Incentivising Higher Level Outcome Achievement in Continuing Education: Five-Year Experience from the ACCME Commendation Criteria

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ABSTRACT
The Accreditation Council for Continuing Medical Education (ACCME®) Menu of Criteria for Commendation was created to incentivise a variety of behaviours and outcomes from accredited providers. ACCME analysed data from among the 1,053 accreditation decisions made between November 2017 and March 2022, of which 122 had applied for commendation. Accredited providers plan for higher level outcomes in their activities at an increasing rate over the past five years. Since 2017, 49 (40%) of the 122 organisations that applied for commendation under ACCME’s new Menu of Criteria for Commendation were awarded this distinction. Of the organisations applying for commendation, 62%, 48% and 31% sought commendation using the “performance”, “quality” and “community health” criteria, respectively. The success rate for each of these criteria was 78%, 68% and 66% respectively. Accreditation incentives can change the performance of educational providers and augment the quality and efficacy of continuing education.

Introduction
The Accreditation Council for Continuing Medical Education (ACCME®) mission is to assure and advance quality learning for healthcare professionals that drives improvements in patient care. As part of that mission the organisation continually modifies its accreditation criteria to incentivise best practices in education that deliver key learning and skill outcomes for the profession.

In 2016 the ACCME released the new Menu of Criteria for Accreditation with Commendation (Figure 1) to incentivise organisations to advance their educational strategy and recognise organisations that excel as continuing medical education (CME) providers[1]. The commendation criteria encourage and reward CME providers for implementing best practices in pedagogy, engagement, evaluation, and change management. The revised criteria newly added an obligatory expectation that commendable providers would demonstrate they could generate meaningful behavioural and health outcomes for their learners and their communities. The criteria further serve as a guidepost for the future of CME, recognising the achievements of organisations that advance interprofessional collaborative practice, address public health priorities, create behavioural change, demonstrate leadership, leverage educational technology, and demonstrate the impact of education on healthcare professionals and patients [2–4].

The menu of 16 commendation criteria is divided into five categories: Promotes Team-based Education, Addresses Public Health Priorities, Enhances Skills, Demonstrates Educational Leadership, and Achieves Outcomes. The Achieves Outcomes category is designed to drive improvement in the performance of learners, improvement in healthcare quality, and improvement in patient or community health. To be eligible for Accreditation with Commendation, CME providers need to submit evidence for, and be found in compliance with all core accreditation criteria and, in addition, demonstrate compliance with eight of the 16 commendation criteria, including at least one from the Achieves Outcomes category. To demonstrate compliance with the Achieves Outcomes criteria, the provider needs to demonstrate that its CME activities have had a positive impact on learner behaviour, healthcare quality, and/or patient/community health.

Educational providers achieving commendation receive a six-year accreditation term, rather than the four years granted to those that achieve accreditation and are awarded a special mark to display this distinction.
Methods

Organisations seeking reaccreditation submit a self-study describing their work, and report on their own continuing programme improvement. This data is stored in a secure data system and was analysed for trends and values. ACCME’s committees and staff make accreditation decisions every four months. Activities from the accreditation term are selected for audit, and the accredited provider must supply these files. ACCME staff and surveyor-volunteers review the material submitted and make findings in the file that are then communicated to the Accreditation Review Committee (ARC) member and presented for consideration and final decision-making by the entire committee. Decisions are cross-checked and confirmed at multiple levels (several staff, surveyor, ARC member, decision committee of the board) to ensure integrity and accuracy of the decision.

The accreditation and commendation criteria have been consistent through a five-year period and continuously applied. ACCME reviews providers’ attestations and claims about measured systems change and audits a fraction of these claims.

Data are amalgamated from ACCME data files as permitted by ACCME data policies and with the annual permission of accredited providers as part of their annual attestation.

Results

In the five years between November 2017 and March 2022, 1,053 organisations had their accreditation status reviewed by the ARC and ACCME staff. Of these, 122 (12%) organisations representing all provider types have applied for Accreditation with Commendation using the Menu of Criteria for Commendation and 49, or 40% of those that applied, achieved commendation status. The percentage of organisations submitting for improves performance, improves healthcare quality and improves patient/
community health were 62% (76/122), 48% (59/122) and 31% (38/122) respectively (Figure 2); 24% of organisations submitted more than one of the outcomes criteria. Examples for each are shown in Table 1. The fraction of organisations that were judged to have successfully met the criteria were 78% (59/76 organisations), 68% (40/59 organisations) and 66% (25/38 organisations) respectively.

Of the 122 organisations that applied for commendation, 44 (36%) were membership organisations, 18 (15%) were hospitals or healthcare facilities, 29 (24%) were medical schools, 19 (16%) were medical education companies or publishers, 5 (4%) were insurance or managed care companies (Figure 3). This represented 23% (44/189 membership organisations), 3% (18/548 hospitals or healthcare facilities), 32% (29/90 medical schools), 18% (19/107 medical education companies or publishers), and 3% (5/16 insurance or managed care companies) of these types of organisations that could have applied for commendation during that five-year period. The success rate at achieving commendation by organisation type was 30% (membership organisations), 33% (hospitals or healthcare organisations), 52% (medical schools), 47% (medical education companies or publishers) and 80% (insurance company/managed care organisation) respectively.

**Discussion**

CPD for healthcare professionals has little utility if it is not driving changes in individual behaviour, evolving processes of care, or improving community or population health [4–6]. Despite the consistent signal that CPD is effective at driving the learning and knowledge outcomes for healthcare professionals, it is always more challenging

![Diagram showing Provider Distribution by Organization Type](image-url)

**Figure 2.** Provider distribution by organisation type.

| Table 1. Reported impact on outcomes related to an educational intervention. |
|---------------------------------|---------------------------------|
| Achieves Outcomes Criterion | Reported improvements                                      |
| Improves Performance          | 60% percent of respondents described specific practice changes each had made, including application of new surgical techniques that improve outcomes and safety of care, purchased new equipment to facilitate ideal surgical practices, and increased ratings by colleague staff in the surgical suite related to communications. Majority of respondents implemented specific practice changes, including consulting and deploying evidence-based guidelines, utilising antimicrobial stewardship principles, and participating in a team-based approach to patient care. Majority of survey respondents made documented improvements to their practice, including reports documenting the implementation of new screening practices for population health and documented improved compliance with an appropriate diagnostic algorithm. |
| Improves Healthcare Quality    | Increase in the evaluation of patients for primary hyperparathyroidism using renal imaging from 20% to 50% of patients. 60% increase in patients receiving smoking cessation interventions over a one-year period compared to before the activity. Decrease in opioid prescription dispense rates and statistically significant 26% decrease in morphine milligram equivalents and 19% decrease in drug overdose deaths for county residents. Reduced new cases of Hepatitis A from 495 to 0 in just over two years. |
| Improves Patient/Community Health | Absolute increase in 7% of eligible patients in the community who received the human papillomavirus (HPV) vaccine, and 12% increase in patients 65 years and older who received the pneumococcal vaccine, exceeding the national pace of change. HIV viral load suppression rates improved to 90% in the patient population following the activities. Combo-3 (paediatric) community vaccination rate rose to 71%, a 7% improvement from baseline, reversing a preceding trend. Several stroke endpoints improved including discharge without disability, response time, efficiency of diagnosis and time to initial treatment. |
and onerous to link educational interventions to higher level individual and system change [7–10].

ACCME’s commendation criteria encourage and challenge accredited CME providers to be innovative in their development of educational activities to drive improvement in learner performance, healthcare quality, and patient/community health [1,2]. Organizations striving for excellence leverage the Achieves Outcomes criteria to elevate their offerings and devise their education to meet the unique and real needs in their healthcare environment.

The data presented here shows that educational organisations of varying types and sizes have responded to ACCME’s call to evolve towards higher level outcomes, have been tracking these outcomes, linking them to community and population health, and showing that CPD can drive meaningful change and evolution in healthcare.

This study’s strengths include its breadth, size and scope including all nationally accredited educational providers for a five-year period. The criteria have remained consistent throughout, are objectively determined using a multi-layer review process that itself is subject to review. The same dataset and system lend themselves to consistency in data management.

The study has limitations that should be acknowledged. The study does not include data from state-accredited educational providers that provide local CPD activities. Higher level outcomes must be linked to the designated educational needs and strategy, but educational strategy alone is not necessarily the only input driving system or organisational performance.

This data demonstrates that CPD providers can drive and facilitate meaningful change in their learners, their organisation, and in their communities. An accreditor’s ability to aggregate data and system performance allows a broader view of educational efficacy and impact through the health professions. Ultimately the data shows that CPD systems can leverage advancing insight into drivers of health professional and team performance to evolve the healthcare system for us all.

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References

[1] Accreditation Council for Continuing Medical Education. Accreditation Criteria. (cited 2022 Jul 28). Available from: https://www.accme.org/accreditation-rules/accreditation-criteria

[2] Accreditation Council for Continuing Medical Education. New commendation criteria resources. [cited 2022 Jul 28]. Available from: https://www.accme.org/highlights/new-commendation-criteria-resources

[3] McMahon GT. Facilitating flexibility: the role of CPD regulators and accreditors during a crisis. J Eur CME. 2021 Nov 11;10(1):1993432.

[4] McMahon GT, Newton WP. Continuing board certification: seeing our way forward. J Am Board Fam Med. 2020 Sep-Oct;33(Suppl):S10–S14.

[5] Ramani S, McMahon GT, Armstrong EG. Continuing professional development to foster behaviour change: from principles to practice in health professions education. Med Teach. 2019 Sep;41(9):1045–1052.

[6] Dave Davis DA, McMahon GT. Translating evidence into practice: lessons for CPD. Med Teach. 2018 Sep;40(9):892–895.

[7] Griebenow R, Mills P, Stein J, et al. Outcomes in CME/CPD - Special Collection: how to make the "pyramid" a perpetuum mobile. J Eur CME. 2020 Oct 27;9(1):1832750.

[8] Moore DE Jr, Green JS, Gallis HA. Achieving desired results and improved outcomes: integrating planning and assessment throughout learning activities. J Contin Educ Health Prof. 2009;29(1):1–7.

[9] Stevenson R, Moore DE Jr. Ascent to the summit of the CME pyramid. JAMA. 2018;319(6):543–544.

[10] Cervero RM, Gaines JK. The impact of CME on physician performance and patient health outcomes: an updated synthesis of systematic reviews. J Contin Educ Health Prof. 2015;35(2):131–138.