreditation Criteria foster leadership, collaboration, and system-wide change by rewarding CME providers with Accreditation with Commendation, if, among other requirements, they act as a strategic partner in quality initiatives within their institution, health system, or community through collaborative alliances. Such accredited providers must implement educational strategies to address, remove, or overcome barriers to physician change.

The Accreditation Criteria are appended at the end of this chapter.
ACCME Standards for Commercial Support℠: Standards to Ensure Independence in CME Activities

The 2004 ACCME Standards for Commercial Support℠: Standards to Ensure Independence in CME Activities are designed to make certain that CME activities are independent and free of commercial bias. The Standards impose stringent restrictions on CME providers’ interactions with drug/device companies and other companies the ACCME defines as a commercial interest. The ACCME allows providers to accept company funding for CME activities, but prohibits any commercial influence, direct or indirect, over CME content.

The ACCME Standards for Commercial Support comprise six standards: independence, resolution of personal conflicts of interest, appropriate use of commercial support, appropriate management of associated commercial promotion, content and format without commercial bias, and disclosures relevant to potential commercial bias.

Building on guidelines that the ACCME first issued in 1987 and formally adopted in 1992, the 2004 ACCME Standards for Commercial Support added the following elements:

- CME providers must ensure that CME planning decisions are made free of the control of a commercial interest, including the selection of all persons and organizations that will be in a position to control CME content.

- A commercial interest cannot take the role of a nonaccredited partner in a joint sponsorship relationship.

- Providers must be able to show that everyone who is in a position to control the content of educational activities has disclosed to the provider all relevant financial relationships with any commercial interest.

- Those who refuse to disclose relevant financial relationships are disqualified from participation in planning or delivering education.

- Providers must implement a mechanism to identify and resolve all conflicts of interest for all persons in control of content, including planners, teachers, and authors.

- The provider must have written policies and procedures governing honoraria for planners, teachers, and authors.

When making decisions about implementing the ACCME Standards for Commercial Support, the ACCME says that CME providers must always defer to independence from commercial interests, transparency, and the separation of CME from product promotion. In other words, the purpose of CME must be to serve physicians’ learning and practice needs and to promote public health.

The full text of the ACCME Standards for Commercial Support is appended at the end of this chapter.
ACCME POLICIES

In addition to the Accreditation Criteria and ACCME Standards for Commercial Support, the ACCME issues policies that supplement the requirements. These policies offer more specific guidelines on areas including educational formats, such as Internet and journal CME, and business practices, such as records retention. In some cases policies are developed to address emerging issues, such as the clinical content validation policies described below.

Accredited providers must adhere to the ACCME policies that are relevant to their organizations, as well as to the Accreditation Criteria and the ACCME Standards for Commercial Support.

POLICY EXAMPLE: CLINICAL CONTENT VALIDATION POLICIES

In 2002, the ACCME released its Clinical Content Validation Policies to ensure that patient care recommendations made during CME activities are based on scientific evidence.

- All recommendations involving clinical medicine and CME activities must be based on evidence that is accepted within the profession of medicine.
- All scientific research used to support patient care recommendations must conform to generally accepted standards of experimental design, data connection, and analysis.
- Providers are ineligible for ACCME accreditation or reaccreditation if their activities promote treatments that are known to have risks or dangers that outweigh the benefits or are known to be ineffective in patient treatment.

FOR MORE INFORMATION

The following resources are available on our Web site, www.accme.org.

About the ACCME

ACCME Accreditation Criteria

ACCME Board of Directors Task Force on Competency and the Continuum Final Report

ACCME Standards for Commercial Support: Standards to Ensure Independence in CME Activities

ACCME Policies

Ask ACCME
### ACCME Accreditation Criteria

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<th>Level 1 Provider</th>
<th>Level 2 Provider</th>
<th>Level 3 Provider</th>
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<tbody>
<tr>
<td></td>
<td>Provisional Accreditation</td>
<td>Full Accreditation</td>
<td>Accreditation with Commendation</td>
</tr>
<tr>
<td>1.</td>
<td>The provider has a CME mission statement that includes all of the basic components (CME purpose, content areas, target audience, type of activities, expected results) with expected results articulated in terms of changes in competence, performance, or patient outcomes that will be the result of the program.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2.</td>
<td>The provider incorporates into CME activities the educational needs (knowledge, competence, or performance) that underlie the professional practice gaps of their own learners.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3.</td>
<td>The provider generates activities/educational interventions that are designed to change competence, performance, or patient outcomes as described in its mission statement.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>4.</td>
<td>The provider generates activities/educational interventions around content that matches the learners’ current or potential scope of professional activities.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>5.</td>
<td>The provider chooses educational formats for activities/interventions that are appropriate for the setting, objectives and desired results of the activity.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>6.</td>
<td>The provider develops activities/educational interventions in the context of desirable physician attributes (e.g., IOM competencies, ACGME Competencies).</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>7.</td>
<td>The provider develops activities/educational interventions independent of commercial interests (Standards for Commercial Support 1, 2 and 6).</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>8.</td>
<td>The provider appropriately manages commercial support (if applicable, Standard for Commercial Support 3).</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>9.</td>
<td>The provider maintains a separation of promotion from education (Standard for Commercial Support 4).</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>10.</td>
<td>The provider actively promotes improvements in health care and NOT proprietary interests of a commercial interest (Standard for Commercial Support 5).</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>11.</td>
<td>The provider analyzes changes in learners (competence, performance, or patient outcomes) achieved as a result of the overall program’s activities/educational interventions.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>12.</td>
<td>The provider gathers data or information and conducts a program-based analysis on the degree to which the CME mission of the provider has been met through the conduct of CME activities/educational interventions.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>13.</td>
<td>The provider identifies, plans and implements the needed or desired changes in the overall program (e.g., planners, teachers, infrastructure, methods, resources, facilities, interventions) that are required to improve on ability to meet the CME mission.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>14.</td>
<td>The provider demonstrates that identified program changes or improvements, that are required to improve on the provider’s ability to meet the CME mission, are underway or completed.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>15.</td>
<td>The provider demonstrates that the impacts of program improvements, that are required to improve on the provider’s ability to meet the CME mission, are measured.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>16.</td>
<td>The provider operates in a manner that integrates CME into the process for improving professional practice.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>17.</td>
<td>The provider utilizes non-education strategies to enhance change as an adjunct to its activities/educational interventions (e.g., reminders, patient feedback).</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>18.</td>
<td>The provider identifies factors outside the provider’s control that impact on patient outcomes.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>19.</td>
<td>The provider implements educational strategies to remove, overcome or address barriers to physician change.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>20.</td>
<td>The provider builds bridges with other stakeholders through collaboration and cooperation.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>21.</td>
<td>The provider participates within an institutional or system framework for quality improvement.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>22.</td>
<td>The provider is positioned to influence the scope and content of activities/educational interventions.</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
STANDARD 1: Independence

1.1 A CME provider must ensure that the following decisions were made free of the control of a commercial interest. (See www.accme.org for a definition of a ‘commercial interest’ and some exemptions.)
   (a) Identification of CME needs;
   (b) Determination of educational objectives;
   (c) Selection and presentation of content;
   (d) Selection of all persons and organizations that will be in a position to control the content of the CME;
   (e) Selection of educational methods;
   (f) Evaluation of the activity.

1.2 A commercial interest cannot take the role of non-accredited partner in a joint sponsorship relationship.

STANDARD 2: Resolution of Personal Conflicts of Interest

2.1 The provider must be able to show that everyone who is in a position to control the content of an education activity has disclosed all relevant financial relationships with any commercial interest to the provider. The ACCME defines “relevant financial relationships” as financial relationships in any amount occurring within the past 12 months that create a conflict of interest.

2.2 An individual who refuses to disclose relevant financial relationships will be disqualified from being a planning committee member, a teacher, or an author of CME, and cannot have control of, or responsibility for, the development, management, presentation or evaluation of the CME activity.

2.3 The provider must have implemented a mechanism to identify and resolve all conflicts of interest prior to the education activity being delivered to learners.

STANDARD 3: Appropriate Use of Commercial Support

3.1 The provider must make all decisions regarding the disposition and disbursement of commercial support.

3.2 A provider cannot be required by a commercial interest to accept advice or services concerning teachers, authors, or participants or other education matters, including content, from a commercial interest as conditions of contributing funds or services.

3.3 All commercial support associated with a CME activity must be given with the full knowledge and approval of the provider.

Written agreement documenting terms of support

3.4 The terms, conditions, and purposes of the commercial support must be documented in a written agreement between the commercial supporter that includes the provider and its educational partner(s). The agreement must include the provider, even if the support is given directly to the provider’s educational partner or a joint sponsor.

3.5 The written agreement must specify the commercial interest that is the source of commercial support.

3.6 Both the commercial supporter and the provider must sign the written agreement between the commercial supporter and the provider.

Expenditures for an individual providing CME

3.7 The provider must have written policies and procedures governing honoraria and reimbursement of out-of-pocket expenses for planners, teachers and authors.

3.8 The provider, the joint sponsor, or designated educational partner must pay directly any teacher or author honoraria or reimbursement of out-of-pocket expenses in compliance with the provider’s written policies and procedures.

3.9 No other payment shall be given to the director of the activity, planning committee members, teachers or authors, joint sponsor, or any others involved with the supported activity.

3.10 If teachers or authors are listed on the agenda as facilitating or conducting a presentation or session, but participate in the remainder of an educational event as a learner, their expenses can be reimbursed and honoraria can be paid for their teacher or author role only.

Expenditures for learners

3.11 Social events or meals at CME activities cannot compete with or take precedence over the educational events.
3.12 The provider may not use commercial support to pay for travel, lodging, honoraria, or personal expenses for non-teacher or non-author participants of a CME activity. The provider may use commercial support to pay for travel, lodging, honoraria, or personal expenses for bona fide employees and volunteers of the provider, joint sponsor or educational partner.

Accountability

3.13 The provider must be able to produce accurate documentation detailing the receipt and expenditure of the commercial support.

STANDARD 4. Appropriate Management of Associated Commercial Promotion

4.1 Arrangements for commercial exhibits or advertisements cannot influence planning or interfere with the presentation, nor can they be a condition of the provision of commercial support for CME activities.

4.2 Product-promotion material or product-specific advertisement of any type is prohibited in or during CME activities. The juxtaposition of editorial and advertising material on the same products or subjects must be avoided. Live (staffed exhibits, presentations) or enduring (printed or electronic advertisements) promotional activities must be kept separate from CME.

- For **print**, advertisements and promotional materials will not be interleaved within the pages of the CME content. Advertisements and promotional materials may face the first or last pages of printed CME content as long as these materials are not related to the CME content they face and are not paid for by the commercial supporters of the CME activity.
- For **computer based**, advertisements and promotional materials will not be visible on the screen at the same time as the CME content and not interleaved between computer ‘windows’ or screens of the CME content.
- For **audio and video recording**, advertisements and promotional materials will not be included within the CME. There will be no ‘commercial breaks.’
- For **live, face-to-face CME**, advertisements and promotional materials cannot be displayed or distributed in the educational space immediately before, during, or after a CME activity. Providers cannot allow representatives of Commercial Interests to engage in sales or promotional activities while in the space or place of the CME activity.

4.3 Educational materials that are part of a CME activity, such as slides, abstracts and handouts, cannot contain any advertising, trade name or a product-group message.

4.4 Print or electronic information distributed about the non-CME elements of a CME activity that are not directly related to the transfer of education to the learner, such as schedules and content descriptions, may include product-promotion material or product-specific advertisement.

4.5 A provider cannot use a commercial interest as the agent providing a CME activity to learners, e.g., distribution of self-study CME activities or arranging for electronic access to CME activities.

STANDARD 5. Content and Format without Commercial Bias

5.1 The content or format of a CME activity or its related materials must promote improvements or quality in healthcare and not a specific proprietary business interest of a commercial interest.

5.2 Presentations must give a balanced view of therapeutic options. Use of generic names will contribute to this impartiality. If the CME educational material or content includes trade names, where available trade names from several companies should be used, not just trade names from a single company.

STANDARD 6. Disclosures Relevant to Potential Commercial Bias

**Relevant financial relationships of those with control over CME content**

6.1 An individual must disclose to learners any relevant financial relationship(s), to include the following information:

- The name of the individual;
- The name of the commercial interest(s);
- The nature of the relationship the person has with each commercial interest.

6.2 For an individual with no relevant financial relationship(s) the learners must be informed that no relevant financial relationship(s) exist.

**Commercial support for the CME activity**

6.3 The source of all support from commercial interests must be disclosed to learners. When commercial support is ‘in-kind’ the nature of the support must be disclosed to learners.

6.4 ‘Disclosure’ must never include the use of a trade name or a product-group message.

**Timing of disclosure**

6.5 A provider must disclose the above information to learners prior to the beginning of the educational activity.
There are approximately 700 organizations across the United States (see Figure 1), accredited by the Accreditation Council for CME (ACCME®) to provide continuing medical education. These accredited providers, representing a range of organizational types, offer CME primarily to national or international audiences of physicians and other health care professionals. This chapter addresses the accreditation system for providers directly accredited by the ACCME.

The ACCME also has a process for “recognizing” state and territory medical societies as accreditors of intrastate providers. This system is discussed in the chapter “The Intrastate Accreditation System.”

The Accreditation Process

The ACCME accreditation system is based on a model of self-regulation, peer evaluation, and quality assurance. When applying for accreditation or reaccreditation, CME providers complete a self-study/self-assessment process to reflect on their CME programs and activities and develop plans for continuous improvement.

Each year, the ACCME reviews approximately 200 CME providers, representing about 30 percent of the provider pool. The accreditation review process is based on three sources of data: the self-study report, the performance-in-practice review, and the interview.

The Self-Study Report

As a result of their self-study, CME providers prepare a self-study report. This report is an opportunity for providers to tell their story — to show, in their own words, how their CME programs are a strategic asset to their institutions and the wider health care community, as well as how their CME activities contribute to improving physician competence, performance, and patient care.
CME providers may spend up to nine months conducting a thorough program analysis, and many staff members and volunteers may be involved. This intensive process gives providers the opportunity to step back and reflect on their programs: to assess their commitment to providing CME, analyze their current practices, identify areas for improvement, and determine their future directions.

**THE PERFORMANCE-IN-PRACTICE REVIEW**

During the year, accredited providers submit information about each of their activities through the Program and Activity Reporting System (PARS). From this database, the ACCME selects up to 15 activities to review from the provider’s current accreditation term. The provider then submits materials documenting how these activities fulfilled accreditation requirements. This process enables the ACCME to ensure that accredited providers are consistently complying with requirements on an activity level.

**THE ACCME ACCREDITATION INTERVIEW**

The next step in the process is facilitated by ACCME’s national network of volunteer surveyors. A team of two surveyors reviews the CME provider’s self-study report and performance-in-practice files, and then meets with the provider for the interview portion of the reaccreditation process.

The purpose of the interview is for the provider to explain how the CME program fulfills accreditation requirements, and to discuss its strengths, accomplishments, and challenges. During the interview, surveyors may ask questions or seek clarification about the information the provider supplied in the self-study report and performance-in-practice files, and providers have the opportunity to submit additional material to further demonstrate their compliance.

CME providers also have the opportunity to share with surveyors any strategies their organizations have implemented to achieve their goals and to explain their plans for future improvements. In addition to involving staff and volunteers, some providers invite their organizational leadership to the interview to give them a deeper understanding of the CME program’s efforts and contributions.

The accreditation interviews are designed to be collegial interactions. Surveyors are expected to demonstrate professionalism and to communicate clearly and effectively. Their role is not to offer consultation or feedback regarding the CME provider’s compliance or the possible accreditation outcome. The purpose of the interview is to gather facts and to facilitate fair and accurate decision-making in the next steps of the process.

The surveyors do not make compliance recommendations or decisions. Following the interview, they use standardized forms to answer a series of questions about the self-study report, the performance-in-practice files, and the interview.

Surveyors are expected to disclose conflicts of interest, and will not be assigned to conduct interviews with providers if they have a current or recent affiliation with the organization. CME providers concerned about a conflict of interest may request a new surveyor.

**ABOUT ACCME VOLUNTEER SURVEYORS**

The ACCME accreditation system is supported by a national pool of volunteer surveyors made up of approximately 100 expert CME professionals from all provider types, ensuring that CME providers are
evaluated by their peers. Surveyors include physicians, CME and other health care professionals, and educators. They are nominated by their peers and must fulfill specific qualifications.

Surveyors are supervised by ACCME staff and must achieve and maintain a set of competencies. The ACCME provides them with intensive initial and ongoing training, and professional development and support, including face-to-face training, conference calls, and webinars. Surveyor training includes online polling, which enables surveyors to answer sample compliance questions anonymously. Through this function, the ACCME can monitor for consistency and identify areas that require further training. In addition, the ACCME has created a dedicated Web page that includes links to surveyor newsletters, forms, recorded webinars, and other accreditation resources.

ACCME surveyors play a critical role in the accreditation process. In return for their donation of time and expertise, surveyors receive the opportunity to learn from their colleagues, gain a broader understanding of the CME environment, and contribute to continuous improvement in the accreditation system. Accreditation surveyors receive no honoraria or other form of compensation; however, they are reimbursed for the expenses they incur in compliance with ACCME’s volunteer expense reimbursement policies.

QUALITY ASSURANCE AND PROCESS IMPROVEMENT

After the interview, CME providers are asked to complete an evaluation about the accreditation process. The ACCME uses this feedback to analyze its current practices and make improvements. If a CME provider gives a negative report about the survey process, the ACCME investigates immediately to address the provider’s concerns and resolve problems. If the ACCME deems necessary, it will initiate another survey to remediate the issue.

In 2010, in response to accredited providers’ feedback, the ACCME significantly revised the ACCME Guide to the Accreditation Process to offer a more user-friendly resource. The Accreditation Review Committee formed a work group to review the revised guide to ensure it met CME providers’ needs. The ACCME also gathered and analyzed feedback from providers about the changes to the Guide.

ACCREDITATION DECISION-MAKING

The ACCME has a rigorous, multilevel process for making accreditation and reaccreditation decisions. These decisions are made three times a year. Accreditation decisions are determined through a review by two ACCME committees: first, the Accreditation Review Committee, and second, the Decision Committee of the Board of Directors. All accreditation decisions are then ratified by the full Board of Directors. Throughout the process, the ACCME staff members provide support and guidance to committee members. This multitiered process provides the checks and balances necessary to ensure fair and accurate decisions. In addition, the ACCME uses a criterion-referenced decision-making system to ensure fairness, consistency, and accuracy.

Members of the Accreditation Review Committee, Decision Committee, and Board of Directors must disclose conflicts of interest related to the accreditation decision-making process and recuse themselves if necessary.
The Accreditation Review Committee’s Role in Decision-Making

The surveyors’ reports (Surveyor Report Form and Documentation Review Form) and the CME providers’ materials are forwarded to the Accreditation Review Committee. Each ARC reviewer is assigned five or six CME providers per accreditation cycle. The reviewer checks the materials to make sure they are complete and then determines whether or not the provider has complied with each of the Accreditation Criteria.

An ACCME staff person is assigned to each reviewer to provide support and to monitor the review process. The staff reviews the surveyors’ observations and the reviewer’s findings for validity and congruity, addressing any differences that are found between the two data sets, and ensuring that the accreditation recommendations are valid and supported by the data.

The Accreditation Review Committee meets three times a year. Each meeting lasts two days and is held at the ACCME’s offices. In addition to the ARC members, about 10 ACCME staff members, including the executive staff, attend the meetings to provide support and monitor the process. At the beginning of each meeting, prior to discussions of individual CME provider practices, members engage in exercises to come to consensus about new or unusual compliance issues regarding the providers under review.

Members present their findings for the CME providers they have reviewed, and then explain their recommendations. All the providers’ materials are in the meeting room, available for the members to review. ARC members are not allowed to discuss “hearsay information”—they must make their decisions based only on the data gathered during the accreditation process. The entire committee asks questions and discusses the compliance issues until they arrive at a consensus and recommend an accreditation decision.

The ACCME implements quality-control measures to make sure that ARC members determine the correct compliance and noncompliance findings for each criterion, and to ensure that their decisions are consistent and impartial. The ACCME produces color-coded grids showing the compliance and noncompliance findings for each criterion and the final accreditation decision for each CME provider in the cohort, so that the ACCME staff, ARC members, and Board members can compare accreditation decisions, making sure that providers that have similar findings receive the same accreditation status.

In the example of a color-coded grid on the following page, each row is a CME provider’s compliance profile. Each column is an accreditation requirement (Criteria 1-22 and policies). Each cell represents a compliance finding: yellow = compliance (c), red = noncompliance (n), white = not ap-
plicable (n/a), gray = evidence not submitted (en). Based on the compliance profile of the CME provider, the committee reaches a decision, as indicated by the section headings in black. Further information on the ACCME's compliance findings and decisions can be found later in this chapter.

**Figure 2. Sample grid used in the ACCME decision-making process**

| 1   | 2  | 3   | 4   | 5   | 6   | 7   | 8   | 9   | 10  | 11  | 12  | 13  | 14  | 15  | 16  | 17  | 18  | 19  | 20  | 21  | 22  |
|-----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
|     |    |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| **Nonaccreditation from initial application** |
| C   | n  | C   | n/a | n/a | n/a | C   | C   | n/a | C   | n/a | C   | C   | C   | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| C   | C  | n/a | n/a | n/a | C   | C   | C   | n/a | C   | n/a | C   | C   | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
|     |    |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| **Probation with progress report** |
| C   | n  | C   | C   | n/a | n/a | n/a | n/a | n/a | n/a | C   | n/a | C   | C   | n/a | n/a | C   | C   | n/a | n/a | n/a | n/a |
| C   | n/a| C   | C   | C   | n/a | n/a | n/a | n/a | n/a | C   | n/a | C   | C   | n/a | n/a | C   | C   | n/a | n/a | n/a | n/a |
|     |    |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| **Accreditation with progress report** |
| C   | n  | C   | C   | n/a | n/a | C   | n/a | C   | n/a | C   | n/a | C   | n/a | C   | n/a | C   | n/a | C   | n/a | C   | n/a |
| n/a | C   | C   | n/a | n/a | C   | n/a | C   | n/a | C   | n/a | C   | n/a | C   | n/a | C   | n/a | C   | n/a | C   | n/a |
|     |    |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| **Provisional Accreditation** |
| C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | n/a | n/a | n/a | n/a | n/a |
| C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | n/a | n/a | n/a | n/a | n/a |
|     |    |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| **Accreditation** |
| C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | n/a | n/a | n/a | n/a | n/a |
| C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | n/a | n/a | n/a | n/a | n/a |
|     |    |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| **Accreditation with Commendation** |
| C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | n/a | n/a | n/a | n/a | n/a |
| C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | C   | n/a | n/a | n/a | n/a | n/a |
|     |    |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |

| C = compliance | n/c = noncompliance | n/a = not applicable | en = evidence not submitted |

**About the Accreditation Review Committee**

ARC members are expert CME professionals who have in-depth knowledge concerning the philosophy and process of CME, the ACCME, and accreditation requirements. Some ARC members have served as surveyors; some have experience with a CME program accredited by the ACCME or a Recognized Accr

The ARC comprises up to 30 members. Of these, at least 21 are nominated by the ACCME’s member organizations and elected by the ACCME Board of Directors. The remaining members are nominated by the ACCME’s CEO and elected by the Board. The initial term is two years; members may serve for a maximum of six years.
New ARC members are trained by ACCME staff. They attend their first meeting as observers; at their second meeting they are assigned one review, which they do under the supervision of a staff person. At their third meeting, they begin doing reviews on their own.

**The Decision Committee’s Role in Decision-Making**

After the ARC completes its work, the Board of Directors’ Decision Committee reviews the materials, which include narrative descriptions of noncompliance findings and justifications for the accreditation decisions. The ARC chair informs the committee about any compliance issues that required new interpretations. The Decision Committee compares the compliance grid for the provider cohort under review with grids from previous cohorts to make sure that decision-making has been consistent. The committee then makes accreditation decision recommendations to the full Board.

**The Board of Directors’ Role in Decision-Making**

As the last step in the accreditation decision-making process, the full Board of Directors ratifies the decisions. All accreditation decisions must be ratified by the ACCME Board of Directors; through this ratification, the Board of Directors ensures that the accreditation process was conducted according to the ACCME's published policies and procedures.

**Compliance Findings**

For each applicable accreditation requirement, an accredited provider receives one of the following compliance findings:

- **Compliance**: The CME provider fulfilled the ACCME’s requirements for the specific criterion or policy.

- **Noncompliance**: The CME provider did not fulfill the ACCME’s requirements for the specific criterion or policy.

- **Not applicable**: The CME provider was not required to comply with the specific criterion or policy. For example, initial applicants must comply with Level I Criteria, (1, 2, 3, and 7–12) in order to be eligible for Provisional Accreditation and would receive a ruling of “not applicable” for the other Criteria. CME providers seeking reaccreditation would receive a finding of “not applicable” in policy areas that do not apply to the types of activities they produce.

- **Evidence not submitted**: The CME provider chose not to submit documentation to demonstrate compliance with Criteria 16–22. Providers applying for full reaccreditation must meet the requirements of Level 2 Criteria (1–15), but are not required to demonstrate compliance with Level 3 Criteria (16–22). If the CME provider chose not to submit documentation to demonstrate compliance for Criteria 16–22, the provider would receive a finding of “evidence not submitted” for those Criteria.

The compliance findings presented in the following tables and grids enable the ACCME, CME providers, and other stakeholders to identify compliance trends. The ACCME analyzes this information to assess providers’ educational needs and develop strategies for improving the accreditation process.
Figure 3. ACCME Findings by Criterion (n=413) November 2008 through November 2010

Figure 3 “ACCME Findings by Criterion” shows the percentage of accreditation findings by criterion with the accreditation criteria. Green = Compliance, Red = Noncompliance, Blue = Not Applicable, Gray = Evidence not Submitted.
TABLE 1 Accreditation Compliance Rates by Cohort illustrates compliance rates for each accreditation cohort. The rate of compliance is shown by percentage for each criterion. This analysis allows the ACCME to assess compliance and noncompliance trends.

### Accreditation Compliance Rates by Cohort (%)

<table>
<thead>
<tr>
<th>Criterion 1</th>
<th>Nov 08</th>
<th>Mar 09</th>
<th>Jul 09</th>
<th>Nov 09</th>
<th>Mar 10</th>
<th>Jul 10</th>
<th>Nov 10</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance</td>
<td>100</td>
<td>96</td>
<td>95</td>
<td>100</td>
<td>100</td>
<td>98</td>
<td>100</td>
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<td>Noncompliance</td>
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<td>4</td>
<td>5</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Criterion 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance</td>
<td>64</td>
<td>72</td>
<td>72</td>
<td>81</td>
<td>70</td>
<td>86</td>
<td>83</td>
<td>75</td>
</tr>
<tr>
<td>Noncompliance</td>
<td>36</td>
<td>28</td>
<td>28</td>
<td>19</td>
<td>30</td>
<td>14</td>
<td>17</td>
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</tr>
<tr>
<td>Criterion 3</td>
<td></td>
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<td></td>
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<td>88</td>
<td>84</td>
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<td>12</td>
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<td>93</td>
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<tr>
<td>Noncompliance</td>
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ACCREDITATION DECISIONS

The decision-making process assesses a CME provider’s compliance or noncompliance with each individual accreditation requirement. Based on these compliance findings, the ACCME decides on the provider’s accreditation status, using one of these five options:

1. **Provisional Accreditation** is a two-year term given to initial applicants that comply with Level 1 Accreditation Criteria (1, 2, 3, and 7–12).

2. **Accreditation** is the standard, four-year term awarded to accredited providers. Providers may be required to submit progress reports; see further explanation below.

3. **Accreditation with Commendation** confers a six-year term of accreditation and is available only to providers seeking reaccreditation, not to initial applicants. Providers must demonstrate compliance with all 22 Accreditation Criteria to achieve Accreditation with Commendation.

4. **Probation** is given to accredited providers that have serious problems meeting ACCME requirements. Probation may also be given to providers whose progress reports are rejected. (Information on progress reports follows.)

5. **Nonaccreditation**: Although Nonaccreditation decisions are rare, the ACCME does make that determination in the following circumstances.
   - An initial applicant is not in compliance with all Level 1 Accreditation Criteria.
   - A provisionally accredited provider has serious noncompliance issues.
   - A provider on Probation is found in noncompliance with one or more of the Criteria.

**Figure 4. Accreditation Decisions for all Providers Assessed Using the 2006 Accreditation Criteria from November 2008 – November 2010 (N=413)**
Figure 5. The percentage of each type of accreditation decision that has been made under the 2006 Accreditation Criteria broken out by provider type. Decisions were made between November 2008 and November 2010 (N = 413).

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<td>4</td>
</tr>
<tr>
<td>Nonprofit other (n = 16)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>9</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>17</td>
<td>5</td>
</tr>
<tr>
<td>Nonprofit physician membership organization (n = 153)</td>
<td>67</td>
<td>6</td>
<td>50</td>
<td>22</td>
<td>36</td>
<td>4</td>
<td>63</td>
<td>10</td>
<td>61</td>
<td>94</td>
<td>45</td>
<td>13</td>
</tr>
<tr>
<td>Not classified (n = 29)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>9</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>7</td>
<td>17</td>
<td>5</td>
</tr>
<tr>
<td>Publishing/education company (n = 89)</td>
<td>11</td>
<td>1</td>
<td>11</td>
<td>5</td>
<td>6</td>
<td>1</td>
<td>8</td>
<td>12</td>
<td>3</td>
<td>1</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>School of medicine (n = 62)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>9</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>7</td>
<td>17</td>
<td>5</td>
</tr>
</tbody>
</table>
### Table 2. A Comparison of Providers’ Accreditation Status Before and After Accreditation Decisions Under the 2006 Criteria (n)

<table>
<thead>
<tr>
<th>Providers’ incoming status at time of decision</th>
<th>Accreditation w/ Commendation</th>
<th>Accreditation</th>
<th>Provisional Accreditation</th>
<th>Accreditation w/ progress report</th>
<th>Probation</th>
<th>Non-accreditation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation (n=38)</td>
<td>23</td>
<td>4</td>
<td>not an option</td>
<td>11</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Accreditation (n=289)</td>
<td>38</td>
<td>48</td>
<td>not an option</td>
<td>170</td>
<td>33</td>
<td>0</td>
</tr>
<tr>
<td>Provisional Accreditation (n=40)</td>
<td>6</td>
<td>9</td>
<td>0</td>
<td>25</td>
<td>not an option</td>
<td>0</td>
</tr>
<tr>
<td>Initial (n=43)</td>
<td>not an option</td>
<td>not an option</td>
<td>22</td>
<td>not an option</td>
<td>not an option</td>
<td>21</td>
</tr>
<tr>
<td>Probation (n=3)</td>
<td>0</td>
<td>0</td>
<td>not an option</td>
<td>not an option</td>
<td>not an option</td>
<td>3</td>
</tr>
<tr>
<td>Total number of providers receiving status (n=413)</td>
<td>67</td>
<td>61</td>
<td>22</td>
<td>206</td>
<td>33</td>
<td>24</td>
</tr>
</tbody>
</table>

### Table 3. A Comparison of Providers’ Accreditation Status Before and After Decisions Under the 2006 Criteria by Percentage

<table>
<thead>
<tr>
<th>Providers’ incoming status at time of decision</th>
<th>Accreditation w/ Commendation</th>
<th>Accreditation</th>
<th>Provisional Accreditation</th>
<th>Accreditation w/ progress report</th>
<th>Probation</th>
<th>Non-accreditation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation</td>
<td>61%</td>
<td>11%</td>
<td>not an option</td>
<td>29%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Accreditation</td>
<td>13%</td>
<td>17%</td>
<td>not an option</td>
<td>59%</td>
<td>11%</td>
<td>-</td>
</tr>
<tr>
<td>Provisional Accreditation</td>
<td>15%</td>
<td>23%</td>
<td>-</td>
<td>63%</td>
<td>not an option</td>
<td>-</td>
</tr>
<tr>
<td>Initial</td>
<td>not an option</td>
<td>not an option</td>
<td>51%</td>
<td>not an option</td>
<td>not an option</td>
<td>49%</td>
</tr>
<tr>
<td>Probation</td>
<td>-</td>
<td>-</td>
<td>not an option</td>
<td>not an option</td>
<td>not an option</td>
<td>100%</td>
</tr>
</tbody>
</table>
**PROGRESS REPORTS**

Accredited providers found in Noncompliance with any Level I or Level 2 Criterion (1–15) must submit progress reports within six months to a year to demonstrate that they have come into compliance. If the accredited provider successfully demonstrates compliance, the progress report is accepted and the provider can then complete its four-year accreditation term.

In some cases, the ACCME issues a decision of Clarification Required, which means the accredited provider has addressed the noncompliance issue in the progress report but the ACCME needs additional information at the next reaccreditation review. This information might be needed because the accredited provider has not had an opportunity to demonstrate improvement. As an example: The accredited provider was found noncompliant because it did not submit written letters of agreement with commercial supporters. The accredited provider created a process to comply but has not yet received a grant.

If the ACCME rejects the progress report, the accredited provider will be required to submit a second progress report and/or the ACCME may require a focused accreditation interview to address the areas of noncompliance. The ACCME can also place an accredited provider on Probation or issue a decision of Nonaccreditation after reviewing a progress report.

As of November 2010, the ACCME had reviewed 310 progress reports for accredited providers found in noncompliance with one or more of the 2006 Accreditation Criteria since November 2008. The ACCME accepted 236 of these progress reports (76%) because the providers have demonstrated compliance with all Level I and Level 2 Criteria previously found in noncompliance. One provider has to clarify compliance at its next review. Seventy three (24%) progress reports were rejected for failure to demonstrate compliance in all Criteria originally found in noncompliance. Providers whose progress reports were rejected were assigned an additional progress report and, in some cases, received a change in accreditation status to Probation or Nonaccreditation.

**THE ACCME DECISION REPORT**

Each CME provider receives an individualized ACCME decision report, a formal notification of its accreditation status and term. The decision report also summarizes the ACCME’s compliance findings. CME providers that receive a decision of Probation or Nonaccreditation are entitled to participate in the ACCME’s Reconsideration and Appeals process.
**Scope of the National Accreditation System**

The national accreditation system comprises a spectrum of organizations in the United States, including medical schools; nonprofit physician membership organizations such as medical specialty and state medical societies; hospitals/health care delivery systems; publishing and education companies; government and military organizations; and insurance and managed-care companies. The ACCME asks providers to identify their organizational type so that stakeholders can see the range of organizations offering accredited CME. (See Table 4.)

As illustrated in Table 5, the total number of accredited providers, as well as the distribution among organizational types, has evolved over the years. The current total of 700 accredited providers represents a 10 percent increase since 1998, when there were 632 providers; however the numbers have declined over the past few years since the 2007 peak of 736 providers. This decline is due to a variety of factors, including changes in the economic, regulatory, and health care environments.

### Table 4. The Count of ACCME-Accredited Providers Grouped by Provider Type as of January 2011

<table>
<thead>
<tr>
<th>Organization Type</th>
<th>Count</th>
<th>% of total providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government or military</td>
<td>14</td>
<td>2%</td>
</tr>
<tr>
<td>Hospital / health care delivery system</td>
<td>84</td>
<td>12%</td>
</tr>
<tr>
<td>Insurance company / managed-care company</td>
<td>14</td>
<td>2%</td>
</tr>
<tr>
<td>Nonprofit other</td>
<td>35</td>
<td>5%</td>
</tr>
<tr>
<td>Nonprofit physician membership organization</td>
<td>260</td>
<td>37%</td>
</tr>
<tr>
<td>Not classified</td>
<td>35</td>
<td>5%</td>
</tr>
<tr>
<td>Publishing / education company</td>
<td>129</td>
<td>19%</td>
</tr>
<tr>
<td>School of medicine</td>
<td>123</td>
<td>18%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>694</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

### Table 5. The Historical Count of ACCME-Accredited Providers Grouped by Provider Type

The decline does not necessarily represent a reduction in physicians’ access to CME. Some providers that withdraw their accreditation status continue to offer CME through partnerships (joint sponsorships) with accredited providers. The number of participants in CME activities has increased steadily over the years.
In 2009, ACCME-accredited providers reported offering more than 95,000 activities, drawing more than 17 million participants. (This figure represents aggregate participant totals, and not the number of unique participants. Participants attending multiple activities are counted multiple times.) For more information about the size and scope of the national accreditation system, see the ACCME Annual Report Data 2009.

**ADDITIONAL VALUE**

**SUPPORT FOR OTHER ACCREDITATION AND CREDIT SYSTEMS**

The ACCME collaborates with other accreditation and credit systems. Through its accreditation process, the ACCME provides support to those institutions’ efforts.

The ACCME accredits institutions that offer continuing medical education, but does not administer a system for providing CME credits directly to learners. During the performance-in-practice review, the ACCME collects evidence from a sample of the accredited provider’s activities to demonstrate its compliance with the requirements of the American Medical Association Physician’s Recognition Award Category 1™ credit system. The ACCME collects and transmits this evidence to the AMA as a service to both the provider and the credit system. The AMA and the ACCME Board of Directors continue to work together to identify potential enhancements to this process.

The ACCME has collaborated with the Accreditation Council for Pharmacy Education (ACPE) and the American Nurses Credentialing Center (ANCC) to develop a joint accreditation process to reward organizations for offering team-focused education that improves patient care. The process decreases the administrative burdens for continuing education providers, as they can take advantage of one unified, streamlined process.

For more information about the joint accreditation process and how the ACCME accreditation system supports other credit systems and physician learning requirements, see the chapter “Governance, Leadership, and Collaboration.”

**SYSTEM IMPROVEMENTS**

**PROGRAM AND ACTIVITY REPORTING SYSTEM (PARS)**

In July 2010, the ACCME opened the Program and Activity Reporting System (PARS), a Web-based portal, designed to streamline and support the collection of program and activity data from ACCME-accredited providers. PARS replaced the PC-based spreadsheets the ACCME previously used to collect data for the reaccreditation process. Instead, accredited providers now submit data on an ongoing basis, deciding when and how often to
upload information. In addition, providers no longer need to submit separate, aggregated data for the ACCME annual reports.

While there are no new data requirements for providers, PARS features optional data fields to collect information about individual CME activity topics, joint sponsors, and commercial support. This additional information will provide a more detailed and comprehensive picture of the national CME enterprise and assist the ACCME, accredited providers, and other stakeholders in demonstrating the value and scope of CME.

**ACCRREDITATION STAFF**

**Open position**, Director, Accreditation and Recognition Services

**David Baldwin, MPA**, Manager of Accreditation Services

**Paul Lawlor**, Assistant Manager of Accreditation and Recognition Services

**Dennis Lott, DEd**, Manager of Accreditation Development

**Erica Hubbard**, Survey Services Coordinator

**Teri McCauley**, Coordinator of Accreditation and Recognition

**Levi Baer**, Administrative Assistant

**F**or **M**ore **I**nformation

The resources below are all available at our Web site, www.accme.org.

**Ask ACCME**

**Program and Activity Reporting System (PARS)**

**Accreditation Process: First-Time Applicants Applying for Accreditation**

**ACCME Accredited Providers: the Reaccreditation Process**

**Accreditation Review Committee**

**Surveyor Qualifications**

**Updated Accreditation Criteria: Surveyor Report Form**

**Updated Accreditation Criteria: Documentation Review Form**

**Tips for the Accreditation Process**: In this four-part video FAQ series on the Education and Training section of the ACCME Web site, Dennis Lott, DEd, ACCME’s Manager of Accreditation Development, shares insights and best practices to guide providers through the accreditation process:

- **Tips for the Accreditation Process: Common Misconceptions About the Accreditation Process**
- **Tips for the Accreditation Process: Preparing for the Interview**
- **Tips for the Accreditation Process: Perspectives on Surveyors**
- **Tips for the Accreditation Process: Addressing Missing or Incomplete Information**
Since 1983, the Accreditation Council for Continuing Medical Education (ACCME®) has implemented a process for recognizing state and territory medical societies as accreditors. The recognition process is a partnership between the ACCME and the state/territory medical societies that empowers the state system to serve as accreditors for intrastate providers.

These providers offer CME primarily to learners from their state or contiguous states as opposed to ACCME-accredited providers, which offer CME primarily to national or international audiences.

There are 45 Recognized Accreditors and approximately 1,450 state-accredited providers. Each year, accredited intrastate providers offer close to 50,000 CME activities in communities across the country, drawing more than four million health care practitioner participants. (This figure represents aggregate participant totals and not the number of unique participants. Participants attending multiple activities are counted multiple times.) For more information about the intrastate system, see the ACCME Annual Report Data 2009.

The ACCME sets and maintains the accreditation standards for the national and intrastate systems, including the Accreditation Criteria, the Standards for Commercial Support, and ACCME policies. These standards are considered a national model. For more information about ACCME accreditation requirements, see the chapters “ACCME Accreditation Requirements” and “Governance, Leadership, and Collaboration.”

State and territory medical societies that are designated by the ACCME as ACCME Recognized CME Accreditors must meet the ACCME’s recognition requirements. The recognition requirements are designed to maintain a uniform, national system of CME accreditation, helping to assure physicians, state legislatures, CME providers, and the public that all CME programs within the ACCME system are held to the same high standards.
THE MARKERS OF EQUIVALENCY

As part of its commitment to continuous improvement, the ACCME released an updated set of recognition requirements in 2008. The Markers of Equivalency were developed by the ACCME in collaboration with Recognized Accreditors and the ACCME’s Advisory Committee on Equivalency, a group composed of state medical society leaders from across the country. The purpose of the Markers is to ensure the equivalency of the accreditation decision-making across the national system, and streamline and strengthen the recognition process.

There are five Markers: equivalency of rules, process, interpretation, accreditation outcome, and evolution/process improvement. Within each Marker, there are several elements. Recognition decisions based on the Markers of Equivalency began in 2010.

The ACCME, in collaboration with Recognized Accreditors, has taken a number of steps to support equivalency, empower the intrastate accreditation system, and strengthen the integration of the state and national systems. Several representatives from the intrastate system serve on the national-level Accreditation Review Committee (whose work is described in the chapter “The National Accreditation System”), and the chair and co-chair of the Committee for Review and Recognition serve on the ACCME Board of Directors. Some of the national surveyors also serve as state surveyors.

THE RECOGNITION REVIEW PROCESS

The ACCME recognition review process is based on multiple sources of data, including the narrative, the performance-in-practice review, and the interview. The process of writing a narrative and preparing materials to demonstrate performance-in-practice is an opportunity for Recognized Accreditors to conduct a self-analysis, identifying their strengths and areas for improvement.

THE NARRATIVE

Recognized Accreditors complete a short narrative to describe their accreditation processes.

Performance-in-Practice

Recognized Accreditors submit a sample of their provider files, as well as examples to demonstrate accreditation processes used in their accreditation program, such as their communications with CME providers about accreditation requirements.

Additional Data Sources

To assess accreditors’ compliance with the Markers of Equivalency, the ACCME also reviews data from its online system for Recognized Accreditors (see more information about the system later in this chapter) and from its comprehensive record of interactions and engagement with Recognized Accreditors. This record helps demonstrate the level of engagement that Recognized Accreditors’ staff, surveyors, and decision-makers have with the ACCME and other Recognized Accreditors. This engagement, which includes participation in ACCME’s educational, training, and outreach activities, can contribute to an accreditor’s ability to develop and implement appropriate changes within its accreditation program. (For more information about the training the ACCME provides to Recognized Accreditors, see the chapter “Education, Outreach, and Communications.”)
The ACCME Recognition Interview

The next step in the process is facilitated by ACCME’s national network of volunteer surveyors, who are specifically trained to conduct recognition interviews. A team of two surveyors reviews the materials from the accreditor’s narrative and performance-in-practice, including provider files, and then meets with the accreditor for the interview portion of the re-recognition process.

The recognition interview provides an opportunity for the surveyors to discuss the accreditation program with the Recognized Accréditour. Surveyors may ask questions or seek clarification about the materials the accreditor submitted, and may collect additional information. Recognized Accreditors have the opportunity to share with surveyors their strengths, accomplishments, and plans for future improvements. In addition to involving staff and volunteers, some accreditors invite their organizational leadership to the interview to give them a deeper understanding of the accreditation program’s efforts and contributions.

The Surveyors’ Role

The interviews are designed to be collegial interactions. Surveyors are expected to demonstrate professionalism, ask thoughtful questions, and listen carefully to the Recognized Accréditour’s responses. The purpose of the interview is to gather facts related to the program’s compliance with the Markers of Equivalency and to facilitate fair and accurate decision-making in the next steps of the process.

The surveyors do not make recognition recommendations or decisions. Following the survey, they complete a standardized surveyor report form that lists each element within each Marker of Equivalency. For each element, surveyors answer “yes” or “no” as to whether the accreditor demonstrated equivalency.

Surveyors are expected to disclose conflicts of interest and will not be assigned to conduct interviews with accreditors if they have a current or recent affiliation with the organization.

After the interview, Recognized Accreditors are asked to complete an evaluation form about the recognition review process. The ACCME uses this feedback to analyze its current practices and make improvements.

About Recognition Surveyors

Recognition surveyors are experienced CME professionals who are actively involved in the state accreditation system. They engage in initial and ongoing training conducted by the ACCME. Surveyors must meet qualifications regarding their experience with CME, accreditation, and the Recognized Accréditour system. Surveyors participate in initial and ongoing training.

The ACCME invites Recognized Accreditors’ staff and volunteers to participate in the one-day intensive surveyor trainings the ACCME holds twice a year at its offices. Participants receive instructions from the ACCME staff, work with actual provider materials, and observe ACCME-led survey interviews. In addition, Recognized Accreditors’ staff and volunteers can take advantage of the resources developed for the national ACCME surveyor pool, available at a dedicated Web page on the ACCME’s Web site.
**RECOGNITION DECISION-MAKING**

The ACCME has a rigorous, multilevel process for making recognition decisions. These decisions are made three times a year. Recognition decisions are determined through a review by two ACCME committees: first, the Committee for Review and Recognition (CRR), and second, the Decision Committee of the ACCME Board of Directors. The ACCME Board of Directors must ratify all recognition decisions; through this ratification the Board of Directors ensures that the recognition process was conducted according to the ACCME’s published policies and procedures. Throughout the process, ACCME staff members provide support to committee members. This multitiered process provides the checks and balances necessary to ensure fair, consistent, and accurate decisions.

Members of the Committee for Review and Recognition, the Decision Committee, and the Board of Directors must disclose conflicts of interest related to the accreditation decision-making process and recuse themselves if necessary.

**THE COMMITTEE FOR REVIEW AND RECOGNITION’S ROLE IN DECISION-MAKING**

In the next step of the process, a reviewer from the Committee for Review and Recognition reviews the surveyor report form and the Recognized Accr-** edited materials and determines compliance findings for each Marker of Equivalency. The reviewer presents his or her findings to the full CRR, which reviews the findings and recommendation, and then makes a recommendation to the Decision Committee. The CRR prepares a report documenting compliance with each Marker of Equivalency and explaining any noncompliance findings.

**ABOUT THE COMMITTEE FOR REVIEW AND RECOGNITION**

The CRR is comprised of seven members; all members are nominated by the Recognized Accreditors and elected by the ACCME Board of Directors. Two senior members of the CRR are elected to serve as co-chairs of the CRR and to serve concurrently on the ACCME Board of Directors during their term of service on the CRR. This ensures representation of the recognition system on the ACCME’s Board of Directors.

**THE DECISION COMMITTEE’S ROLE IN DECISION-MAKING**

After the CRR completes its work, the Board of Directors’ Decision Committee will review the CRR’s recognition recommendation and report. The CRR co-chairs inform the committee about any new or unusual compliance issues that required new interpretations. The committee then makes its recommendation to the full Board.

**THE BOARD OF DIRECTORS’ ROLE IN DECISION-MAKING**

As the last step in the recognition decision-making process, the ACCME Board of Directors will review and ratify the Decision Committee’s recognition decision.
RECOGNITION DECISIONS

The decision-making process assesses the accreditor's fulfillment of the Markers of Equivalency using the following guidelines:

- The accreditors’ performance-in-practice files must demonstrate compliance with an element 100 percent of the time to receive a finding of “yes” on the surveyor report form.
- Accreditors must be compliant with each element within a Marker to receive a finding of compliance for that Marker.

Based on the compliance findings, the ACCME decides on the accreditor’s recognition status, using one of these four options:

1. Recognition is the standard, four-year term awarded to re-recognition applicants.
2. Probation is given for a maximum term of two years to accreditors that are found out of compliance with the Markers.
3. Provisional is given for a maximum of two years to new applicants.
4. Withdrawal of Recognition is generally assigned following a period of Probation. In addition, Withdrawal of Recognition may occur if the Recognized Accrdror fails to demonstrate improvement through a progress report.

Accreditors that receive decisions of Probation or whose Recognition is withdrawn are entitled to participate in the ACCME’s Reconsideration and Appeals process.

PROGRESS REPORTS

Accreditors that are found noncompliant with one or more of the Markers are required to submit a recognition progress report to demonstrate that they have come into compliance. If the accreditor successfully demonstrates compliance, the progress report is accepted and the accreditor can then complete its four-year Recognition term. If the ACCME rejects the progress report, the accreditor will either be required to submit a second progress report, or the ACCME may require a focused recognition survey to address the areas of noncompliance. The ACCME can also place an accreditor on Probation or withdraw Recognition after reviewing a progress report.

SCOPE OF THE INTRASTATE ACCREDITATION SYSTEM

Over the past 10 years there have been between 45 and 48 Recognized Accreditors; the current number is 45. As illustrated in Table 6, the number of intrastate accredited providers has declined approximately 12 percent over the past five years, from 1,653 in 2005 to 1,455 in May of 2011. This decline is due to a variety of factors, including changes in the economic, regulatory, and health care environments. In some cases the decrease represents a reallocation of resources, as some providers that withdraw their accreditation status continue to offer CME through partnerships (joint sponsorships) with accredited providers.

The ACCME is committed to supporting community-based CME for local physicians and health care teams. These resources are paid for, in part, through per-provider fees that the ACCME charges the intrastate system. The ACCME does not charge Recognized Accreditors for recognition services. For more about ACCME's allocation of resources, see the chapter "Financial Report and Operations."
Table 6. CME Providers Accredited by Recognized Accreditors (State Medical Societies or SMS)

<table>
<thead>
<tr>
<th>State Medical Society</th>
<th>Number of providers accredited by each SMS</th>
<th>At May 1st</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2005</td>
<td>2006</td>
</tr>
<tr>
<td>Medical Association of the State of Alabama</td>
<td>23</td>
<td>26</td>
</tr>
<tr>
<td>Alaska State Medical Association</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Arizona Medical Association</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Arkansas Medical Society</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>California Medical Association</td>
<td>382</td>
<td>381</td>
</tr>
<tr>
<td>Colorado Medical Society</td>
<td>29</td>
<td>31</td>
</tr>
<tr>
<td>Connecticut State Medical Society</td>
<td>30</td>
<td>34</td>
</tr>
<tr>
<td>Florida Medical Association</td>
<td>59</td>
<td>58</td>
</tr>
<tr>
<td>Georgia Medical Association</td>
<td>54</td>
<td>56</td>
</tr>
<tr>
<td>Hawaii Medical Association</td>
<td>19</td>
<td>18</td>
</tr>
<tr>
<td>Idaho Medical Association</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Illinois State Medical Society</td>
<td>52</td>
<td>53</td>
</tr>
<tr>
<td>Indiana State Medical Association</td>
<td>47</td>
<td>49</td>
</tr>
<tr>
<td>Iowa Medical Society</td>
<td>18</td>
<td>17</td>
</tr>
<tr>
<td>Kansas Medical Society</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>Kentucky Medical Association</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>Louisiana State Medical Society</td>
<td>29</td>
<td>26</td>
</tr>
<tr>
<td>Maine Medical Association</td>
<td>26</td>
<td>28</td>
</tr>
<tr>
<td>MEDCHI, Maryland State Medical Society</td>
<td>44</td>
<td>58</td>
</tr>
<tr>
<td>Massachusetts Medical Society</td>
<td>64</td>
<td>63</td>
</tr>
<tr>
<td>Michigan State Medical Society</td>
<td>41</td>
<td>38</td>
</tr>
<tr>
<td>Minnesota Medical Association</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Mississippi State Medical Association</td>
<td>23</td>
<td>24</td>
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<tr>
<td>Missouri State Medical Association</td>
<td>50</td>
<td>49</td>
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<tr>
<td>Nebraska Medical Association</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Nevada State Medical Association</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>New Hampshire Medical Society</td>
<td>23</td>
<td>18</td>
</tr>
<tr>
<td>New Mexico Medical Society</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Medical Society of New Jersey</td>
<td>47</td>
<td>51</td>
</tr>
<tr>
<td>Medical Society of the State of New York</td>
<td>47</td>
<td>50</td>
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<tr>
<td>North Carolina Medical Society</td>
<td>17</td>
<td>18</td>
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<td>North Dakota Medical Association</td>
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<tr>
<td>Ohio State Medical Association</td>
<td>63</td>
<td>62</td>
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<tr>
<td>Oklahoma State Medical Association</td>
<td>23</td>
<td>22</td>
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<tr>
<td>Oregon Medical Association</td>
<td>14</td>
<td>19</td>
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<td>Pennsylvania Medical Society</td>
<td>56</td>
<td>57</td>
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<tr>
<td>Puerto Rico Medical Association</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Rhode Island Medical Society</td>
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<td>South Carolina Medical Association</td>
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<tr>
<td>South Dakota State Medical Association</td>
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<td>11</td>
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<tr>
<td>Texas Medical Association</td>
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<td>66</td>
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<td>Utah Medical Association</td>
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<td>16</td>
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<tr>
<td>Medical Society of Virginia</td>
<td>14</td>
<td>11</td>
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<tr>
<td>Washington State Medical Association</td>
<td>26</td>
<td>29</td>
</tr>
<tr>
<td>West Virginia State Medical Association</td>
<td>24</td>
<td>21</td>
</tr>
<tr>
<td>Wisconsin Medical Society</td>
<td>59</td>
<td>57</td>
</tr>
<tr>
<td>Wyoming Medical Society</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>

| Total | 1653 | 1680 | 1608 | 1598 | 1559 | 1456 | -12% | 1455 |
SUPPORT AND RESOURCES FOR THE INTRASTATE ACCREDITATION SYSTEM

The ACCME offers a variety of educational resources and support services for the intrastate accreditation system, including monthly webinars, regional forums, and an annual conference. ACCME staff members make presentations at Recognized Accreditors' conferences for their providers, offer training for recognition surveyors and Recognized Accreditors' CME committee members, and provide one-on-one consultations with Recognized Accreditors. These resources are described in more detail in the chapter “Education, Outreach, and Communications.”

DATA COLLECTION

The ACCME supports Recognized Accreditors in maintaining accurate records of their accredited providers' accreditation terms and expiration information. The ACCME views this not only as a service to Recognized Accreditors, but as a responsibility to the accreditation system as a whole. To facilitate this process, the ACCME provides an online system for Recognized Accreditors to report information regarding accreditation decisions. As an additional support to Recognized Accreditors, the ACCME routinely identifies state-accredited providers whose terms are expiring in the upcoming four-month period, and informs the appropriate Recognized Accreditor.

This online system also enables the ACCME to collect data from Recognized Accreditors about their providers, which is analyzed and published as part of the ACCME Annual Report Data, providing Recognized Accreditors and other stakeholders with information about the size and scope of the intrastate accreditation system. As an additional resource, the ACCME maintains updated lists of Recognized Accreditors and state-accredited providers on its Web site.

SYSTEM IMPROVEMENTS

In July 2010, the ACCME opened the Program and Activity Reporting System (PARS), a Web-based portal, designed to streamline and support the collection of program and activity data from ACCME-accredited providers. The ACCME is exploring options for making PARS available to the intrastate accreditation system. For more information about PARS, see the chapter “The National Accreditation System.”
RECOGNITION STAFF

Open position, Director, Accreditation and Recognition Services

Sharon Nordling, Manager of Recognition Services

Paul Lawlor, Assistant Manager of Accreditation and Recognition Services

Erica Hubbard, Survey Services Coordinator

Teri McCauley, Coordinator of Accreditation and Recognition

Levi Baer, Administrative Assistant

FOR MORE INFORMATION

The resources below are available at our Web site, www.accme.org.

Markers of Equivalency

List of Recognized State Medical Societies

List of CME Providers Accredited by a State Medical Society
Over the past few years, the Accreditation Council for Continuing Medical Education’s (ACCME®) has greatly expanded its education, professional development, outreach, and communications efforts in order to advance its mission and foster the development of quality CME. The purpose of these efforts is to better meet the needs of volunteers, accredited providers, and Recognized Accreditors. These activities educate participants about meeting ACCME accreditation requirements and support their efforts to improve physicians’ competence, performance, and patient care. In addition, these activities assist CME providers in aligning their CME programs with health care quality and safety initiatives. The ACCME also aims to facilitate dialogue with the CME community and communicate the value of accredited CME to the wider health care system, the media, and the public. This chapter addresses the ACCME’s education and outreach within the United States; international activities are explained in the chapter “Governance, Leadership, and Collaboration.”

The ACCME identifies learners’ educational and outreach needs based on a variety of sources. In pre- and post-activity surveys, participants communicate their needs, questions, concerns, and feedback about the activities, and share the changes they plan to make as a result. The ACCME staff review frequently asked questions and compliance data from the accreditation process to identify compliance trends. Through numerous interactions year-round with CME providers, accreditors, and other stakeholders across the country, the ACCME staff members gather input about the CME community’s most pressing problems in practice. All of this information is analyzed and integrated on an ongoing basis into the ACCME’s educational, outreach, and communications efforts.

RESOURCES FOR ACCME-ACCREDITED PROVIDERS AND OTHER CME PROFESSIONALS

MEETING FORMATS
Live meetings offer the opportunity for open dialogue among participants and the ACCME staff, and facilitate participants’ sharing their successes and challenges with their colleagues. The ACCME uses a combination of formats, including face-to-face meetings, webinars, hybrid meetings, and conference calls to maximize this valuable interaction, while offering cost-effective options that enable more participants to attend.

CME AS A BRIDGE TO QUALITY™ ACCREDITATION WORKSHOPS
The Chicago-based CME as a Bridge to Quality™ accreditation workshop A plenary session at a 2010 CME as a Bridge To Quality accreditation Workshop
Ty™ Accreditation Workshops are designed for all levels of experience, from CME novices to veterans. The intensive workshops offer participants the opportunity to work closely with ACCME staff, national CME leaders, and colleagues to learn practical strategies for complying with the ACCME Accreditation Criteria. Each workshop features a session for CME providers who are preparing for the reaccreditation process.

Each year, the ACCME offers sessions held as an adjunct to the workshop that focus on topics of high interest to providers. In 2010, two new sessions were added to the workshops: “Engagement with the Environment,” an advanced session focusing on ACCME Criteria 16–22 for providers seeking Accreditation with Commendation; and “Next Steps for Organizations Seeking Accreditation,” for those preparing to apply for ACCME accreditation for the first time.

Support for Providers with Special Concerns

The ACCME reaches out to CME providers with special concerns to assist them in attaining and maintaining accreditation. Beginning in 2010, Murray Kopelow, MD, ACCME Chief Executive, along with other staff members, conducted a two-part conference call for accredited providers that are required to submit progress reports, a conference call for non-accredited organizations applying for Provisional Accreditation, and individual calls with providers that received a decision of Probation or Nonaccreditation. The calls offer participants the opportunity to ask questions and receive specific, individualized feedback about their compliance issues.

Special Workshops

The ACCME offers special workshops on specific topics to foster accredited providers’ professional development. In September 2009, the ACCME hosted “Fundamentals of Assessment in Medical Education” (FAME), an intensive, interactive workshop designed and presented by experts from the Foundation for Advancement of International Medical Education and Research, and the National Board of Medical Examiners. The workshop introduced CME providers to enhanced strategies for the evaluation and assessment of their physician learners.

The ACCME will continue to offer special workshops on an occasional basis in the future, in response to accredited providers’ educational and professional development needs.

“I appreciated the discussion and enthusiasm of the faculty, the spirit of collaboration and encouragement, the intent to help committed providers succeed in the accreditation process, and the balance between effective planning, documentation, and adherence to the requirements [expected of] an accredited provider.”

—Workshop participant

Murray Kopelow, MD, ACCME’s CEO, presents at an ACCME Workshop
Presentations at Educational Conferences

The ACCME provides speakers for numerous educational and professional development events throughout the year held by Recognized Accreditors, member organizations, CME organizations, and other stakeholder groups. Customized to meet the needs of the audience, these presentations address a variety of topics. These include the role of accredited CME as a strategic partner in health care quality and safety initiatives; how the Accreditation Criteria support the goals of Maintenance of Licensure, Maintenance of Certification, and hospital credentialing requirements; communicating accredited CME’s value to health care executives and other stakeholders; and the role of the Standards for Commercial Support in maintaining a self-regulated accreditation system. Presentations also describe trends in provider compliance with accreditation requirements and offer practical compliance strategies.

Town Hall Meetings

Throughout the year, the ACCME conducts a series of town hall–style meetings for different types of accredited organizations and other stakeholders. The purpose of the town hall is to facilitate open discussion among the ACCME and participants about issues and questions related to specific provider groups.

Discussions between Providers at an ACCME 2010 Town Hall Meeting

Commercial Supporters’ Forums

The ACCME hosts meetings bringing together education and regulatory staff from pharmaceutical and medical device companies to discuss their strategies for supporting accredited CME that is independent from commercial influence. These forums provide an opportunity for the ACCME and participants to address emerging issues related to funding and to reinforce their commitment to ensuring that commercially supported CME advances public health and serves the public interest.

Web Resources

The ACCME Web site features a variety of tools and information to assist accredited providers. There are tool kits for the Standards for Commercial Support and regularly scheduled series, as well as guides for each accreditation cohort. A compendium of real-world case examples drawn from the accreditation review process helps CME providers learn from each other and understand how the ACCME evaluates compliance.
**Education and Training Web Pages**

The Education and Training Web pages at the ACCME Web site offer providers multimedia resources. Video FAQs answer CME providers’ most pressing questions about compliance with accreditation requirements, video tutorials offer step-by-step guidance for planning and implementing CME activities, and audio commentaries explain the latest calls for comment and policy decisions. The Perspectives section features video interviews with CME and other health care system leaders who share their approaches to planning effective education, including strategies they use to overcome challenges and build bridges with other health care stakeholders. Launched in 2009, the Education and Training Web pages are continually updated in response to CME providers’ needs.

**Ask ACCME**

The ACCME is committed to providing support for CME providers throughout the accreditation process. CME providers’ questions are addressed through a variety of forums, including the educational and outreach events described in this chapter. In addition, providers can submit questions or concerns via e-mail. These questions are answered by a staff person, dedicated to responding to providers’ queries. FAQs are added to the Ask ACCME Web pages and incorporated into the ACCME’s educational activities.

**Communications Outreach and Support**

The ACCME produces regular, timely communications, including a newsletter and news releases, to inform CME stakeholders, the media, and the public about important developments in accredited CME. In addition, the ACCME provides support upon request to accredited providers and Recognized Accreditors to assist their efforts in communicating the value of accredited CME. The ACCME produces its own publications as described below, and also contributes to other publications that offer education and resources about accredited CME.

**Publications**

- **CME as a Bridge to Quality: Leadership, Learning, and Change within the ACCME System**, first published in printed form and now available in PDF format, is a resource to help providers demonstrate the value of accredited CME to their stakeholders.

- **The ACCME Report**, ACCME’s monthly e-newsletter, is distributed to approximately 5,000 subscribers. Created in 2009, the newsletter offers providers and other stakeholders updates about ACCME developments and educational resources.

“Thank you for your outreach efforts ... The frequent invitations to communicate with ACCME in a variety of ways all promote a two-way conversation and are very helpful.”

— 2010 Town Hall attendee
EDUCATION AND SUPPORT FOR THE INTRASTATE ACCREDITATION SYSTEM

REGIONAL FORUMS
In 2009, the ACCME launched regional forums in collaboration with Recognized Accreditors. Held across the country, these interactive forums offer the opportunity for state-based accreditation volunteers, state medical society CME staff, and intrastate providers to develop strategic and tactical approaches for positioning their CME programs as valued assets in their health care organizations and for building collaboration with the regional health care system. The forums were planned with input from an advisory committee comprising CME leaders from state medical societies nationwide.

MONTHLY WEB CONFERENCES
Each month, ACCME staff conducts an interactive Web conference with Recognized Accreditors’ staff and volunteers to discuss hot topics, accreditation practices and requirements, and the CME environment.

ACCME STATE/TERRITORY MEDICAL SOCIETY CONFERENCE
The annual ACCME State/Territory Medical Society Conference focuses on the professional development of Recognized Accreditors’ staff and volunteers. Participants develop strategic plans for improving their accreditation programs and elevating CME’s value within their communities, learn the latest updates about accreditation requirements, and share their successes and challenges with their colleagues and ACCME staff.

ADDITIONAL SUPPORT FOR THE INTRASTATE ACCREDITATION SYSTEM
The ACCME provides ongoing support for the intrastate accreditation system, including presentations at educational workshops for state-accredited providers, as well as training for recognition surveyors and Recognized Accreditors (state medical society) CME committee members and one-on-one consultations with Recognized Accreditors. The ACCME presents a webinar, “Preparing for Your Recognition Review,” for each group of Recognized Accreditors scheduled to go through the recognition process. During the webinar, ACCME staff review the recognition review timelines, process, and expectations, and answer participants’ questions. The ACCME staff is available throughout the recognition review process to answer questions and provide clarification when needed.

“It is always good to hear that other accreditors encounter similar problems [to ours]. Hearing solutions or attempts [at] overcoming the same or similar barriers is of great help.”
—Recognized Accrreditore
**WEB SITE RESOURCES**

The ACCME Web site features a section dedicated to Recognized Accreditors and an extranet, which include informational materials, forms, and resources about the recognition process. In addition, Recognized Accreditors have access to all the other resources on the ACCME Web site.

**EDUCATION, OUTREACH, AND COMMUNICATIONS STAFF**

*Steve Singer, PhD,* Director, Education and Outreach

*Tamar Hosansky,* Director, Communications

*Marcia K. Martin,* Manager, Provider Education and Outreach

*Kelly Roberts,* Manager, Systems Education and Outreach

*Ailene Cantelmi, MFA,* Manager, Systems Improvement

*Dennis Lott, DEd,* Manager of Accreditation Development

*Katherine Swimm,* Administrative Secretary, Education and Outreach

**FOR MORE INFORMATION**

The resources below are all available at our Web site, [www.accme.org](http://www.accme.org).

ACCME Education Page

*The ACCME Report, ACCME's Monthly e-Newsletter*

*Sign up for ACCME e-mail alerts*

*List of Upcoming ACCME Events*

*CME as a Bridge to Quality Booklet*
Summary of 2010 ACCME Education, Outreach, and Communications Efforts

Provider Education and Outreach

- The ACCME conducted three ACCME Accreditation Workshops for 408 participants representing more than 240 providers. The workshops included special sessions for:
  - Individuals who are newcomers to CME (100 participants)
  - Providers beginning the self-study process for reaccreditation (110 participants from 80 providers)
  - Providers seeking initial accreditation
  - Providers seeking Accreditation with Commendation

- The ACCME conducted five town halls, drawing a total of 637 participants. The table below offers a breakdown of the number of participants and provider organizations represented at each town hall meeting.

<table>
<thead>
<tr>
<th>ACCME 2010 Town Hall Meetings</th>
<th>Participants</th>
<th>Participants/providers represented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face to Face</td>
<td>Phone</td>
<td>Total</td>
</tr>
<tr>
<td>Education companies</td>
<td>-</td>
<td>54</td>
</tr>
<tr>
<td>Medical specialty societies</td>
<td>31</td>
<td>166</td>
</tr>
<tr>
<td>Medical schools</td>
<td>15</td>
<td>214</td>
</tr>
<tr>
<td>Hospitals</td>
<td>-</td>
<td>131</td>
</tr>
<tr>
<td>U.S. government</td>
<td>26</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL</td>
<td>72</td>
<td>565</td>
</tr>
</tbody>
</table>

- The ACCME held a meeting with accredited providers to discuss how to develop CME about procedures using medical devices that is compliant with the Standards for Commercial Support. The meeting was co-chaired by Murray Kopelow, MD, ACCME Chief Executive, and Damon Marquis, Director of Education and Member Services, the Society of Thoracic Surgeons.

- ACCME executive staff conducted focus groups with providers to garner feedback about ACCME accreditation requirements.

Web Resources

- The ACCME continued to produce new audio and video interviews, FAQs, and commentaries for the Education and Training Web pages. Traffic to the site has steadily increased since its launch, along with the length of time visitors spend on the various sections. From June 2010 to September 2010, the Web pages drew more than 9,000 unique visitors from 106 countries/territories, a 6 percent increase in visitors from the previous four-month period.

SUPPORT FOR PROVIDERS WITH SPECIAL CONCERNS

- ACCME executive staff conducted four group conference calls for 62 accredited providers that received noncompliance findings to explain the findings and answer questions.

- ACCME Chief Executive Murray Kopelow, MD, met one-on-one with the CME leadership of 40 organizations that had been put on Probation, failed to demonstrate compliance in a progress report, received Nonaccreditation from Probation, or went to Nonaccreditation from initial application, to explain the findings and answer questions.

- ACCME executive staff held two conference calls with the CME leadership of the 16 organizations that are preparing or have submitted initial applications for Provisional Accreditation to offer support and explain common causes of noncompliance findings.

- ACCME Chief Executive Murray Kopelow, MD, offered support to the deans of 14 new medical schools in the early stages of receiving accreditation from the Liaison Committee on Medical Education.
SURVEYOR TRAINING

- The ACCME held new surveyor training sessions for 19 new surveyors. Staff from five Recognized Accreditors participated in this training as part of their own professional development.
- The ACCME presented ongoing surveyor training sessions, which attracted 110 participants.
- ACCME executive staff conducted focus groups with experienced surveyors to discuss their perceptions of the survey process.

COMMERCIAL SUPPORTERS FORUMS

- The ACCME held two meetings with the education and executive leadership of 10 pharmaceutical manufacturers as part of its ongoing efforts to address emerging issues in commercial support and ensure that commercially supported CME serves the public interest.

PRESENTATIONS AT EDUCATIONAL CONFERENCES

During 2010, the ACCME gave presentations at numerous education conferences, including the following:

- 2010 AHME/AODME Educational Institute, which included a full day of CME programming for the first time. Co-organized by the Association for Hospital Medical Education (AHME) and the Association of Osteopathic Directors & Medical Educators (AODME)
- Alliance for CME 2010 annual conference, including presentations at six member section meetings; Alliance for CME special summer meetings of medical specialty societies
- Alliance of Independent Academic Medical Centers Annual Meeting
- Drug Information Association Annual Meeting
- Grand Rounds, University of Chicago Department of Anesthesia
- National Association Medical Staff Services Annual Conference
- National Task Force on CME Provider/Industry Collaboration Conference

- New York Medical College annual educational forum for accredited medical schools
- Society for Academic CME Summer Leadership Institute

MEDIA AND PUBLICATIONS

- The ACCME published 10 e-newsletters and 19 news releases, including five news releases issued jointly with other organizations and two news releases supporting member organizations’ initiatives.
- The ACCME collaborated with Recognized Accreditors and intrastate providers to promote the regional forums. The forums received coverage in Presbyterian Healthcare Focus, a publication of Novant Health, which hosted the North Carolina forum; and The Bulletin, the publication of the Medical Society of the County of Queens and the Academy of Medicine of Queens County, which hosted the New York regional forum.
- ACCME staff contributed two chapters to the Guide to Medical Education in the Teaching Hospital, 4th ed., edited by Jeffrey L. Levine, PhD, by the Association for Hospital Medical Education, an ACCME member organization. ACCME Chief Executive Murray Kopelow, MD, wrote the chapter entitled “Accredited Continuing Medical Education as a Bridge to Quality,” and ACCME staff wrote the chapter, “Accredited Continuing Medical Education: A Primer.”

EDUCATION AND SUPPORT FOR THE INTRASTATE ACCREDITATION SYSTEM

- The ACCME held monthly phone meetings with Recognized Accreditors’ staff and volunteers with an average of 46 participants representing 26 states on each call.
- ACCME executive staff attended or participated in accredited provider conferences and/or leadership meetings of the following states’ medical societies:
  - Alabama
  - California
  - Connecticut
  - Florida
  - Georgia
  - Kentucky
  - Massachusetts
  - Mississippi
  - Nevada
  - New Hampshire
  - New Mexico
  - North Carolina
  - North Carolina
  - South Carolina
  - Virginia
  - West Virginia

- The ACCME held four regional forums across the country for Recognized Accreditors and their providers. The table below offers a breakdown of the number of participants from provider organizations and Recognized Accreditors at each forum.

<table>
<thead>
<tr>
<th>2010 Regional Forums</th>
<th>Numbers of Participants/Organizations</th>
<th>(Providers, Recognized Accreditors) Represented</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York</td>
<td>From Providers 32/24</td>
<td>From RA 16/8</td>
</tr>
<tr>
<td></td>
<td>Total 48/32</td>
<td></td>
</tr>
<tr>
<td>Charlotte</td>
<td>From Providers 27/17</td>
<td>From RA 14/11</td>
</tr>
<tr>
<td></td>
<td>Total 41/28</td>
<td></td>
</tr>
<tr>
<td>St Louis</td>
<td>From Providers 27/18</td>
<td>From RA 14/11</td>
</tr>
<tr>
<td></td>
<td>Total 41/29</td>
<td></td>
</tr>
<tr>
<td>Las Vegas</td>
<td>From Providers 11/10</td>
<td>From RA 10/5</td>
</tr>
<tr>
<td></td>
<td>Total 21/15</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>From Providers 97/69</strong></td>
<td><strong>From RA 54/35</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Total 151/104</strong></td>
<td></td>
</tr>
</tbody>
</table>

- The 2010 ACCME State/Territory Medical Society Conference: A Conference of Leaders drew 50 participants from 31 states.
The Accreditation Council for Continuing Medical Education (ACCME®) has taken a number of steps to increase the transparency and accountability of the ACCME accreditation system, to strengthen the requirements concerning CME’s independence from commercial influence, and to accelerate the enforcement of those requirements. The purpose of these changes is to reinforce accredited CME’s validity and credibility, while addressing concerns expressed by the government, the media, the medical profession, and the public. The ACCME’s goal is to assure that accredited providers design CME that is based on valid content, is free of commercial influence or bias, and contributes to the quality and safety of health care. As the US health care system continues to evolve, the ACCME will respond by making any changes that are necessary to assure that the purpose of CME is to serve the best interests of the public.

A summary of these steps follows; they are described in more detail in the rest of the section. During the past few years, the ACCME

• published more information about ACCME-accredited providers, including whether or not they accept commercial support,
• published more data about accreditation decisions and compliance findings,
• accelerated the improvement process for accredited providers found in noncompliance,
• revised its complaints process to balance transparency with confidentiality and include CME providers’ responsibilities to learners, and
• expanded the definition of a commercial interest to further safeguard the separation of promotion from education.

INCREASING TRANSPARENCY: ACCREDITED PROVIDER LISTS, COMPLIANCE, AND DECISION-MAKING DATA

MORE INFORMATION IN ACCREDITED PROVIDER LISTS

Beginning in August 2009, the ACCME began including more information in the lists of ACCME-accredited providers on its Web site. The lists include basic contact information plus the following details for each ACCME-accredited provider:

• Accreditation status (Accreditation, Accreditation with Commendation, Probation, or Provisional Accreditation)
• Accredited based on the ACCME 2006 Accreditation Criteria (yes or no)
• Total numbers of activities, hours, and participants reported
• Types of activities produced
• Receives commercial support (yes or no)
• Receives income from advertising or exhibits (yes or no)
• Participates in joint sponsorship (yes or no)

The ACCME made more data public to empower all stakeholders—including physician learners, licensing and certification bodies, and the public—to assess individual ACCME-accredited providers’ size, scope, and funding structure, as well as the diversity and reach of the accredited CME enterprise in the United States.

TRANSPARENCY IN ACCME DECISION-MAKING

Beginning with the July 2009 accreditation decisions, the ACCME made public accreditation grids depicting the accreditation decision and the compliance findings, by criterion, for each provider that has received a decision under the 2006 Accreditation Criteria. (Results are blinded to ensure providers’ confidentiality.) These grids enable providers and other stakeholders to assess areas of compliance and noncompliance with the Accreditation Criteria and Standards for Commercial Support, and to see the consistency of ACCME decision-making.

STRicter monitoring: accelerating remediation of noncompliance issues

As explained in the chapter “The National Accreditation System,” accredited providers must submit evidence that demonstrates their compliance with the Standards for Commercial Support: StandardsSM to Ensure Independence in CME Activities, as well as the other accreditation requirements, during the initial or reaccreditation process. Accredited providers that are found out of compliance are given the opportunity to correct the problem and asked to submit progress reports to demonstrate improvement.

During the past few years, the ACCME accelerated its accreditation enforcement process to ensure more timely and rigorous oversight, particularly of noncompliance issues related to independence. CME providers that are found out of compliance with the Standards for Commercial Support must submit progress reports within four, eight, or twelve months. Previously, providers were given 12 or 18 months to submit reports.

Accredited providers whose progress reports do not demonstrate compliance are put on Probation. While on Probation, they are given the opportunity to submit another progress report. If a provider demonstrates that it has come into compliance, but is again found in noncompliance during the next accreditation review cycle, that provider is immediately put on Probation, which is the step before the provider loses accreditation. Providers can remain on Probation for only 24 months. If they do not demonstrate compliance within that time frame, they will lose their accreditation. The vast majority of providers implement improvements quickly, leading to sustained compliance.

For data about accreditation decisions, see the chapter “The National Accreditation System.”
REVISED COMPLAINTS PROCESS:
BALANCING TRANSPARENCY AND CONFIDENTIALITY

The ACCME has a multilayered accreditation process for evaluating CME providers' compliance with the ACCME's requirements. As an additional safeguard, the ACCME has a Process for Handling Complaints Regarding ACCME-Accredited Providers, which it uses to respond to complaints from the public and the CME community about ACCME-accredited providers' compliance with accreditation requirements. A wide range of issues are addressed through the complaints process. Increasingly, the ACCME is asked to investigate if the issues are about commercial bias and/or content validity. From August 2009 to December 2010, the ACCME received 33 complaints; of those, 18 were deemed not relevant to ACCME requirements. The ACCME completed 15 complaint reviews; 12 of these involved the Standards for Commercial Support. Five reviews resulted in findings of Noncompliance; 10 reviews resulted in findings of Compliance.

As with other aspects of the accreditation system, the ACCME relies on volunteers to support the complaints process. The ACCME often asks clinicians with relevant expertise to volunteer to review content for validity or commercial bias if an activity is under review due to a complaint. The ACCME staff integrates the expert's opinion into its own review to arrive at a compliance finding.

The ACCME revised the complaints process in July 2010. The revised process enhances transparency while preserving providers' confidentiality, following a model similar to the ACCME's accreditation review procedures. The ACCME keeps confidential the identity of providers that have an activity found in Noncompliance through the complaints process. When the ACCME changes a providers' accreditation status as a result of the complaints process, the new status is made public, but the ACCME does not disclose the reason for the change in status. In accordance with the revised policy, the ACCME began publishing blinded summaries and case examples from the complaints process as an educational resource for providers. The proposal for these revisions received widespread support from the CME community and other stakeholders during the call for comment, which was released in January 2010. The call for comment and the responses are posted on the ACCME Web site.

If the ACCME finds a provider in Noncompliance, the provider is responsible for demonstrating that it has rectified the issue. If the corrective actions do not adequately demonstrate compliance, the ACCME may decide to do an immediate reaccreditation survey, which could affect the CME provider's accreditation status. Under certain circumstances, the CME provider's status may be changed to Probation or Nonaccreditation. Documentation regarding the complaint will be placed in the provider's file and made available to the accreditation survey team and The Accreditation Review Committee reviewer as part of the reaccreditation process.

REVISED COMPLAINTS PROCESS:
PROVIDERS’ RESPONSIBILITIES TO LEARNERS

Under the complaints process, communications about noncompliance are between the ACCME and the provider, and they are kept confidential by the ACCME. As part of its ongoing commitment to accredited CME's accountability, and in response to feedback from stakeholders, the ACCME deliberated about whether accredited providers should also have obligations to learners if an activity is found Noncompliant. In considering the options, the ACCME continued to balance accountability...
with the confidentiality of CME providers, which is an integral part of its complaints process, and to consider the best interests of the accredited CME system, physician learners, and the public. The ACCME issued a call for comment about providers’ responsibilities to learners in August 2010. After considering the feedback received, the ACCME adopted the proposal. The refinement to the process requires accredited providers to supply corrective information to the learners, faculty, and planners if the provider is found in Noncompliance through the complaints process with the ACCME’s Standard for Commercial Support 1 (Independence) Standard for Commercial Support 5 (Content and Format without Commercial Bias), or the Content Validation Value Statements. Additionally, the accredited provider is expected to submit to the ACCME a report describing the action that was taken and the information that was transmitted. Accredited providers determine how to communicate the corrective information and are under no obligation to communicate that the activity was found in noncompliance with ACCME requirements.

SAFEGUARDING INDEPENDENCE: EXPANDED DEFINITION OF A COMMERCIAL INTEREST

In August 2007, the ACCME announced that it was expanding its definition of a commercial interest in order to further safeguard CME’s independence. The redefinition states that a commercial interest is “any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients.” Entities that meet this definition are not eligible for ACCME accreditation and cannot act as joint sponsors (educational partners of accredited providers). Previously, the ACCME had defined commercial interests as “any proprietary entity producing health care goods or services consumed by, or used on, patients.”

The ACCME broadened the definition in response to evolution in the CME environment. Some accredited providers were part of a corporate structure that had units involved in marketing, re-selling, or distributing health care goods or services, and because of that relationship the accredited providers could fall under the expanded definition of commercial interest unless they took steps to restructure their organizations. The ACCME’s goal is to ensure that those accredited providers are structured in a manner that protects their independence.

The ACCME allowed accredited providers that were affected by the redefinition a two-year grace period, until August 2009, to alter their organizational structure and separate their CME program from the commercial interest. To assist CME providers, the ACCME published information on its Web site, worked individually with accredited providers affected by the redefinition, and reviewed providers’ proposed solutions before they were implemented, to help assure that the plans complied with ACCME requirements.

In 2008 and 2009, the ACCME reviewed 30 accredited providers that appeared to be affected by the change in the definition of a commercial interest and found that 17 would be considered commercial interests. Of those, 14 successfully restructured and retained their accreditation; three did not restructure and withdrew from accreditation. As an additional safeguard, in August 2009, the ACCME asked all accredited providers to take a self-assessment to ensure they were not commercial interests. This self-assessment can also be used by accredited providers that are determining whether or not to work in joint sponsorship with a nonaccredited entity.
The ACCME offered several alternatives for corporate restructuring that would meet its requirements. For case examples, see the news release “Accredited CME Providers Restructure to Ensure Compliance with ACCME Independence Policies.” For more information about the commercial interest redefinition, see ACCME Policies – Commercial Support and Disclosure. For FAQs regarding the redefinition of commercial interests, visit Ask ACCME – Standards for Commercial Support, 1: Independence.

**MONITORING STAFF**

Jennifer Dunleavy, MSA, Director, Business and Operations

Ed Kennedy, Manager of Information and Technology

Heidi Richgruber, Manager, Monitoring and Improvement

**FOR MORE INFORMATION**

The resources below are available at our Web site, www.accme.org.

- Lists of ACCME-Accredited Providers
- Accreditation Decision and Compliance Data
- Standards for Commercial Support: Standards℠ to Ensure Independence in CME Activities
- Process for Handling Complaints Regarding ACCME-Accredited Providers
- Complaints Process Web Page
- Call for Comment: Complaints Process—Balancing Transparency and Confidentiality
- Audio Commentary: Complaints Process – Balancing Transparency and Confidentiality
- News Release: Accreditation Council for CME Revises Complaints Process
- Call for Comment: Complaints Process — Providers’ Responsibilities to Learners
- Audio Commentary: Providers Responsibilities to Learners
- News Release: Accreditation Council for CME Includes Providers’ Responsibilities to Learners in Complaints Process
- Commercial Interest Definition
- News Release: Accredited CME Providers Restructure to Ensure Compliance with ACCME Independence Policies
- Ask ACCME – Standards for Commercial Support, 1: Independence
GOVERNANCE, LEADERSHIP, AND COLLABORATION

GOVERNANCE

ACCME BOARD OF DIRECTORS

The Accreditation Council for Continuing Medical Education (ACCME®), a nonprofit corporation under the laws of the State of Illinois, conducts its business according to its bylaws. The Board of Directors is the governing body of ACCME. It is charged with setting the strategic direction for the organization and leading the ACCME in identifying, developing, and promoting standards for quality continuing medical education. ACCME’s seven member organizations and the public nominate individuals to serve on the ACCME’s Board of Directors. In addition, two senior members of the Committee for Review and Recognition serve on the ACCME Board of Directors during their terms of service on the CRR. The Board also includes two nonvoting representatives of the federal government, who are named by the federal government. All directors and representatives are elected to the Board by the Board.

The Board of Directors conducts business through the following standing committees, made up of its members.

- **The Executive Committee** manages the ACCME’s affairs in the interim between regular or special Board of Directors meetings, and conducts the CEO’s performance assessment.

- **The Decision Committee** reviews and takes action on the accreditation and recognition recommendations made by the Accreditation Review Committee (ARC) and the Committee for Review and Recognition (CRR). Those actions are reported to the full Board of Directors for ratification. The Decision Committee’s charge is to ensure that the recognition and accreditation processes are conducted according to the ACCME’s published policies and procedures. For more information about the accreditation and recognition decision-making processes, see the chapters “The National Accreditation System” and “The Intrastate Accreditation System.”

- **The Finance Committee** is responsible for monitoring the ACCME’s fiscal matters, including budgeting, financial planning, investments, accounts, and records. The committee oversees financial performance and recommends investment policy, reviews the proposed budgets of the ACCME and presents them to the Board of Directors for approval, tracks the income and expenses of the ACCME on an ongoing basis, and makes recommendations as necessary.

- **The Quality Improvement Committee** assesses the effectiveness of the ACCME’s accreditation, recognition, and monitoring functions and develops policy recommendations to further ACCME’s goal of continuous quality improvement. The Quality Improvement Committee also
provides interpretations of accreditation and recognition policies, to support the work of the Accreditation Review Committee and the Committee for Review and Recognition.

- **The Compensation Committee** develops recommendations regarding compensation and benefits for ACCME staff members.

- **The Nominating, Elections, and Awards Committee** reviews nominations for volunteer awards, and nominations for members of the Board, the Board committees, the Accreditation Review Committee, and the Committee for Review and Recognition. It then presents these nominations to the full Board of Directors for election.

**ACCME Board of Directors Task Forces**
The ACCME Board of Directors convenes task forces to address important and emerging issues. During the past decade, task forces have led the process for creating the ACCME’s 2002 content validation policy, the 2002 Internet policies, the 2004 updated Standards for Commercial Support, and the 2006 Accreditation Criteria. In 2009 and 2010, the Board created the following five task forces to focus on issues concerning providers and stakeholders:

- **The Bylaws Task Force** reviewed the bylaws and recommended revisions that would improve the ACCME’s governance. These recommended revisions will be reviewed by the Board and the ACCME member organizations in 2011.

- **The Board Policies and Practices Task Force** was convened to review and improve the document “Policies and Practices of the ACCME to Meet Its Responsibilities As a Not-For-Profit Corporation.” These policies give the Board a framework for governance of the ACCME. The Task Force completed editing the document and the Board adopted the revised manual at its July 2010 meeting and modified ACCME policies in keeping with those revisions.

- **The Monitoring Task Force** reviewed and affirmed the ACCME’s internal controls for ensuring that accreditation decision-making is consistent and accurate. The task force also reviewed the historical background and environmental factors that influence the ACCME’s process for monitoring CME providers during their accreditation term. The task force completed its work, and the Quality Improvement Committee will continue to explore issues related to monitoring and accreditation decision-making.

- **The Accreditation Requirements Task Force** conducted a comprehensive analysis of the ACCME’s experience applying the 2006 accreditation requirements. In response to the task force’s review, the ACCME significantly revised the ACCME Guide to the Accreditation Process to offer a more user-friendly resource, and enhanced its education and support for initial applicants and CME providers with special concerns, including those that are required to submit progress reports or receive decisions of Probation or Nonaccreditation. The task force completed its work, and the Quality Improvement Committee will continue to discuss issues related to the implementation of the Accreditation Criteria and monitor compliance data to identify accredited providers’ educational needs.
• **The ACCME PRA and Activity Task Force** was convened to discuss synergies between the ACCME and the American Medical Association’s Physician’s Recognition Award systems and to explore implementing the AMA Division of Continuing Physician Professional Development’s request for the ACCME to assist the AMA in monitoring providers’ compliance with AMA PRA requirements during the accreditation review process.

**ACCME Focus Groups**

To support the work of the task forces and the ACCME’s improvement process, the ACCME held a series of focus groups in 2010 with surveyors, providers, and Accreditation Review Committee members to promote open dialogue and gather feedback. Participants were asked to share their perspectives on ACCME’s requirements, processes, and services; offer their observations, interpretations, and questions regarding the ACCME accreditation process and requirements; and provide input about staff services, and communications, education, and outreach efforts.

**Calls for Comment and Policy-Making**

The ACCME Board of Directors undertakes a multistep, deliberative process to recommend new policies or modifications to policies and procedures. When considering possible changes, the Board first undertakes a comprehensive analysis of the issues, reviewing relevant historical and current data. If the Board determines that a new or modified policy or procedure has the potential for improving the accreditation system and serving the needs of the CME community, physician learners, and the public, the Board will move forward and develop a proposal.

The next step is for the ACCME to undergo a formal process for soliciting feedback from stakeholders and the public. The ACCME’s [Rule-Making Policy](#), adopted in July 2009, says that the public will have the opportunity to comment on proposed rules or policies that directly affect member organizations and accredited providers. The ACCME gathers this feedback through [calls for comment](#). Following a call for comment, an analysis of the responses as well as the complete text of the responses is posted on the ACCME Web site.

The Board of Directors reviews and analyzes the responses, and issues its decision. That decision is posted on the Web site and communicated to the CME provider and stakeholder community through the e-newsletter, *The ACCME Report*. If the Board approves a change in policy or rules, the ACCME staff prepares educational resources to assist accredited providers and other stakeholders in understanding and implementing the change.

Since adoption of the 2009 Rule-Making Policy, the ACCME has issued five calls for comment. In 2010, the ACCME issued four calls for comment: Complaints and Inquiries Process: Balancing Transparency and Confidentiality; Knowledge-based CME Activities; ACCME’s Recognition Process; and Complaints Process: Providers’ Responsibilities to Learners. In April 2011, the ACCME issued a call for comment regarding disclosure of commercial support.

**Volunteer Recognition**

As it has since its inception, the ACCME continues to rely on a network of dedicated volunteers. Currently, approximately 150 volunteers serve on the national level as surveyors and ACCME Board and committee members; thousands of volunteers serve at the state level. Taking into account national-level volunteers, intrastate accreditation volunteers, and CME committee volunteers serving ACCME-
accredited and state-accredited providers, an estimated 20,000 people across the country support the system.

To express its support and appreciation for these volunteers, the ACCME presents service awards to volunteers who have completed their terms of service. In addition, the ACCME presents the following special recognition awards:

**The Robert Raszkowski, MD, PhD, ACCME Hero Award**

The Robert Raszkowski, MD, PhD, ACCME Hero Award recognizes volunteers who have provided exemplary and long-term service to the ACCME, through service on the Board of Directors, the Accreditation Review Committee, the Committee for Review and Recognition, the Monitoring Committee, and/or as volunteer surveyors. The award is named for the late Robert Raszkowski, MD, PhD, a longtime, dedicated ACCME volunteer.

**Robert Raszkowski, MD, PhD, ACCME Hero Award Recipients**

<table>
<thead>
<tr>
<th>Year</th>
<th>Recipients</th>
</tr>
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| 2010 | William W. Greaves, MD, MSPH  
Karen E. Heiser, PhD |
| 2009 | George Mejicano, MD, MS  
Ronald Murray, EdD  
J. Brian O’Toole, PhD  
David Swee, MD |
| 2008 | Stephen S. Biddle, MEd  
Marcia J. Jackson, PhD  
Jack Dolcourt, MD, MEd |
| 2007 | Errol Alden, MD  
Richard Ashby, MD  
Jann Torrance Balmer, RN, PhD  
Barbara E. Barnes, MD  
Arnold J. Berry, MD, MPH  
Dean R. Bordeaux, MD, MAEd  
Stanley M. Bugaieski, MD  
Linda Casebeer, PhD  
Ellen M. Cosgrove, MD  
Howard Dworkin, MD  
Melvin Freeman, MD  
Harry A. Gallis, MD  
Jerry Hammon, MD  
James E. Hartfield, MD  
Marten O. Hotvedt, PhD  
John Jurica, MD, MPH |
| 2006 | Robert E. Kristofco, MSW  
Brian W. Little, MD, PhD  
J. David Marler, Jr., PhD  
Albert May, MD  
Howard McQuarrie, MD  
Steven E. Minnick, MD, MBA  
Don Moore, PhD  
Robert C. Moravec, MD  
Elizabeth Murphy, EdD, RN  
Donald Pochyly, MD, MSEd  
George Porter, MD  
Robert Pyatt, MD  
Robert C. Rock, MD  
Deborah Sutherland, PhD  
Patrick Sweeney, MD, PhD  
K. M. Tan, MD  
Henry Tulgan, MD |

**The Rutledge W. Howard, MD, Awards**

The Rutledge W. Howard, MD, Awards recognize state medical societies, their staff, and volunteers for their contributions and commitment to advancing community-based CME programs and the intrastate accreditation system. The awards are named for Rutledge W. Howard, MD, who worked with every state, the District of Columbia, and four US territories to develop a system for accrediting intrastate CME providers. The awards are given in two categories.

The 2010 recipients were given their awards during a ceremony at the ACCME State/Territory Medical Society Conference: A Conference of Leaders, held December 15–16, 2010, in Chicago.
2010 Award for Outstanding Collaboration between Accreditors and Providers

This award honors an ACCME Recognized Accrder for achieving an exemplary working relationship with its providers by collaborating on projects, issues, or initiatives. The 2010 Award was given to the Pennsylvania Medical Society, represented by Leslie Howell (second from left) and M. Steven Bortner (far right). The award was presented by Richard Reiling, MD, 2011 Chair of ACCME’s Board of Directors (far left), and Kate Regnier, MA, MBA, ACCME’s Deputy Chief Executive (second from right).

2010 Award for Individual Service to the Intrastate Accreditation System

This award recognizes state staff or volunteers for their service to intrastate accreditation. James Liljestrand, MD, MPH, was given the 2010 award to honor his work with the Massachusetts Medical Society. He accepted the award from Murray Kopelow, MD, ACCME’s Chief Executive (left), and Richard Reiling, MD, 2011 Chair of ACCME’s Board of Directors (right).
Previous Recipients of the Rutledge W. Howard, MD, Awards

2007
Carol S. Havens, MD (individual category)
Oklahoma State Medical Society (accreditor category)

2006
Jane Phillip (individual category)

2005
Florida Medical Association (accreditor category)

2004
Dean Bordeaux, MD, MAEd (individual category)
Louisiana State Medical Society (accreditor category)

2003
Richard Ashby, MD (individual category)

2002
Jeanette Harmon (individual category)
Illinois State Medical Society (accreditor category)

2000
Texas Medical Association (accreditor category)

1999
Massachusetts Medical Society (organizational award)
Minnesota Medical Association (organizational award)

1998
Washington State Medical Association (organizational award)

1997
Arizona Medical Association (organizational award)
Medical and Chirurgical Faculty of State of Maryland (organizational award)
Puerto Rico Medical Association (organizational award)

Leadership and Collaboration

One of the ACCME's primary responsibilities is to continually review its role in CME to ensure it remains responsive to public and professional needs. Toward that end, the ACCME engages in ongoing dialogue with stakeholders, including its member organizations, accredited providers, Recognized Accreditors, institutions of medicine, physician learners, the government, and the public.

Trends and Growth Data

Each year since 1998, the ACCME has released Annual Report Data, providing an in-depth view of the size and scope of the CME enterprise nationwide. The report includes statistics on CME program revenue, funding, numbers of participants, and format of educational activities. The 2009 ACCME Annual Report Data marked the eleventh year the ACCME has been collecting and analyzing information for accredited providers, and it offers more than a decade-long perspective on CME trends and growth on both the national and state levels.
C O L L A B O R A T I O N W I T H M E M B E R O R G A N I Z A T I O N S

The ACCME’s seven member organizations, representing the profession of medicine, were the founders of the ACCME. They are responsible for nominating individuals to the Board of Directors, for providing input into ACCME’s strategic directions, and for oversight of ACCME actions and bylaws changes.

The ACCME’s seven member and founding organizations are the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, the Association for Hospital Medical Education, the Council of Medical Specialty Societies, and the Federation of State Medical Boards of the United States.

The Board introduced a new session at the July 2010 meeting, convening the member organization liaisons before the Board meeting to offer them the opportunity to speak directly to the ACCME Board of Directors about issues of concern, in keeping with their special role as the ACCME’s founding and member organizations. This constructive dialogue addresses the work of the ACCME Board task forces and committees, as well as other high-level, timely issues.

The ACCME collaborates with its member organizations in a number of ways. ACCME executive staff members make presentations at member organizations’ meetings and participate in their committees and task forces. Through joint leadership initiatives, the ACCME and member organizations identify and implement strategies for improving physicians’ continuing professional development and patient care.

Following are selected recent examples of ACCME collaboration with each member organization:

The ACCME provides ongoing support for the American Board of Medical Specialties Maintenance of Certification® initiative. ACCME executive staff and volunteers serve as members of the ABMS MOC committee and the ABMS-ACCME Joint Task Force on MOC CME. Maintenance of Certification sets standards for specialists’ continuing professional development and competency, with the goal of reducing medical errors, improving physician/patient communication, and raising the quality of clinical care.

ACCME executive staff made a presentation at the American Hospital Association Annual Leadership Retreat in 2009 and participated in the AHA Committee on Health Professions meeting.

In 2010, ACCME executive staff participated in meetings of the American Medical Association Council on Medical Education and AMA Reference Committee Hearings, and, in addition, gave a presentation at the AMA Commission to End Health Care Disparities meeting in 2010. The AMA and the ACCME continue their long-standing relationship: within the United States, the AMA authorizes organizations that are accredited by the ACCME or by an ACCME Recognized Acccreditor to designate and award AMA PRA Category 1™ Credit to physicians. (For more about this relationship, see the chapter “The National Accreditation System.”)

ACCME executive staff gave a presentation at the Association of American Medical Colleges 2010 annual meeting and participated in a 2009 consensus conference, “Promoting Lifelong Learning in Medicine and Nursing: From Research to Practice,” organized jointly by the AAMC and the American Association of Colleges of Nursing and funded by the Macy Foundation.
ACCME executive staff gave a presentation about the Accreditation Criteria at the 2010 AHME/AODME Educational Institute. Co-organized by the Association for Hospital Medical Education and the Association of Osteopathic Directors and Medical Educators, the conference included a full day of CME programming for the first time.

The ACCME expressed its support for the CMSS Code for Interactions with Companies. Released on April 21, 2010, by the Council of Medical Specialty Societies, the code provides guidance to medical specialty societies about appropriate interactions with health care companies. The ACCME continues to serve as a member of the Conjoint Committee on CME, a collaborative group of organizations formed by CMSS in 2000.

The ACCME expressed its support for the Federation of State Medical Boards Maintenance of Licensure Initiative. Maintenance of Licensure (MOL) aims to strengthen the licensure renewal process by implementing new standards for physicians’ lifelong learning and practice improvement. In April 2010, the FSMB adopted a policy report that lays the groundwork for implementing MOL. The FSMB recognizes CME as an integral part of this process. The ACCME served as a member of the FSMB’s Special Committee on Maintenance of Licensure, participated in writing the special committee’s reports, and attended the Physician Accountability for Physician Competence Summits. Dr. Kopelow currently serves on a CEO Advisory Council to the Maintenance of Licensure Implementation Group.

Collaboration with Other Regulatory Bodies

At the invitation of the ACCME, Paul M. Schyve, MD, Senior Vice President, The Joint Commission, met with the Board during its July 2010 meeting to discuss how CME can support The Joint Commission in fulfilling its mission and the missions of the hospitals and health systems it accredits. Dr. Schyve explained The Joint Commission’s quality and safety improvement initiatives and the role CME can play in achieving those goals. To extend this dialogue to providers, health care institution executives, and other stakeholders, Dr. Schyve recorded a two-part interview for the Education and Training section of the ACCME’s Web site.

In July 2010, the Board accepted an invitation from the American Osteopathic Association for the ACCME to join its House of Delegates. This participation will expand the already cooperative relationship between the ACCME and the AOA.

In 2009, the ACCME collaborated with the Accreditation Council for Pharmacy Education and the American Nurses Credentialing Center to develop a joint accreditation process. Joint accreditation rewards organizations for offering team-focused education that improves patient care. The process decreases the administrative burdens for continuing education providers, as they can take advantage of one unified, streamlined process rather than needing to obtain three different accreditations. Joint accreditation offers an additional option—not a restriction—for continuing education providers. Organizations that are accredited separately can also produce education for health care teams, and organizations that are awarded joint accreditation can also produce education that is not team-related. In July 2010, the Institute for Healthcare Improvement and VHA became the first two organizations to receive this joint accreditation as providers of continuing education for health care professionals.
STANDARDS FOR COMMERCIAL SUPPORT: A MODEL FOR SAFEGUARDING INDEPENDENCE

The ACCME’s November 2008 strategic plan states that it is a strategic imperative for the ACCME to continue to develop strategies to evaluate and prevent the influence of commercial interests on CME and to provide leadership in matters relating to CME funding. To fulfill that responsibility, the ACCME continues to serve as the custodian for the 2004 Standards for Commercial Support: Standards to Ensure Independence in CME ActivitiesSM, and to facilitate dialogue about strategies for ensuring independence in accredited continuing professional development across the spectrum of health professions.

The Standards for Commercial Support continue to be viewed as a model system. They have been adopted by the ACCME Recognized Accreditors and the Accreditation Council for Pharmacy Education. They have been accepted by the American Academy of Family Physicians, the American Nurses Credentialing Center, the American Osteopathic Association, and the Association of Regulatory Boards of Optometry Committee on Optometric Practitioner Education. The Council of Medical Specialty Societies Code on Interactions with Companies includes a section on CME, which begins by stating: “Societies will comply with ACCME Standards for Commercial Support, including by adopting policies and procedures designed to identify and manage conflicts of interest in company-supported society CME programs.” The Standards have been referenced in state legislation as the standard for independent CME. Representatives from industry have asked other health care professions to consider adopting the ACCME Standards to provide a basis for their interactions.

STANDARDS FOR COMMERCIAL SUPPORT USERS GROUP MEETING

To address the challenges presented by the evolving health care environment, the ACCME convened a Standards for Commercial Support Users Group meeting in September 2010. The meeting brought together leadership from eight organizations to discuss strategies for ensuring the independence of continuing education in health care and related fields. The eight organizations represented were the American Nurses Credentialing Center, the Accreditation Council for Pharmacy Education, the American Osteopathic Association, the American Academy of Family Physicians, the Association of Regulatory Boards of Optometry, the American Dental Association, the International Board of Lactation Consultant Examiners, and the American Academy of Physician Assistants. The ACCME looks forward to participating in similar meetings in the future to facilitate further strategic planning, collaboration, and dialogue.

STANDARDS FOR COMMERCIAL SUPPORT: ADDITIONAL GUIDANCE

Since the release of the Standards for Commercial Support in 2004, the ACCME has worked closely with accredited providers and Recognized Accreditors as they have adapted their CME programs to comply. The ACCME and accredited providers have worked together to develop strategies that facilitate the appropriate free flow of new information and scientific exchange, while preserving accredited CME’s independence and freedom from commercial influence. The ACCME has provided additional guidance related to specific circumstances in response to questions and concerns expressed by accredited providers and other stakeholders.

One such circumstance is training about medical devices. The Food and Drug Administration sets training requirements for some medical equipment. To facilitate the fulfillment of these requirements...
and to support accredited providers’ commitment to offering high-quality, independent education about procedures using medical devices, the ACCME offered additional guidance to accredited providers about how to develop procedural CME that is compliant with the Standards for Commercial Support. This guidance was posted in the form of FAQs on the “Ask ACCME” section of the ACCME Web site. In addition, the ACCME convened a meeting with accredited providers to address these issues, as described in the chapter “Education, Outreach, and Communications."

In 2010, the ACCME released additional guidance about the role of ACCME-defined commercial interest employees in accredited CME, which outlined the ACCME standards for ensuring independence for CME about discovery and research. This guidance was the result of the ACCME and accredited providers working together and recognizing that there are circumstances where an employee of an ACCME-defined commercial interest can make a scientific presentation within accredited CME about their company’s research and be compliant with the ACCME Standards for Commercial Support. The guidance includes examples of important factors for accredited providers and the ACCME to consider in determining an appropriate role for an employee of an ACCME-defined commercial interest in planning or presenting accredited CME. In response, the ACCME received the following statement:

"We applaud the Accreditation Council for Continuing Medical Education’s efforts to provide additional guidance for ensuring research independence and a free flow of scientific exchange, while safeguarding accredited CME from commercial influence. Your vigilance in this important matter contributes to the best practices of unbiased information-sharing and will benefit, ultimately, the health of the American public."

— Raynard S. Kington, MD, PhD, Deputy Director, National Institutes of Health
Collaboration with CME Providers and Other Stakeholders

The ACCME convened a roundtable in December 2009, bringing together a spectrum of CME leaders and the ACCME Board of Directors to address the challenges and opportunities facing accredited CME in 2010 and beyond. The roundtable comprised 50 participants, representing the ACCME Board of Directors and executive staff; the ACCME's seven member organizations; other accrediting organizations, including Recognized Accreditors, the American Academy of Family Physicians and the American Osteopathic Association; and the following stakeholder organizations: the Alliance for CME, the Alliance of Independent Academic Medical Centers, the Society for Academic CME, and the National Association of Medical Education Companies.

In 2008, under the leadership of then Chair, Russell Thomas, DO, the ACCME conceived the roundtable as part of a broader strategy to enhance communications with member organizations and stakeholders. Facilitated by 2009 Board Chair Barbara Barnes, MD, and 2010 Board Chair Debra Perina, MD, the roundtable fostered a high-level, candid dialogue, encompassing issues including ACCME accreditation requirements, CME leadership training, the relationship of CME to physician maintenance of certification and licensure, and communicating CME's value to the wider health care system. This roundtable laid the foundation for an ongoing dialogue about how to advance CME's contributions to health care quality initiatives.

Collaboration with International CME Initiatives

According to ACCME's November 2008 strategic plan, one of its strategic imperatives is to enhance the ACCME's outreach and collaborative roles within the national and global CME community. Throughout the years, the ACCME has participated in and supported CME initiatives with the European Accreditation Council for Continuing Medical Education in Brussels, and with government, health system, and CME representatives from a wide range of countries, including France, India, Ireland, Italy, Japan, Jordan, New Zealand, Singapore, South Africa, Spain, the Sudan, and the United Arab Emirates. Currently, Dr. Kopelow is a member of the International Rome Group on Harmonization of CME/CPD Credit.

In 2010, Dr. Kopelow attended a meeting of the EACCME Advisory Committee, whose members include CME leaders from Germany, Greece, Italy, the United Kingdom, the European Board of Accreditation for Cardiology, and the European Union of Medical Specialties, which operates the EACCME. He gave a presentation at the 2nd International Invitational Forum on CPD Accreditation, co-sponsored by the Royal Australasian College of Physicians and the Royal College of Physicians and Surgeons of Canada.

ACCME executive staff also welcomed visitors from the Jordanian Medical Council, who are seeking assistance for the development of accreditation standards. In November 2010, Dr. Kopelow made two presentations at the First China International Continuing Medical Education Conference in Beijing.

The ACCME provided consultation during the development of a statement on the use of live case demonstrations at cardiology meetings, issued in 2010 by six cardiovascular societies from around the world.
The ACCME has recognized two Canadian CME organizations as substantially equivalent to the ACCME’s accreditation system. The ACCME recognized the Royal College of Physicians and Surgeons of Canada in 2008 and The Association of Faculties of Medicine of Canada in 2010. The recognition of the RCPSC’s and AFMC’s substantial equivalency builds on a relationship between the Canadian CME system and the ACCME that dates from 1984.

**INTERACTIONS WITH GOVERNMENT**

Through its interactions with government, the ACCME aims to fulfill its responsibilities of transparency and accountability, inform public officials about the value of accredited CME, and support national health care quality and safety initiatives.

Dr. Kopelow and other medical organization CEOs were invited to a meeting with David Blumenthal, MD, National Coordinator for Health Information Technology, in February 2011, to discuss integrating health IT with professional medical education, certification, and licensure.

In 2010, the ACCME participated in an Institute of Medicine special project about uniform disclosure of relationships with industry.

Dr. Kopelow and Kate Regnier, MA, MBA, Deputy Chief Executive and Chief Operating Officer, met with representatives from the Senate Committee on Health, Education, Labor, and Pensions; and the House Ways and Means Committee Subcommittee on Health in 2009. In addition, through the efforts of S. Kalani Brady, MD, former ACCME Board member and current member of the Committee for Review and Recognition, Ms. Regnier met with members of the Hawaii congressional delegation. The purpose of the meetings was to discuss the role of accredited CME as a strategic partner in national health care quality and safety initiatives.

**Dr. Kopelow served as special advisor to the White House Office of National Drug Control Policy (ONDCP) from June through December 2009.** He was one of several experts appointed by the ONDCP to help the office formulate long-term drug control policies that improve public health and safety. Dr. Kopelow’s role was to encourage medical organizations, physicians, and health care teams to integrate Screening and Brief Intervention (SBI) into health care practice. SBI is an evidence-based strategy that has been proven effective in identifying and treating substance abuse problems with patients. The ACCME has a long-standing, ongoing collaboration with the ONDCP.

**Dr. Kopelow testified before the U.S. Senate Special Committee on Aging during a July 2009 hearing addressing conflicts of interest in CME.** He detailed the ACCME’s enhanced monitoring and enforcement measures, assuring the committee that the ACCME was an effective firewall between pharmaceutical industry marketing and independent continuing education.

**Dr. Kopelow made a presentation to an advisory committee of the Food and Drug Administration’s Center for Drug Evaluation and Research** during a meeting on Risk Evaluation and Mitigation Strategies (REMS) for extended-release and long-acting opioid analgesics. The July 22–23 meeting was held jointly by the Anesthetic and Life-Support Drugs Advisory Committee and the Drug Safety and Risk Management Advisory Committee. The ACCME was one of two organizations invited to present about continuing education; the Accreditation Council for Pharmacy Education also made a presentation. Dr. Kopelow explained how accredited continuing medical education could be a strategic asset to REMS initiatives, provided the proper controls are in place to ensure independence. The
ACCME is also working with the leadership of CME organizations to explore the role of accredited CME in REMS.

**Governance Staff**

Murray Kopelow, MD, MS (Comm), FRCPC, Chief Executive

Kate Regnier, MA, MBA, Deputy Chief Executive and Chief Operating Officer

Jennifer Dunleavy, MSA, Director, Business and Operations

Ailene Cantelmi, MFA, Manager, Systems Improvement

Ed Kennedy, Manager of Information and Technology

Debbie Payne, MA, Manager, Business and Corporate Governance

Agnes Srebro, BA, Systems Coordinator

**For More Information**

The following resources are available on our Web site, [www.accme.org](http://www.accme.org).

- ACCME Bylaws
- ACCME Board of Directors
- ACCME Board Committees
- ACCME Board of Directors Meetings Executive Summaries
- ACCME Rule-Making Policy
- ACCME Calls for Comment
- ACCME Volunteer Awards

**News Release:** Accreditation Council for CME Announces the Recipients of the 2010 Robert Raszkowski, MD, PhD, ACCME Hero Award

**News Release:** ACCME Announces the Recipients of the 2010 Rutledge W. Howard, MD, Awards

**ACCME Annual Report Data 2009**

**News Release:** Accreditation Council for CME Supports CMSS Code on Interactions with Companies

**News Release:** Accreditation Council for CME Supports Maintenance of Licensure Initiative

**Video Interview:** Paul M. Schyve, MD, Senior Vice President, The Joint Commission

**Joint Accreditation for the Provider of Continuing Education for the Health Care Team**
News Release: Continuing Education Accreditors in Nursing, Pharmacy, and Medicine Award Joint Accreditation to Support Team-based Patient Care

Medical Device and Procedural CME FAQ: Standards for Commercial Support 1: Independence (See question 12 in the FAQ.)

Planning Activities that Utilize Medical Devices: a video interview with Damon Marquis, Director of Education and Member Services for The Society of Thoracic Surgeons, and ACCME Chief Executive Murray Kopelow, MD

News Release: Accreditation Council for CME Releases Additional Guidance on Role of Commercial Interest Employees in CME

Role of Commercial Interest Employees in CME FAQ: Standards for Commercial Support 1: Independence (See questions 8 – 12 in the FAQ.)


News Release: ACCME Chief Executive Testifies at Senate Hearing

News Release: Accreditation Council for CME Provides Input for FDA’s REMS Initiatives
FINANCIAL REPORT AND OPERATIONS

Since its founding in 1981, the Accreditation Council for Continuing Medical Education's (ACCME®) decisions about its operational structure have been guided by its mission and responsibilities as a national accreditation body. The ACCME's goal is to take a prudent and conservative approach to financial management, while maintaining high-quality services for accredited providers, Recognized Accreditors, and volunteers.

OPERATIONAL HISTORY

There have been three major phases in the ACCME's development, as described below.

PHASE 1: CONTRACTED SERVICES AND SPACE

In its early years, the ACCME relied on its member organizations for support and services. Until 1994, the Council of Medical Specialty Societies served as the ACCME's contractor, succeeded by the American Medical Association. As contractors, these organizations provided the ACCME with office and meeting space, part-time executive staff, and administrative services including financial services and information technology support. The ACCME reimbursed these organizations for the services provided with the exception of the years 1994 to 1996, when the AMA provided large annual donations of services and operating funds to support the ACCME's growth, as explained in the following paragraph.

In 1992, the AMA proposed to the other ACCME member organizations that the ACCME expand its operations in order to fulfill its role as a national accrediting body and to provide more resources to the CME provider community. To facilitate the realization of this vision, the AMA succeeded the CMSS as the ACCME's contractor in 1994, and the ACCME relocated its offices to the AMA headquarters in Chicago. In addition to supplying operational support, the AMA provided annual donations of $250,000 in operating funds and $250,000 in services to support the ACCME's transition. To further support the ACCME’s growth, the AMA launched a search for a physician to assume the position of ACCME executive director.

PHASE 2: ACHIEVING INDEPENDENCE

In 1995, with the appointment of Murray Kopelow, MD, as ACCME executive director and secretary, the ACCME began the process of strengthening its position as a national accrediting body. It expanded its services and staff, growing from four to eleven staff members over the next decade. The ACCME was incorporated as a nonprofit corporation in 2003. This status solidified the fiduciary responsibility of the ACCME Board members. In addition, the ACCME ended its financial dependence on the member organizations. The ACCME is now supported solely by fees from CME providers and workshop registrants.
**Phase 3: Expansion**

As the ACCME entered the 21st century, it faced new challenges and responsibilities. The CME enterprise grew in scope and diversity, with accredited providers reporting increasing numbers of activities, instruction hours, and participants. The development of the Internet spurred the creation of new activity formats. Providers’ corporate and organizational structures became more complex. CME program revenue and expenses rose. The amount of commercial support grew dramatically, and the relationships between physicians and industry became increasingly intertwined. These changes generated heightened scrutiny from the government: Two US. Senate committees conducted investigations into CME. The member organizations—representing the profession of medicine, as well as the government—the media, and the public expected more accountability and leadership from the national accreditation system.

Responding to the needs of the evolving CME enterprise and health care environment, the ACCME strengthened its accreditation requirements, increased its transparency, and expanded its services in areas including accreditation, recognition, monitoring, education, outreach, communications, and information technology. In 2008, the ACCME released a strategic plan, outlining its values, goals, and strategic imperatives moving forward. To support this transition, which is described in detail in the preceding chapters, the ACCME expanded its office space and increased its staff. This growth, which began around 2005, enabled the ACCME to improve the services and resources offered to accredited providers, Recognized Accreditors, volunteers, leadership, and staff. This growth also enabled the ACCME to maintain CME accreditation as a voluntary, self-regulatory system.
FINANCIAL REPORT

Since its founding, the ACCME has incurred expenses necessary to support the demands of the CME community and external stakeholders. For its first 20 years, the ACCME experienced small increases in annual expenditures, and reported modest positive margins each year. Beginning in 2003, in response to the growth described in the operational history section above, the ACCME increased expenditures at a more rapid rate. This expansion was supported by accredited provider fee increases. ACCME-accredited providers pay annual accreditation fees as well as periodic reaccreditation fees. One-time fees are assessed for accreditation services, including pre-applications for accreditation and initial accreditation. Progress report fees are assessed as needed based on the results of a provider’s reaccreditation review. Table 7 shows years when there were significant fee changes.

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual ACCME Accredited Provider Fee</th>
<th>Reaccreditation Fee</th>
<th>Pre-Application Fee</th>
<th>Initial Accreditation Fee</th>
<th>Accreditation Progress Report Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>$ -</td>
<td>$ 1,750</td>
<td>$ 75</td>
<td>$ 2,600</td>
<td>$ 200</td>
</tr>
<tr>
<td>1995</td>
<td>$ 750</td>
<td>$ 2,600</td>
<td>$75</td>
<td>$ 2,600</td>
<td>$ 200</td>
</tr>
<tr>
<td>1997</td>
<td>$ 990</td>
<td>$ 3,850</td>
<td>$75</td>
<td>$ 3,850</td>
<td>$ 200</td>
</tr>
<tr>
<td>2000</td>
<td>$ 1,200</td>
<td>$ 3,850</td>
<td>$75</td>
<td>$ 3,850</td>
<td>$ 555</td>
</tr>
<tr>
<td>2004</td>
<td>$ 1,400</td>
<td>$ 5,000</td>
<td>$500</td>
<td>$ 5,000</td>
<td>$ 900</td>
</tr>
<tr>
<td>2007</td>
<td>$ 2,000</td>
<td>$ 6,500</td>
<td>$500</td>
<td>$ 6,500</td>
<td>$ 900</td>
</tr>
<tr>
<td>2010</td>
<td>$ 2,500</td>
<td>$ 7,500</td>
<td>$1,000</td>
<td>$ 7,500</td>
<td>$ 1,500</td>
</tr>
<tr>
<td>2011</td>
<td>$ 3,000</td>
<td>$ 7,500</td>
<td>$1,000</td>
<td>$ 7,500</td>
<td>$ 1,500</td>
</tr>
</tbody>
</table>

TABLE 7

In addition to the fee increases delineated above, in 2009, a nonrecurring special assessment fee provided ACCME with the funds necessary to maintain a positive cumulative margin in the face of new expenses related to the expansion described in the previous section. With the special assessment, providers were charged one-half of 1% of the expenses that they reported in their 2006 annual report data, paying a minimum of $1,200 and a maximum of $7,000.
THE INTRASTATE ACCREDITATION SYSTEM

Beginning in the 1990s, to support its oversight of the intrastate accreditation system, the ACCME charged Recognized Accreditors (state medical societies) fees for recognition services, and collected annual fees per intrastate provider. Beginning in 2004, the ACCME eliminated the fees charged to Recognized Accreditors to decrease their financial burdens and in recognition of the contributions they make to the national accreditation system through their intrastate accreditation programs. The ACCME increased the intrastate provider annual fee from $40 to $80 to compensate for the decrease in income. At their request, Recognized Accreditors have served as the facilitator for fee collection.

In 2008, the ACCME considered increasing intrastate accredited providers’ 2010 annual fees from $80 to $550 in order to achieve a fairer balance between the revenues received by national and intrastate providers, and so that the intrastate providers would support more of the resources they receive from the ACCME. However, in response to concerns that the fee increases would place excessive burdens on intrastate providers, especially in the current economic environment, the ACCME decided to implement the fee increase incrementally, beginning in 2011 instead of 2010. The fee remained $80 in 2010, increased to $250 in 2011, and will increase to $450 in 2012 and to $550 in 2013, as illustrated below. Table 8 shows years when there were significant fee changes.

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual SMS* Accr-</th>
<th>Recognition Fee</th>
<th>Recognition Progress Report Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Recurring Fee (Recurring - paid by SMS-accredited providers)</td>
<td>(eliminated in 2004 - paid by recognized SMS)</td>
<td>(eliminated in 2004 - paid by recognized SMS)</td>
</tr>
<tr>
<td>1991</td>
<td>$</td>
<td>-</td>
<td>150</td>
</tr>
<tr>
<td>1995</td>
<td>30</td>
<td>750</td>
<td>555</td>
</tr>
<tr>
<td>1997</td>
<td>30</td>
<td>3,850</td>
<td>555</td>
</tr>
<tr>
<td>2000</td>
<td>40</td>
<td>3,850</td>
<td>555</td>
</tr>
<tr>
<td>2004</td>
<td>80</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2007</td>
<td>80</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2010</td>
<td>80</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2011</td>
<td>250</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2012 (projected)</td>
<td>450</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2013 (projected)</td>
<td>550</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

*In the table above, SMS stands for state medical societies (Recognized Accreditors).
**FINANCIAL OUTLOOK**

The chart below illustrates the financial growth that has occurred in tandem with the ACCME’s operational expansion. The ACCME’s 2011 budget includes projected 2011 expenses of $5,346,569 and estimated revenues of $4,948,990. The projected 2011 deficit is covered by the funds the ACCME is holding in excess of required reserves. Under the ACCME’s financial plan, the deficit will be closed by 2013.

![ACCME Historical and Projected Revenue and Expense Chart](chart.png)

*Figure 7*
**INCOME AND EXPENSES BY FUNCTION**

The majority of the ACCME’s revenues are derived from fees paid by ACCME-accredited providers. The chart below illustrates the source of the ACCME’s 2010 revenue. SMS stands for state medical societies (Recognized Accreditors).

![ACCME 2010 Revenue Chart]

**Figure 8**

<table>
<thead>
<tr>
<th>2010 Revenue Source</th>
<th>Amount</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual ACCME-Accredited Provider Fees</td>
<td>$1,754,300</td>
<td>38%</td>
</tr>
<tr>
<td>Accreditation Process Fees</td>
<td>$1,569,675</td>
<td>34%</td>
</tr>
<tr>
<td>Annual SMS-Accredited Provider Fees</td>
<td>$124,160</td>
<td>3%</td>
</tr>
<tr>
<td>Donated Volunteer Revenue</td>
<td>$391,275</td>
<td>8%</td>
</tr>
<tr>
<td>Bridge-to-Quality Workshop Revenue</td>
<td>$327,412</td>
<td>7%</td>
</tr>
<tr>
<td>SMS Conference Revenue</td>
<td>$23,175</td>
<td>1%</td>
</tr>
<tr>
<td>Investment Income</td>
<td>$368,566</td>
<td>8%</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>$66,891</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong>:</td>
<td><strong>$4,625,454</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Table 9. ACCME 2010 Revenue: Amounts and Percentages**
The chart above illustrates that the ACCME spent 18% of its 2010 budget on administration and operations expenses, which are necessary for ACCME to accomplish its mission but are not attributed to a specific ACCME program or service. Examples of these expenses are financial accounting and reporting services, fees for corporate insurance, and depreciation of furniture and computer equipment.

The ACCME spent 82% of its 2010 budget on specific programs and services in support of its tax-exempt purpose. These expenditures include the following:

- Accreditation services: Thirty-six percent of 2010 expenditures supported accreditation services for ACCME-accredited providers. This included facilitating the initial and reaccreditation processes for providers, surveyor training, and the development and release of the Program
and Activity Reporting System (PARS). In addition, this category includes a portion of ACCME’s costs incurred for liaison work with outside organizations. This work is for the purpose of promoting the value of accredited CME and for developing and refining accreditation standards. For more information, see the chapter “Governance, Leadership, and Collaboration.”

- Recognition of State Medical Societies: Eleven percent of 2010 expenditures supported the process for recognizing state medical societies as accreditors of intrastate CME providers. These costs included facilitating the recognition process, as well as data collection and analysis services. For more information about Recognized Accreditors, see the chapter “The Intrastate Accreditation System.” In addition, this category includes a portion of ACCME’s costs incurred for liaison work with outside organizations, as described in the paragraph above.

- Accredited Provider Education and Outreach: Eighteen percent of 2010 expenditures supported education services that are made available to all CME providers within the ACCME accreditation system, whether they are directly accredited by the ACCME or are accredited by Recognized Accreditors. See the paragraph below for more information.

- Recognized Accradiator Education and Outreach: Sixteen percent of 2010 expenditures supported education for Recognized Accreditors (state medical societies). See the next paragraph for more information.

The purpose of the ACCME’s education efforts is to advance its mission, foster the development of quality CME, and support volunteers, accredited providers, and Recognized Accreditors. ACCME education is delivered through a variety of channels, including live events, conference calls, webinars, and the ACCME Web site. For more information, see the chapter “Education, Outreach, and Communications.”

**Cost-Containment for the ACCME and Accredited Providers**

The ACCME has implemented measures to contain its own costs and maximize resources, while maintaining the quality of services for accredited providers. These cost-containment measures include the following:

- In 2011, the ACCME will hold two, rather than three, accreditation workshops. The capacity at the two workshops will be expanded to accommodate the demand.

- The ACCME hosts the following events in its offices, eliminating hotel meeting room rental fees, and significantly reducing associated food and beverage costs. The new offices provide more opportunities for the ACCME to facilitate dialogue with accredited providers, volunteers, and other stakeholders.
  - Board of Directors meetings
  - Accreditation Review Committee meetings
  - Town Hall meetings for accredited providers
  - Standards for Commercial Support Users Group meetings
  - Stakeholder meetings
  - Special workshops for accredited providers
As part of its budgeting process, the ACCME evaluates options for controlling the accreditation costs for accredited providers. In 2010, the ACCME moved to telephone conference calls as the standard format for accreditation interviews, rather than on-site or TeleVideo interviews. This move eliminated the cost of paying surveyor travel expenses and TeleVideo costs for some providers. In some cases, this reduced the providers’ accreditation costs by 20 percent. Providers and the ACCME still have the option of requesting or requiring the other formats of interview should circumstances warrant it.

**Operational Structure: Staff and Volunteers**

As it has since its inception, the ACCME continues to rely on its network of dedicated volunteers. Currently, approximately 150 volunteers serve at the national level as surveyors and ACCME Board and committee members.

**Staff Structure**

Initially staffed by a few part-time personnel, the ACCME now has more than 20 employees.

![ACCME Full-Time Equivalents](image)

**Figure 10**
As the diagram below illustrates, staff members are divided into teams, each responsible for one of the ACCME’s major functions. The list of current staff is appended at the end of this section.

**ACCME Staff Structure, 2011**

![Staff Structure Diagram]

**Figure 11**

**FOR MORE INFORMATION**

The resources below are all available at our Web site, [www.accme.org](http://www.accme.org).

- [ACCME Accreditation Fees](#)
- [ACCME Staff](#)
ACCME STAFF

Executive Management Team

**Murray Kopelow, MD, MS(Comm), FRCPC**—Chief Executive
mkopelow@accme.org
As Chief Executive, Dr. Kopelow directs the executive and staff leadership functions of the ACCME, including its relationships with ACCME member organizations as well as external organizations, and serves as the ACCME’s primary media spokesperson.

**Kate Regnier, MA, MBA**—Deputy Chief Executive and Chief Operating Officer
kregnier@accme.org
Ms. Regnier provides executive leadership to the management of the accreditation, recognition, education, and monitoring processes of the ACCME. She is primary liaison to the ACCME’s Board of Directors, and manages ACCME’s relationships with government stakeholders and other health professions’ accreditors.

**Ailene Cantelmi, MFA**—Manager, Systems Improvement
acantelmi@accme.org
Ms. Cantelmi assists the executive staff with the oversight and improvement of the accreditation, recognition, education, communication, and monitoring functions of the ACCME.

**Staff Directors**, listed under their teams below, are also part of the executive management team.

Accreditation and Recognition Team

**Open Position**—Director of Accreditation and Recognition Services
This position involves the oversight of ACCME activities involving accreditation of CME providers and the recognition of state accrediting bodies.

**David Baldwin, MPA**—Manager of Accreditation Services
dbaldwin@accme.org
Mr. Baldwin manages the ACCME’s accreditation process. In addition, he serves as the primary staff liaison for the Accreditation Review Committee.

**Paul Lawlor**—Assistant Manager of Accreditation and Recognition Services
plawlor@accme.org
Mr. Lawlor assists with the validation and implementation of the accreditation and recognition decision-making process, and he serves as the primary resource for CME providers with questions about initial applications, reaccreditation, and progress reports.

**Dennis Lott, DEd**—Manager of Accreditation Development
dlott@accme.org
Dr. Lott contributes to the continuous development and improvement of ACCME’s accreditation function and serves as the primary resource for providers with questions about accreditation policies.
Sharon Nordling—Manager of Recognition Services
snordling@accme.org
Ms. Nordling manages the recognition process for intrastate accreditors. She is the primary contact for state and territory medical societies with questions about recognition.

Erica Hubbard—Survey Services Coordinator
ehubbard@accme.org
Ms. Hubbard facilitates the accreditation and recognition survey interview processes at the ACCME, including interview scheduling and management of accreditation/reaccreditation materials.

Teri McCauley—Coordinator of Accreditation and Recognition
tmccauley@accme.org
Ms. McCauley coordinates the implementation of the accreditation and recognition processes. She administers system-wide production and execution deadlines, reviews recognition materials from accreditors, and provides support for accreditation and recognition-related education activities.

Levi Baer—Administrative Assistant
lbaer@accme.org
Mr. Baer assists the Manager of Accreditation Services in providing support for the Accreditation Review Committee and organizations seeking accreditation or reaccreditation.

Business and Operations Team

Jennifer Dunleavy, MSA—Director
jdunleavy@accme.org
Ms. Dunleavy is responsible for the financial and administrative operations of the organization.

Ed Kennedy—Manager of Information and Technology
ekenndy@accme.org
Mr. Kennedy manages the ACCME’s information and technology resources. He has primary responsibility for the ACCME’s data collection activities. He works with ACCME staff to determine how ACCME can best use technology to support its day-to-day activities.

Debbie Payne, MA—Manager, Business and Corporate Governance
dpayne@accme.org
Ms. Payne is responsible for managing corporate governance issues and for the routine business of the Board of Directors. She is also responsible for managing administrative functions of the ACCME, including accounts payable and accounts receivable.

Open Position—Information and Technology Support Analyst
This position encompasses responsibility for the day-to-day maintenance of ACCME’s information technology resources, and also for assisting in ACCME’s data collection activities.
Open Position— Data and Internet Systems Specialist
This position involves supporting the development and use of ACCME’s database and Web applications to collect, store, and distribute information.

Kathleen Mikulski, MA—Office Coordinator
kmikulski@accme.org
Ms. Mikulski coordinates administrative resources for all staff, processes accounts payable and accounts receivable, coordinates ACCME’s archives, and provides assistance in the continuous improvement of processes and procedures.

Agnes Srebro, BA—Systems Coordinator
asrebro@accme.org
Ms. Srebro coordinates projects related to meetings of the Board and its committees and the activities of the ACCME’s senior management team.

Desiree Banks—Administrative Assistant
dbanks@accme.org
Ms. Banks assists Debbie Payne, Manager of Business and Corporate Governance, in maintaining the day-to-day operations of the ACCME, and is primarily responsible for answering questions from individuals who phone or e-mail ACCME and have questions about ACCME accreditation and the accreditation process.

Education and Outreach Team

Steve Singer, PhD—Director, Education and Outreach
ssinger@accme.org
Dr. Singer directs the education and outreach activities of the ACCME, which include educational support for accredited providers, volunteers, and state accreditors within the ACCME system.

Marcia K. Martin—Manager, Provider Education and Outreach
mmartin@accme.org
Ms. Martin manages ACCME’s education and improvement initiatives for national and state-accredited providers, including the “Understanding ACCME Accreditation” workshops.

Kelly Roberts—Manager of Systems Education and Outreach
kroberts@accme.org
Ms. Roberts manages education and outreach activities to various stakeholders within the national CME system, including education and training for ACCME volunteers and Recognized Accreditors.

Katherine Swimm—Coordinator, Education and Outreach
kswimm@accme.org
Ms. Swimm provides support to the Department of Education and Outreach in the planning and implementation of the ACCME’s educational initiatives for national and state-accredited providers, the intrastate accreditation system, and ACCME volunteer surveyors.
Communications

**Tamar Hosansky**—Director, Communications  
thosansky@accme.org
Ms. Hosansky manages media relations, and develops strategies for communicating the value of accreditation and ACCME’s mission to the public, media, healthcare professionals, and other stakeholders.

Monitoring and Improvement

**Heidi Richgruber**—Manager, Monitoring and Improvement  
hrichgruber@accme.org
Ms. Richgruber works to refine and expand ACCME's monitoring and surveillance systems.