COMMENTARY

The benefits of accrediting institutions and organisations as providers of continuing professional education

Murray Kopelow¹ and Craig Campbell²

¹ Accreditation Council for Continuing Medical Education (ACCME), Chicago, IL, USA
² Royal College of Physicians and Surgeons of Canada, Office of Professional Affairs, Ottawa, Canada

Abstract

Professionals learn and change throughout their careers. This continuing professional development is supported, in part, by educational activities developed by individuals, organisations or institutions.

In Europe and North America, processes have been established to set standards for the design and delivery of continuing healthcare professionals’ education (CE) that involve either approval of organisations as institutional providers of CE (i.e. accreditation) or approval of individual CE activities.

In systems based on provider accreditation, the accredited organisations develop into communities of practice that show evidence of learning and changing such as to allow the CE system to evolve. In addition the provider accreditation model provides an amplification effect not found in activity accreditation systems, whereby one accreditation decision can result in multiple activities being generated. Additional efficiencies can be identified and may be useful to those determining if a provider accreditation system is an appropriate fit for their system, for their context and for the culture of professional education in which they operate.

Keywords: accreditation, continuing, medical, education

Professionals learn and change throughout their careers.¹ This continuing professional development is supported, in part, by educational activities developed by individuals, organisations or institutions.

In Europe and North America, processes have been established to set standards for the design and delivery of continuing healthcare professionals’ education (CE) and to certify that these standards have been met.²–⁵ These processes involve either approval (i.e. accreditation) of organisations as institutional providers of CE,²,³ or approval of individual CE activities.⁴,⁵ The latter is referred to as activity accreditation.

In activity accreditation, there are standards set for the educational event or activity. Applicants for accreditation first plan the educational activity and then present documentation to the accreditor verifying compliance with the accreditor’s standards. If the activity meets those standards, then the event is approved. The second approach is referred to as provider accreditation, where an organisation or institution as a whole, as well as a sample of individual activities, is evaluated to see if that organisation or institution meets the accreditor’s standards. If it does, then the organisation is accredited as a provider of continuing professional education activities. In provider

Correspondence: Murray Kopelow MD, MS(Comm), FRCP, President and Chief Executive Officer, Accreditation Council for Continuing Medical Education (ACCME), 515 North State Street, Suite 1801, Chicago, IL 60654, USA. Tel: +312-527-9200. Email: mkopelow@accme.org. Web: www.accme.org

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accreditation, the accredited provider is responsible for ensuring that every activity complies with the accreditation requirements, but all the activities are not individually reviewed by the accreditor.

In this essay, we seek to offer some perspectives on the attributes and outcomes of provider accreditation within our two continuing medical education systems. We hope that these perspectives will be of assistance to those considering whether a provider accreditation system is an appropriate fit for their system, for their context and for the culture of professional education in which they operate. This essay does not intend to compare and contrast provider accreditation and activity accreditation. The authors leave that comparison to the readers.

We believe there are four organisational or operational attributes of provider accreditation that are not often recognized and should be considered by those making decisions about the development of accreditation systems.

**Organisational and operational advantages of provider accreditation**

1. Provider accreditation contributes directly to the development and evolution of an institution or organisation beyond its ability just to create continuing education activities.

In provider accreditation there are requirements that relate to the whole organisation (e.g., a statement of organisational mission; the need for the organisation to collaborate with other organisations; evidence that the organisation participates in healthcare quality improvement activities). These requirements result in accredited providers, as organisations, measurably changing and improving, over time, towards a common set of goals (Figure 1). The system becomes populated with organisations that have demonstrated criterion-referenced development.

2. Provider accreditation predisposes to the development of a community of practice.

A community is “a group of people with a common characteristic or interest living together within a larger society”. A community of practice develops around common goals or common interests. The development of a community of practice among accredited providers is based on their commitment to demonstrate the values and principles articulated within the system’s accreditation standards. This community is self-organising with formal and informal membership groups (e.g., LIST-SERVEs, LinkedIn discussion groups, Twitter feeds created by accredited providers), that offer the opportunity for interaction among leaders, educators and administrators in this community with common interests.

This community is a learning community and acts as an academy for learning about CE which, as a scholarly pursuit can evolve and improve. This scholarship goes beyond discovery and includes the integration and application of new information on the effectiveness of CE into the practices of CE providers. There are evidence-based accreditation requirements that reflect the integration of discovery into practice. As such, the community’s learning can integrate the new knowledge developed in discovery within their CE programmes. This community is a conduit for the dissemination and distribution of important developments in education, administration and evaluation which are relevant to the effectiveness of CE (e.g., innovations in CE; compliance strategies; new laws; external forces impacting on accredited providers).

![Figure 1](image-url)
The provider community is also an evolving community. Changes in provider accreditation tend to be second-order changes where the community itself is changed through accreditation requirements (e.g. the Accreditation Council for Continuing Medical Education (ACCME)’s 2006 engagement criteria and the ACCME’s 2004 addition of requirements regarding the identification and resolution of conflict of interest). The self-organisation, tacit learning and the commitment to demonstrate quality within this community of practice are associated with interactions, interdependency and competition that contribute to the vibrancy and continuous improvement of accredited providers. As a community, accredited CE providers can participate in national and international systems for healthcare quality improvement. As a community of accredited providers, there are individuals and organisations for accreditation and CE advocacy that relate to and influence other parts of the health care system. For example, there are interactions between professional organisations, government and health care providers. Through this engagement, the community has the opportunity to integrate within and be relevant to the broader health care system and becomes a vehicle for advocacy and implementation of accreditation standards and practices.

Table 1. Where energy is expended for accredited continuing education.

| Energy Expended | Description |
|-----------------|-------------|
| 1. Maintain an organization’s whole program of continuing education |
| 2. Develop a single activity, in compliance |
| 3. Submit a single activity for accreditation/approval |
| 4. Submit a whole program for accreditation |
| 5. Have an accreditor review a single activity for compliance |
| 6. Have an accreditor review an organization’s whole program of continuing education for compliance |

Table 1 lists parameters the authors have identified that describe where providers and accreditors expend effort, or energy to ensure accreditation standards are met. The parameters represent the provider side (items 1, 2, 3 and 4) and the accreditor side (items 5 and 6) of the energy equation. In this model, regardless of the type of accreditation system, providers spend energy maintaining their organisation, developing educational activities and then submitting them for review by the accreditor. Accreditors spend a certain amount of energy reviewing each organisation’s programme of CME and/or their activities. We believe, that while there is some variation, the amount of energy expended on each of these could be considered constant, in an energy equation or calculation.

Therefore, the number of activities created and the number of activities reviewed become the variables that determine the energy expended in the system.
Each activity would have to be reviewed by an accredditor in an activity approval/accreditation system. However, the number of activities reviewed by a provider accreditter is set by the accreditter. In the authors’ provider systems the accreditors have set this as 15 activities reviewed in each accreditation cycle.

Hypothetical values can be assigned to all these parameters from which the energy costs across a range of activity numbers within the two accreditation formats can be extrapolated. The authors have represented the results of these calculations in Figure 2.

Figure 2 shows that in this theoretical calculation, the energy cost within an activity accreditation system is lower than the energy cost of a provider accreditation system when providers are producing fewer than 15 activities per year. At this tipping point, the sum cost of approving each activity outweighs the providers’ costs of a programme review and the accreditors costs of performing a programme review. There are few opportunities for economies of scale or scope within activity accreditation. It is not clear how many CE submissions an activity accreditation system can accommodate. The ACCME system, which operates under provider accreditation, reports about 100,000 activities per year and utilises about 100 surveyors, 25 committee reviewers and 7 ACCME staff to accomplish this task. The human and fiscal resources required to review 100,000 activities per year have never been determined but would surely be enormous.

**Conclusion**

Accreditation involves the setting of standards by an accreditter followed by a process to determine the degree to which adherence to these standards has been met. We have described the organisational and operational benefits of provider accreditation that include the development of a community of practice to foster learning, scholarship and system change. In addition, provider accreditation offers an amplification effect in the number of accredited CE activities that can be handled by the system as well as striking economies of scale and scope over activity accreditation.

Interestingly, regardless of the type of accreditation, in all cases, providers are notified they have been given approval by the accreditter based on their ability to demonstrate their adherence to the established standards and requirements. So, one might say in the end, that all CE accreditation is in fact provider accreditation in which some systems offer provider accreditation one activity at a time. The cost effectiveness of this choice can be based in part on the economics resulting from our hypothetical model, as well as the potential impact that accreditation systems can have on both organisations and the broader health-care systems within which they exist.

**Declaration of interest**

The authors report no declarations of interest. The authors alone are responsible for the content and writing of the paper.

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