

# CME BRIEFING®

NEWS, OPINIONS, AND PERSPECTIVES IN CONTINUING MEDICAL EDUCATION • APRIL-JUNE 2004

## Setting the Stage for Something Big

By now you've probably heard rumblings (and then some!) about new concepts in CME, one example being physicians getting CME credit for answering a clinical question about a patient by using a fact-based resource at the time of the patient encounter, and then applying that answer to the management approach for that patient. You may have heard this referred to as *point of care learning*, *real-time learning*, *practice-based learning*, *reflection in practice*, or a *self-directed learning activity*, but by whatever term, many agree that this is the quintessential CME experience for the clinician.

Incorporating this type of activity into the existing credit system required a good deal of thought, and also some "experimenting." Several ongoing pilot programs are helping to assess this concept in physician learning and apply it to the current CME credit system.

### The Pilot Programs

Both the American Medical Association (AMA) and the American Academy of Family Physicians (AAFP) are involved in several pilot programs at this time.

To start, the AMA is addressing different uses of dynamic database searching as a physician learning activity within AMA's credit system. One application, explained Charles Willis, Administrative Director of AMA's Continuing Physician Professional Development (CPPD), is the awarding of credit based on investigating a topic at the time of the patient encounter. AMA is also looking at awarding an additional increment of credit for work subsequent to

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**Leadership Conference Team tackles CME challenges**

**New guidelines from Advamed are in effect**

## Leadership Conference Team Generates Ideas for CME Providers

CME mentors and those who plan to follow in their footsteps met at the second *CME Leadership in the 21st Century*, a 5-day event cosponsored by the Duke University School of Medicine, Durham, North Carolina, and Thomson Professional Postgraduate Services®, Secaucus, New Jersey. Daytime sessions of the Leadership Conference featured discussions, interactive lectures, debates, and case studies on CME principles, leadership topics, and healthcare issues. Working dinners and informal after-dinner sessions completed the day. Together, these elements of the 2003 curriculum offered many unique learning

opportunities to enhance the professional roles and performance of seasoned, new, and future CME leaders. One of these opportunities was the Team Project.

### The Team Project: Background

The task for one of the teams was to identify a typical CME challenge, prepare a 15-minute presentation for fellow Leadership Conference participants, and submit the project for publication to *CME Briefing*. The "Wolfpack Team" decided to tackle the problem of *outcomes assessment*. The team included seven members from diverse CME backgrounds: two

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## CME BRIEFING®

CME BRIEFING is published by Thomson Professional Postgraduate Services® (PPS), a division of Thomson Physicians World. The mission of this newsletter is to disseminate news and information about CME and to foster dialogue among the concerned parties, including the medical profession, government, industry, and CME sponsors.

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## FOR YOUR CALENDAR

### UPCOMING CME MEETINGS FOR CME PROFESSIONALS

#### **The Alliance for CME (ACME), the Association for Hospital Medical Education (AHME), and the Society for Academic CME (SACME) "CME Congress 2004"**

May 15-18, 2004  
Toronto, Ontario, Canada

#### **For more information, contact:**

Conference Secretariat,  
University of Toronto  
**Phone:** 1 (416) 978-2719;  
1 (888) 512-8173 (toll-free North America only)  
**Fax:** 1 (416) 971-2200  
**Website:** [www.cmecongress.org](http://www.cmecongress.org)

#### **GAME Annual Meeting**

June 20-22, 2004  
New York, NY

#### **For more information, contact:**

**Phone:** 1 (845) 888-0080  
**Fax:** 1 (845) 888-0082  
**Website:** [www.game-cme.org](http://www.game-cme.org)

#### **15th Annual Conference of the National Task Force on CME Provider/Industry Collaboration**

September 27-30, 2004  
Baltimore, MD

#### **For more information, contact:**

Regina Littleton  
**Phone:** 1 (312) 464-4637  
**E-mail:** [regina\\_littleton@ama-assn.org](mailto:regina_littleton@ama-assn.org)

#### **NAAMECC Annual Education Meeting**

September 29, 2004, 5:30-7:30 PM  
Baltimore, MA

#### **For more information, visit:**

**Website:** [www.naamecc.org](http://www.naamecc.org)

#### **Society for Academic Continuing Medical Education (SACME) Fall Meeting**

November 5-7, 2004  
Boston, MA

#### **For more information, contact:**

Jim Ranieri  
**Phone:** 1 (205) 978-7990  
**Website:** [www.sacme.org](http://www.sacme.org)

#### **Accreditation Council for Continuing Medical Education (ACCME) ACCME Workshops for 2004**

August 1-2, 2004  
December 10-11, 2004  
Chicago, IL

#### **For more information, contact:**

ACCME  
**Phone:** 1 (312) 755-7401  
**Fax:** 1 (312) 755-7496  
**Website:** [www.accme.org](http://www.accme.org)

#### **Alliance for Continuing Medical Education Future Annual Conferences**

**30th Annual Conference**  
January 26-29, 2005  
San Francisco, CA

**31st Annual Conference**  
January 25-28, 2006  
New Orleans, LA

**32nd Annual Conference**  
January 17-20, 2007  
Phoenix, AZ

#### **For more information, contact:**

Alliance for Continuing Medical Education  
**Phone:** 1 (205) 824-1355  
**Fax:** 1 (205) 824-1357  
**Website:** [www.acme-assn.org](http://www.acme-assn.org)

## Leadership Conference

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from medical communication companies; a doctoral student in adult education; a hospital CME director; a medical school CME director; and two faculty advisors, one from the industry side and one from a medical association (see **The Wolfpack Team**).

The goal of the project was to identify methods of outcomes assessment that could be conducted in conjunction with various educational methodologies: a live activity; an enduring material; an Internet-based CME activity; and small group, case-based sessions. The intention was to prepare a menu of helpful ideas that could be shared with other CME providers. The team was interested in measuring both short-term and long-term outcomes.

### Team Decisions: Selecting a Frame of Reference and Making Some Assumptions

In the book, *The Continuing Professional Development of Physicians – From Research to Practice* (see **Resources**, page 9), Donald E. Moore, Jr, PhD, Director, Division of CME, Vanderbilt University School of Medicine, Nashville, Tennessee, defines outcomes as “the result of the effect of an event or the consequences of an action.” As a frame of reference, the Wolfpack Team considered the six levels of outcomes assessment discussed by Dr Moore:

- 1) Participation
- 2) Satisfaction
- 3) Learning
- 4) Performance
- 5) Patient Health
- 6) Population Health

However, because most CME providers are currently measuring *Participation*, *Satisfaction*, and *Learning* through the postactivity evaluation form, the team decided to direct their efforts to developing outcomes assessment strategies that focused on *Performance*.

To place the task within the framework of a real-life situation, the team devised an example of an educational need and made several assumptions\*:

**Target Audience:** Primary care physicians in a small health clinic.

**Educational Need:** With the current epidemic of diabetes in the United States and the debilitating effects of the disease, it is critical that primary care physicians routinely perform a foot examination of their patients with diabetes.

**Educational Objective:** At the conclusion of this activity, the participant will begin to include a foot examination at every appointment with a patient with diabetes.

**\*Note: This scenario is greatly simplified for the purpose of creating an example. The team acknowledged that in clinical practice, quality care of patients with diabetes requires a much more extensive clinical examination.**

### “Outcomes” From the Wolfpack Team

Within the context of this example, the Wolfpack Team created a list of potential techniques to measure outcomes for various educational methodologies. These techniques are described here.

#### Live Activity

Perform a chart review of a sample population of the health clinic patients with diabetes to determine the rate of foot examinations (ie, establish baseline data). Conduct an educational activity on the importance of routine foot examinations in patients with diabetes. Perform chart review of the same population 3 months after the educational intervention and compare data for measurement of performance change.

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*“Working with such a diverse group enabled us all to get a glimpse of the challenges faced by CME staff in various types of organizations.”*

Julie L. White, MS  
Wolfpack Team Member

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This could be expanded to include distribution (to the participants at the educational activity) of a physician self-reporting chart or checklist used to document behaviors such as: 1) ordering laboratory tests for lipid profiles, blood glucose, and hemoglobin

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### The Wolfpack Team

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## Setting the Stage for Something Big

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the encounter—in other words, the depth of research on topics of clinical interest after the patient leaves. And finally there is a change in practice in accordance with what has been searched. As Willis noted, “the ultimate recognition of the activity is a change in clinical practice.”

The biggest participant in the AMA's pilot on physician-directed interactive Internet CME was UpToDate, a database system of evidence-based medicine that clinicians can tap into to answer a clinical inquiry. AMA's pilot program includes other participants as well. By using any of these systems, the clinician gains access to massive amounts of published clinical information—information that has been sorted, sifted, categorized, and reviewed—through a hand-held device or a desktop/laptop computer. Some of the common features of clinical decision support tools are shown in Table 1.

According to Willis, UpToDate was structured for this type of activity, is accredited by the Accreditation Council for Continuing Medical Education (ACCME), and has extensive experience producing certified enduring materials (CME activities in CD-ROM format)—all bonuses in conducting the AMA pilot.

In its pilot program, the AAFP has been working with the developers of InfoRetriever, another database system of evidence-based medicine. InfoRetriever in particular was developed by family physicians for family physicians, making it the obvious choice for the AAFP pilot program.

A goal of the AAFP pilot was to develop a process and a proposal for awarding Prescribed credit for this type of activity, which Nancy Davis, PhD, Director, Division of Continuing Medical Education at AAFP, calls “meaningful CME.”

Why these organizations for the pilot? AMA and AAFP represent two of the major physician credit systems in the United States (the third being the American Osteopathic Association), and between them, will touch virtually all physicians. It made sense that with reciprocity between the AMA PRA and

AAFP credit systems, both organizations would seek to conduct parallel pilot projects in these areas.

### **Preparing for a Different Type of CME Activity: Where Does It Fit in the Credit System?**

As Willis describes it, there is really nothing new about physicians looking things up. The whole *raison d'être* for a county medical society was that physicians would have a physical resource for checking on medical information and getting their questions answered. Physician-driven learning is not new. The fact that it is recognized as important by the AMA also is nothing new.

But within the AMA credit system, this type of physician-driven learning experience was always classified as eligible for Category 2 credit (where physicians independently determine their learning activities), serving an important function by supplementing the formal activities that fall under Category 1. When finally approved at the AMA, this type of activity will be eligible for Category 1 credit. “We are retrieving some of these physician-directed activities that have historically been part of Category 2,” said Willis, “and formally recognize them as part of Category 1.”

Likewise within AAFP, there has always been a mechanism for family physicians to report this type of activity for a limited amount of Elective credit, but the new system would allow for Prescribed credit.

### **Philosophical Differences Emerge: What Is Being Measured?**

Incorporating this type of an activity into existing credit systems raised a big question at AAFP. What was being measured by these new modalities of CME? According to Davis, “It isn't ‘time.’ We need to be measuring how the doctor is using this information.”

In January 2004, AAFP's Commission on CME came up with a proposal for awarding credit that will require physicians to document the clinical question, the database source they used to research the question, and how they applied it to the patient (or if they didn't eventually use it with the patient, as long as it's documented). Realizing how onerous this may sound, AAFP will be developing a template that

will make it very easy to document this process, either in a hand-held or desktop computer format. AAFP proposes awarding .5 credit per question, capping it at 15 credits for the total number of required credits that are permitted under this type of activity. This proposal will be considered by AAFP's Commission on CME at their June 2004 meeting.

"The issue is the critical thinking and the clinical decision that is made," said Davis. If the physician has a question, she noted, "they search the evidence for the answer, and then they make a clinical decision as to whether or not it is appropriate for that patient. That certainly is learning. It forces them into a reflection process, and that is something we would like to see more of in CME."

For the most part, AAFP expects that at the outset, the database sources themselves (UpToDate, InfoRetriever, etc) will be the CME provider for this type of activity. Some of the database sources are accredited by the ACCME to provide CME credit, although AAFP does not require that a provider be ACCME accredited. It is also likely that other types of CME providers can get involved in this type of activity.

The AMA sees incorporation of this type of CME into their credit system a little differently. Even if "time" is not the metric, it may serve as a simple tool by which to track the depth of a clinician's engagement with the literature. An additional clinical inquiry or a further examination of the patient-oriented literature should be recognized for an additional increment of credit, as long as the physician provides a structured response to the search. "The physician can be as ambitious as they want to be in terms of implementing this," said Willis. AMA has yet to finalize its recommendations on the physician-directed interactive Internet CME; a workable format will not be ready until later this year.

### **Performance in Practice/Quality Improvement Pilot Programs**

Both the AMA and AAFP are also running pilot programs in the area of performance in practice/quality improvement.

"Point of care learning and quality improvement certainly fit together," said Davis.

"The clinical decision support tools used for point of care learning will be helpful in not only helping physicians know what the practice norms are but also the interventions they might implement to get themselves there."

What Willis refers to as the "poster child" of performance measurement is determination of compliance in practice with well-established chronic disease management protocols or screening protocols. An example often cited is management of the diabetic patient, during which clinicians periodically assess the checks and measures for this particular chronic disease (retinal examination, extremi-

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## **TABLE 1. Learn More About Clinical Decision Support Tools**

- Databases
- All web-based; many are available in a hand-held format
- Evidence-based to varying degrees
- Helps the physician answer a clinical question at the point of care
  - What is the differential diagnosis?
  - What is the appropriate treatment for this condition?
  - How should I manage this disease?

### **UpToDate:**

<http://www.uptodate.com/>

### **InfoRetriever:**

<http://www.info poems.com/>

### **SKOLAR:**

<http://www.skolar.com/>

### **ACP PIER:**

<http://pier.acponline.org/index.html?hp>

### **DynaMed:**

<http://www.dynamicmedical.com/>

### **MDConsult:**

<http://www.mdconsult.com/>

### **PDxMD:**

<http://www.pdxmd.com/home/pdxmd.htm?/>

### **Changed to FIRST Consult:**

[http://www.firstconsult.com/home/framework/fs\\_main.htm](http://www.firstconsult.com/home/framework/fs_main.htm)

### **MerckMedicus:**

[http://www.merckmedicus.com/pp/us/hcp/hcp\\_home.jsp](http://www.merckmedicus.com/pp/us/hcp/hcp_home.jsp)

# Medical Technology Association Updates Its Ethical Guidelines

The Board of Directors of AdvaMed, the Advanced Medical Technology Association, has approved its Code of Ethics on Interactions with Health Care Professionals, effective January 1, 2004. Like the Pharmaceutical Research and Manufacturers of America (PhRMA) Code on Interactions, the AdvaMed Code is voluntary (Table 1) but is being widely distributed and strongly encouraged, to ensure a high standard of ethical conduct by the medical technology industry.

By reaching out to its members alone, AdvaMed is casting a very wide net with its Code. AdvaMed is the largest medical technology association in the world, representing more than 1,000 manufacturers of medical devices, diagnostic products, and medical information systems; its members manufacture 90% of the US healthcare technology purchased annually.

Because AdvaMed members and healthcare professionals must interact closely on several levels, it is especially important to promote ethical relations during these encounters. The types of interaction that can occur between AdvaMed members and healthcare professionals are:

- Collaborative and consulting relationships between parties to develop new technology or improve existing technology

- Member roles of instructor or educator, or the training, service, and technical support offered by members to healthcare professionals on the safe and effective use of the technology
- For research and education purposes or when enhancing a healthcare professional's skills

The principle of the Code is this: "Members shall encourage ethical business practices and socially responsible industry conduct and shall not use any unlawful inducement in order to sell, lease, recommend, or arrange for the sale, lease, or prescription of, their products." Table 2 summarizes "do's and don'ts" of the Code. (For a review of do's and don'ts for the PhRMA Code, see the article titled "Cutting the Strings on Gifts and Other Questionable Marketing Practices: PhRMA Takes a Stand" ([www.ppscme.org/CMEBriefing/CMEBriefingSummer2002.pdf](http://www.ppscme.org/CMEBriefing/CMEBriefingSummer2002.pdf)); or "Summer 2002" issue at the "Download back issues" section of CME Briefing at [www.ppscme.org](http://www.ppscme.org)).

For more information on AdvaMed and its Code, visit [www.advamed.org](http://www.advamed.org). Available to AdvaMed members only: a valuable resource that can help the CME professional easily relate, compare, and contrast the following guidelines and recommendations—AdvaMed, American Medical Association, and PhRMA Codes and the Final OIG Compliance Guidance for Pharmaceutical Manufacturers.

**TABLE 1.** AdvaMed and PhRMA Codes

	<b>AdvaMed</b>	<b>PhRMA</b>
<b>Effective:</b>	January 1, 2004	July 1, 2002
<b>Participation:</b>	Voluntary	Voluntary
<b>Available at:</b>	<a href="http://www.advamed.org/publicdocs.html">www.advamed.org/publicdocs.html</a>	<a href="http://www.phrma.org/publications/quickfacts/19.04.2002.388.cfm">http://www.phrma.org/publications/quickfacts/19.04.2002.388.cfm</a> - summary  <a href="http://www.phrma.org/publications/policy/2002-04-19.391.pdf">http://www.phrma.org/publications/policy/2002-04-19.391.pdf</a>
<b>Addresses interactions between:</b>	Medical technology companies and healthcare professionals	Pharmaceutical companies and healthcare professionals
<b>Goal:</b>	To facilitate ethical interactions	To facilitate ethical interactions

**TABLE 2.** Medical Technology Industry Working Within the Code

<b>Areas of Interaction</b>	<b>Yes, per Code</b>	<b>No, per Code</b>
<p><b>Member-Sponsored Product Training and Education</b></p> <p><i>It is the members' responsibility to educate and train healthcare professionals on medical technology products. (It is mandated by the FDA in some cases.) Such sessions are usually centrally located and may be more than 1 day</i></p>	<p>Training and education conducted at a facility conducive to teaching and learning</p> <p>"Hands-on training" conducted at an appropriate facility by qualified staff members with technology expertise</p> <p>Modest* meals/receptions</p> <p>Reasonable travel and modest lodging</p> <p>* Moderate or low value and subordinate in time and focus</p>	<p>Meals that overshadow the educational focus, or extend beyond modest value</p> <p>Meals, hospitality, travel, or other expenses for guests of healthcare professionals, or for anyone without a bona fide interest in the information</p>
<p><b>Third-Party Educational Conferences</b></p> <p><i>Independent, educational, scientific, or policy-making conferences that promote scientific knowledge, medical advancement, and the delivery of effective healthcare</i></p> <p><i>*Responsible for and should control selection of program content, faculty, healthcare professionals in training, educational methods, and materials</i></p>	<p>Grants to the conference sponsor* to reduce conference costs for the benefit of all attendees, or to the sponsor or training institution to cover attendance for healthcare professionals in training</p> <p>Funding to conference sponsor for modest meals/receptions</p> <p>Recommendations on knowledgeable faculty (but conference sponsor has final decision)</p> <p>Funding to conference sponsor for reasonable honoraria, travel, lodging, and meals for faculty</p>	<p>Direct payment of registration or seminar fees or travel for attendees</p> <p>Dictating conference attendees/faculty</p>
<p><b>Sales and Promotional Meetings</b></p> <p><i>Discussion of product features, contract negotiations, and sales terms. Such sessions are usually held close to the healthcare professional's place of business</i></p>	<p>Modest meals/receptions that are conducive to an information exchange</p> <p>Reasonable travel for attendees when necessary</p>	<p>Meals, hospitality, travel, or lodging for guests of healthcare professionals, or for anyone without a bona fide interest in the information</p>
<p><b>Arrangements With Consultants</b></p> <p><i>Consultants who provide bona fide consulting services (research, advisory board participation, presentations at training, or product collaboration). Arrangements are written, with all services specified, and signed by all parties (written research protocol for research consulting)</i></p>	<p>Selection of consultant based on his/her qualifications and expertise</p> <p>Reasonable compensation</p> <p>Venue conducive to an information exchange</p> <p>Modest hospitality</p> <p>Reasonable expenses for consultant's travel, meals, lodging</p>	<p>Selection of consultant based on his/her volume or value of business</p> <p>Compensation outside fair market value for services</p> <p>No legitimate need or purpose for the service</p> <p>Hospitality that overshadows the focus of the meeting, or extends beyond modest value</p>
<p><b>Gifts</b></p> <p><i>Items that benefit patients or serve a genuine educational purpose (not including provision of sample products and opportunities for product evaluation)</i></p>	<p>Fair market &lt;\$100 (other than textbook or anatomical models)</p> <p>Branded promotional items (pens/notebooks) of minimal value related to work or for patient benefit</p>	<p>Cash or cash equivalents or inappropriate gifts, such as wine baskets</p> <p>Repeated gifts to the same person or gifts to multiple members of a physician practice group (may violate spirit of the Code)</p> <p>Branded promotional items that do not benefit patients, such as golf balls or tee shirts</p>
<p><b>Reimbursement and Other Economic Information</b></p> <p><i>Provide reimbursement information to a healthcare professional (related to coverage, coding, billing)</i></p>	<p>Support accurate and responsible billing to Medicare and other payors by providing reimbursement information</p>	<p>Provide technical or other support for the purpose of unlawfully inducing healthcare professionals to purchase, lease, recommend, use, or arrange for purchase, lease, or prescription of products</p>
<p><b>Grants and Other Charitable Donations</b></p> <p><i>Donations made for a charitable purpose (supporting genuine independent medical research for the advancement of science or education; providing medical devices to those who perform volunteer disaster relief)</i></p>	<p>Donations for charitable purposes, for the most part made to charitable organizations and appropriately documented</p>	<p>Donations made for the purpose of unlawfully inducing healthcare professionals to purchase, lease, recommend, use, or arrange for purchase, lease, or prescription of products</p>

# The Evolution and Future of CME, Through the Eye of a Leader: *One-on-One With Dennis Wentz, MD*

**A**fter 15 years of service with the American Medical Association (AMA), Dennis K. Wentz, MD, has retired, although, as you can imagine, he is still vitally active in the field. *CME Briefing* had one last sit-down with this respected figure in medicine and CME, and we share his insights and perspectives here.

**CMEB:** What surprises you most about how CME has evolved over the past 25 years?

**DKW:** How fast the field has grown to encompass a variety of CME providers. I thought medical schools and specialty societies would be the major players, always. Now we have many other organizations accredited to provide CME that bring new skills and innovative approaches to physician learning.

What disappoints me is that we haven't reached a true continuum of medical education with the full commitment of all the players in medical education. An example is our medical schools, which observe the reality of the continuum firsthand: teaching medical students, teaching residents, and then staying involved with keeping practicing physicians current. It surprises me that this hasn't evolved further.

The nicest surprise is that CME has really gotten to be much more organized and much better. We are even beginning to ask—and we are teaching physicians to regularly ask—“What is the evidence for this approach?”

**What do you consider the greatest accomplishment of the AMA?**

Fostering a movement of self-directed physician learning, and rewarding physician learning in the workplace. Ongoing pilot programs at the AMA are developing this: credit for CME that brings knowledge to the physician when they need it, and moving CME to assist the physician in learning from their own practices—studying what they are doing in relationship to their peers and national norms to achieve the best outcomes. From that sort of feedback will come motivation for improvement.

The pressures on physicians are many, and the AMA is trying to help them in many ways, including keeping CME relevant to their needs. In our discipline of CME, we must relate CME to what physicians are doing and to what they need in their practices—to make the best information available when they need it, and then help them reflect on what they have done and use that knowledge to analyze how they compare with their peers and relevant practice guidelines.

But we had to do all this very carefully, because AMA PRA credit is used to satisfy mandatory requirements and regulations from licensing boards, hospitals, etc, so we have to “retrofit” the credit system to recognize these new types of learning and have it accepted.

**How can CME providers prepare for the future?**

Providers of CME will need to educate the healthcare system about CME and its key role in patient care, in terms of funding for it and time available for physicians to participate in it.

How can a doctor, who today is pressed to see more and more patients, make time for CME? Shouldn't CME be built into the healthcare system somehow, and shouldn't funding be built in to support it? You have to build in a new approach in order to give physicians time and access to quality CME at a cost they can afford.

The funding now is too unidirectional. It is not from tuition, because physicians pay relatively small fees to attend. There is a lot of support coming from industry, but for example, there is virtually none coming from any government sources, from the managed care industry, from hospitals, or from many others who should be supportive. I think the funding will change dramatically as we move CME away from fixed “courses” into the daily life of the doctor.

All this is a major challenge that CME providers will have to agree and unite on, to figure out a better way. In doing so, they will also have to enlist the public and make the public aware of the need for CME and what it does for them.

**In the Winter 2004 CPPD Report (published by the AMA), you wrote, “We now live in a CME environment that fosters academic inquiry.” How will this play out in CME?**

The big move is for physicians to always ask the question, “What is the evidence for this point of view?” Asking that question will drive the provision of CME. We must always foster the spirit of inquiry. In this sort of environment, all of us—physicians, CME professionals, and CME teachers—will learn. Of course, there is still much to learn about how new knowledge translates into practice.

**What can the next generation of physicians look forward to in CME?**

The next generation of physicians will be trained so that CME is a part of their daily life, and they will get “tailor-made CME” when they need it. Changing times and demographics will ensure that we don't rely as much on “attending activities” or bringing formal programs to physicians, but rather on getting CME to them at the point of practice need.

The physician community is also going to have to work in parallel with the other professions in medicine (pharmacy, nursing) in order to integrate different levels of knowledge.

I hope we can also work with the osteopathic community through the American Osteopathic Association to unify our approaches to CME. AMA and AOA provide two different CME credit systems with different requirements. Yet in the real world, once physicians are licensed, they do and need the same things. We have to build a unified CME front with the osteopathic medical community.

## Leadership Conference

Continued from page 3

A1C levels; and 2) physical examination components such as foot examinations or examining for signs of retinopathy (microvasculature), and smoking history. The physician would be asked to maintain this chart over 3 months to track changes in the laboratory profiles of blood glucose levels, for example, of their patients. The patient could also be asked to monitor and chart their own blood glucose levels during a 3-month period and report this information back to their physician. Changes in performance—and with it, potentially changes in patient health—could be noted.

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*“The readiness of physicians for CME activities that focus on performance varies from person to person and from topic to topic. The more facts and numbers we can provide to physicians on the benefits of such programs, the greater that ‘readiness’ will be.”*

George Bousaba, MD  
Wolfpack Team Member

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### Enduring Material

A monograph could be developed on the topic of foot examinations in the patient with diabetes. On the evaluation form that accompanies the enduring material, participants are asked if they intend to make changes in their practice as a result of this activity and if they would be willing to complete a short postactivity survey to measure outcomes. A database of these names is maintained; the group is then contacted (by fax or email) 3 months after returning the monograph posttest to determine if changes in practice have been made as intended.

### Internet-Based CME Activity

A website could be created for participants of an Internet-based activity, in which primary care physicians could enter practice data anonymously, after a CME activity, on the frequency that the foot examination is conducted for their patients with diabetes. This information could be processed into measurable data—for physicians to com-

pare themselves against their peers and for the CME provider to measure outcomes.

### Small Group, Case-Based Sessions

In this type of activity, physicians from the same or similar practices could meet in a small group to tackle a practice-based problem. The group is led and facilitated by an area thought leader. Specific take-home tools, such as checklists and charts to measure the frequency of foot examinations, are provided to participants. Additional faculty experts are available to the participants to discuss practice issues and patient problems. The group is assigned the task of measuring the frequency of foot examinations in their practice, employing the checklists and charts that have been provided.

The group reconvenes in 3 months, at which time participants return with data produced through use of the practice tools, revealing the outcomes of the collective impact of these tools. The thought leader discusses the results of the data with the group, and facilitates discussion centering on creating future practice change.

### Conclusion

These suggestions for measuring outcomes at the level of physician performance offer a few preliminary ideas for CME professionals. In order for the measurement of outcomes to be successful, the physician must be committed to measuring and making changes in practice. As far as we may have come, there is still much work to do in the area of outcomes assessment.

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*“The Leadership Conference is an opportunity for networking and for the growth and development of our CME professionals, so they can enhance their knowledge and skills base in parallel with the professional growth of the physicians they serve.”*

Dennis K. Wentz, MD  
Wolfpack Team Faculty Advisor

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### Resources

Davis D, Barnes B, Fox R. *The Continuing Professional Development of Physicians: From Research to Practice.*

Chicago IL: AMA Press, 2003.

This book takes the concept of continuing professional development, which has been adopted by the American Medical Association, and turns it from theory into practice as an agent for positive physician performance change. In 16 chapters edited and organized into three major sections, more than two dozen noted contributors from throughout the medical education field consider how forces driving the evolution of the physician workforce are affecting the approach to lifelong learning. The importance of physicians reflecting on their clinical experience to direct their learning is emphasized, and specific examples of ways to help the self-directed learner can be found throughout. All who are dedicated to assisting physicians in that learning and improving healthcare will find the book to be forward-looking, comprehensive, thought-provoking, and informative.

## Setting the Stage for Something Big

*Continued from page 5*

ties check, hemoglobin A1C levels, etc) against current standards for care. If the clinician's practice is not in line with the norms, changes can occur, and the cycle can be repeated and remeasured.

"AMA's goal," explained Willis, "is to provide opportunities for clinicians to self-assess their practice and end up with a documented change in practice, which is what everybody wants." In Willis's perfect world, any effort by a physician that enables him or her to critically examine a facet of practice for the purpose of improving it should be eligible for credit.

"Building on quality improvement," said Willis, "will assist physicians in meeting some of the outside mandates for documenting improvement." In fact, documented performance improvement in practice is of great interest to sources *outside* the AMA (state societies, medical boards, certifying boards). Willis continued, "I can't recommend that the AMA credit system be in the business of satisfying exogenous demands; however, we can work within the credit system to help physicians meet those demands."

Willis sees performance measurement improvement (vs the physician-directed interactive Internet CME) as the more profound change in terms of CME and CPPD—and not surprisingly, the more difficult to accomplish. "It requires more planning and execution over time," explained Willis, "it is more resource intensive, and there is no easy 'Jack-in-the-Box' business model for it."

### **Important Goals to Meet: Maintaining Physician Certification/Competence**

One goal of CME is to have objective, measurable outcomes and evidence of positive changes in physician practices. As noted by James Thompson, MD, President and CEO of the Federation of State Medical Boards (FSMB) of the United States, point of care learning and quality improvement initiatives allow physicians to promote efficient and effective practice patterns in their area of expertise. (The FSMB is a national organi-

zation whose mission is to improve the quality, safety, and integrity of healthcare by promoting high standards for licensure and regulation of the practice of medicine in the United States.)

In Thompson's view, through these types of CME activities, physicians will be able to develop personalized, self-directed learning and assessment strategies to improve the quality of their work and also improve patient outcomes. "Point of care learning and quality improvement," Thompson noted, "are essential components of CME and credible mechanisms that help to assure the public that physicians are maintaining a level of competence throughout their professional careers."

Maintenance of certification by the American Board of Medical Specialties (ABMS), includes four core elements, one of which is participation in lifelong learning and self-assessment. (The aim of the ABMS is to assure the public that physicians can provide quality patient care.)

"The key to CME from the vantage point of ABMS is learning," said Stephen Miller, MD, MPH, Executive Vice President of the ABMS. The ABMS has been very vocal in trying to move the construct from considering CME as simply an "educational program" to making sure that learning occurs; that it is documented that learning occurs; and as a result of the learning, there is a change in behavior. "Point of care learning (lifelong learning) and quality improvement in practice (self-assessment) fit in precisely with the essence of maintenance of certification," said Miller.

What excites Miller is that these new directions in CME get away from simply documenting that a physician attended a course and instead shift it to the heart of learning: Did the physicians learn something that was then useful and caused them to change their behavior in a positive way to affect patient care? "This is the ultimate outcome for learning in my view," concluded Miller.

So, stay tuned as we all learn more from these ongoing pilot programs. Those rumblings you've been hearing are the sound of something big in CME.

# C M E C O N G R E S S 2 0 0 4

## How Continuing Medical Education Helps Translate Knowledge Into Practice

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Mark Smith, MD, MBA, *President and CEO, California Health Care Foundation, Oakland, CA*

##### Commentary: National and International Perspectives on the Forces for Change

Dennis K. Wentz, MD, *Director Emeritus, Division of CPPD, AMA*  
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Sharon Straus, MD, *Knowledge Translation Program, Department of Medicine, University of Toronto*

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Karen Mann, BN, MSc, PhD, *Professor and Director, Division of Medical Education, Dalhousie University, Halifax, NS*

##### Commentary: Applying Educational Theory in:

- **the Academic Medical Center**  
Barbara E. Barnes, MD, MS, *University of Pittsburgh*
- **the Specialty Society**  
Nancy Davis, PhD, *American Academy of Family Physicians*
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Jeremy Grimshaw, MB, ChB, PhD, *Director, Clinical Epidemiology Program, Ottawa Health Research Institute, Director, Centre for Best Practice, Institute of Population Health, University of Ottawa, Ottawa, ON*

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Steven Minnick, MD, *St. John Hospital, Detroit, MI*
- **Community Practices**  
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Donald E. Melnick, MD, *Senior Vice President, National Board of Medical Examiners, Philadelphia, PA*

##### Commentary: Relationships Among Recertification, Re-licensure and CME

Dale Dauphinee, MD, *Medical Council of Canada*

##### Commentary: MEP — One Model Linking Licensing Bodies and CME Providers

Daniel Klass, MD, *College of Physicians and Surgeons of Ontario*

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