

CME BRIEFING

NEWS, OPINIONS, AND PERSPECTIVES IN CONTINUING MEDICAL EDUCATION ~ DECEMBER 2002–FEBRUARY 2003

A SERVICE OF THOMSON PROFESSIONAL POSTGRADUATE SERVICES®, SECAUCUS, NEW JERSEY

CME Leadership in the 21st Century: Preparing for a Different CME

According to current leaders, CME is in for a radical change. Although not a particularly new insight, it has been gaining momentum lately. Those who plan to lead CME in the future need to know what that future will be. An intense leadership program is helping people understand the nature and scope of the change, how the change can affect CME providers, and how leaders can be most effective in the new CME system.

CME: A New View

So what will the future be? According to Joseph Green, PhD, Associate Dean for CME at Duke School of Medicine, Durham, North Carolina, "The bottom line of CME in the past has been the activities we produced—how many, how much they cost, how many people came." In essence, CME was more activity-oriented than learner-oriented. "Not only do you have to focus on the learner," explained Green, "you have to focus on the learner in the context in which they are learning, which is the healthcare environment where they practice medicine."

With this comes an entirely different approach to designing, implementing, and evaluating CME, because it starts with understanding where the problems are in the provision of healthcare. With a shift toward improvement in healthcare outcomes, CME providers would work backward from outcomes to the appropriate learning experiences for the individual and/or the healthcare team, rather than starting with the activity itself. As an example, Green noted that CME is likely to revolve around activities relevant to physician self-assessment of their competencies. "These are the kinds of things we need to do," he said.

And others agree. "We need to shift from offering episodic live meetings to a more multifaceted

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generation of CME leaders
need to know?*

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to be an effective leader
in a changing CME world?*



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Changing Physician Behavior With an Online Program in Domestic Violence

Introduction

Injury or trauma resulting from domestic violence is a frequent reason for healthcare visits, but the signs are going unnoticed by healthcare professionals, so says the literature and John M. Harris, Jr, MD, President of Medical Directions, Inc. (MDI), an education company working to promote change in this area. The changes are for good reasons: there is a high societal cost associated with failing to address domestic violence, and experts in the field agree that healthcare professionals who deal with domestic violence issues need to improve skills and build confidence when encountering a situation in practice.

Harris noted, "The best approaches to domestic violence by healthcare systems seem to involve professional education along with case management and systems solutions that anticipate needs and reduce the burden of response on individual healthcare professionals." Of course, they also need to reach a multitude of physicians. Here is where an Internet-based domestic violence CME program offers promise.

Changing Behavior Through Education

Harris knows the value of the Internet. "There is no other medium out there that lets us

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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.

PPS is dedicated to health-related education for physicians, para-professionals, and patients.

Thomson Professional Postgraduate Services® is accredited by the ACCME to provide continuing medical education for physicians.

We are proud of our 30-year history of medical publishing, and feel a responsibility to enhance medical education by improving communication among interested parties. Our proactive relationship with the government, the medical profession, industry, and CME sponsors will benefit from the input of our readers. Please send comments or questions about this newsletter to the CME BRIEFING Editor.

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Just Ask

To begin a network among readers and to address some of the practical issues facing those who work in continuing medical education, CME Briefing is starting a column of commonly asked questions and answers. If you have a question about CME issues, Just Ask. Contact PPSCME-Editor@pwcg.com. Here's a sample of what you can expect in coming issues of CME Briefing.

Is there a new statement that can be used by CME providers prior to receiving official notification by the American Academy of Family Physicians (AAFP) of CME credit determination?

Yes. In June 2002, the AAFP's Commission on Continuing Medical Education approved the statement CME providers can use prior to receiving official notification of AAFP CME credit determination but only after the application for CME credit has been received by the AAFP for review. The statement must be printed as follows and the second sentence must appear in bold: "Application for CME credit has been filed with the American Academy of Family Physicians. **Determination of credit is pending.**"

Is it true that some of the accrediting organizations have "joined forces" in their application process for providers seeking accreditation?

Yes. In an effort to consolidate documentation for accreditation that is essentially the same, the Accreditation Council for Continuing Medical Education (ACCME), the American Council on Pharmaceutical Education (ACPE), and the American Nurses Credentialing Center (ANCC) have developed a unified self-study report for accreditation, which means that providers seeking accreditation status from two or more of these accreditors can get some relief in the accreditation process. The new unified report will be field-tested through September 2003. For more details, interested providers should visit the websites for these organizations: www.accme.org, www.acpe-accredit.org, www.nursecredentialing.org.

AMA PRA Booklet Is Available

The American Medical Association Physician's Recognition Award (AMA PRA) Information Booklet for CME Providers Version 3.2 is available. The PRA certificate and credit system was established by the AMA to recognize those physicians who stay current in the field by taking part in CME activities. The AMA PRA Booklet provides in one convenient source the standards that must be applied for CME activities designated for AMA PRA category 1 credit—a vital tool for all accredited providers.

To obtain a PRA booklet, application, or other information, visit www.ama-assn.org/go/pr, or send an email to pra@ama-assn.org, or call 1 (312) 464-4672.

Bulk copies of the booklet or application may be ordered from the AMA by calling 1 (800) 621-8335.

Changing Physician Behavior With an Online Program in Domestic Violence

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many people interact with each other," he said, "and that's the power of it." He sees it as a golden opportunity for a program on this topic.

The online CME program on domestic violence started in 1999. At this time, MDI worked with Dr Zita Surprenant and Dr Roland Maiuro, experts in these issues, to create scenarios that would engage primary care physicians in the medical aspect of a case, and then offer a trigger or clue that something is not right or that a situation of domestic violence could be sus-

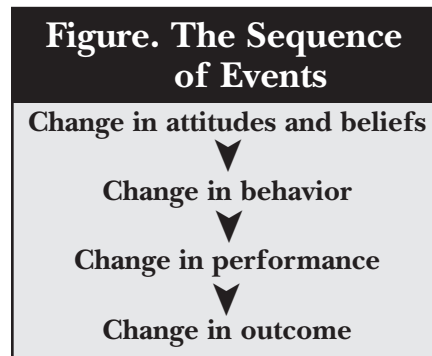
"The best approaches to domestic violence by healthcare systems seem to involve professional education along with case management and systems solutions that anticipate needs...."

pected. The program provided a specific educational message around the mnemonic "RADAR" to help physicians better manage domestic violence patients: Routinely screen female patients, Ask direct questions, Document your findings, Assess patient safety, and Review options and referrals.

The program communicated key behavioral messages, guided physicians through the office screening process, and offered downloadable tools to be used as office aids. Hundreds of physicians took part, giving many positive responses to this version of the program, which is being updated and expanded for

specific specialty groups.

Harris emphasizes, "CME really is about changing behavior through education—about doing something different, doing it better." But he also knows behavior may not change without an accompanying change in attitudes, beliefs, and knowledge (see Figure).



The Logistics of All This

Harris calls domestic violence a CME "orphan," standing with some other social issues not associated with a drug and, therefore, not always benefiting from traditional sources of grant support.

A resource his company used for the program's development was the government's Small Business Innovation and Research (SBIR) program. The National Institutes of Health funds the program to allow small businesses to develop innovative projects that deal with healthcare. The SBIR process includes three phases: the first phase provides a grant for "proof of concept"; the second provides a grant for development of a product and testing (evaluation); the third (not funded by SBIR) is commercialization of the product.

MDI used a Phase 1 grant in 2000 to improve and evaluate the online domestic violence program. This work was detailed in a 2002 *Family Medicine* article. When MDI studied the effects of the online program, it measured the program's results in changing physician attitudes and beliefs using a survey developed at the University of Washington. Surprisingly, the

online program showed better results than had been achieved by researchers at the University of Washington in a live 2-day course.

Based on these strong findings, MDI received a second SBIR grant in 2002 to measure actual changes in physician performance after participation in the program, as demonstrated by increased screening and an improved ability to refer patients to appropriate community resources. In other words, the grant will enable MDI to look for very specific behavior outcomes to see if physicians, after participating in this program, are better at screening and referring patients. "The way physicians can improve the health outcome in domestic violence," Harris said, "is by screening for it, and when they find it, by doing the right thing."

Under the second grant, MDI will conduct two studies on online CME in domestic violence in four cities. One of the studies will be done in Phoenix, Arizona, and Kansas City, Kansas. MDI will be working in Phoenix with PrimeCare, a physician network managed by Banner Health, a large hospital system, and in Kansas City with a

"CME really is about changing behavior through education—about doing something different, doing it better."

local medical society, to recruit physicians from several primary care specialties and randomly assign them to the online program (education arm) or not (control group, no education).

The 3-year study will evaluate physician offices of the education and control arms before and immediately following the education program to determine if the prac-

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approach of nontraditional education interventions, based heavily on physician self-assessment,” said Bruce Bellande, PhD, Executive Director of the Alliance for CME, Birmingham, Alabama. He noted many of the factors in the CME environment that are driving this new focus (Figure).

Robert E. Kristofco, MSW, Director of CME at the University of Alabama in Birmingham, also has a good idea about physician needs. According to Kristofco, “We have to pay attention to activities that are going to change the landscape of CME, including residency training, maintenance of competence, and recertification.” Echoing the sentiments of many, Kristofco added, “How we get from where we are today to where we need to be is where leadership comes in.”

How leaders can move the current system of CME toward its new future is what the Leadership Conference was all about.

CME Leadership in the 21st Century: Satisfying a Current Need

One major problem with cultivating a new generation of leaders to guide, direct, and implement the profound and significant changes facing CME is that there are no established programs to do so. Green noted, “We don’t have any mechanism for training the next generation of CME leaders, not in a formal systematic way.” While Green was uncovering this need, Murray Kopelow, MD, MSC, FRCPC, Chief Executive of the Accreditation Council for Continuing Medical Education, Chicago, Illinois, had been considering a program for physician leadership in CME. According to Kopelow, “Physician leaders in CME need to know about education, they need to know about education in the context of quality improvement, and they need to know system issues across the healthcare and health education system in order to conceptualize their role.” In fact, there was really

Figure. Driving Factors in CME: An Environmental Scan

Deaths related to medical errors are increasingly apparent, calling into question patient safety and whether CME is addressing physicians’ true needs

Organized medicine focuses on the use of CME in maintaining physician core competencies (ie, ABMS, FSMB, AMA, CMSS)

Relationship between the healthcare professional and industry is addressed (ie, PhRMA Code, OIG Draft Guidance)

CME community focuses on obtaining tangible evidence of physician behavior change, and on content validity (use of evidence-based CME vs alternative medicine or practice not supported by qualified research findings)

CME system overhaul likely to address the need for physician self-assessment and maintenance of competency (all players)

ABBREVIATIONS

ABMS = AMERICAN BOARD OF MEDICAL SPECIALTIES; FSMB = FEDERATION OF STATE MEDICAL BOARDS; AMA = AMERICAN MEDICAL ASSOCIATION; CMSS = COUNCIL OF MEDICAL SPECIALTY SOCIETIES; PhRMA = PHARMACEUTICAL RESEARCH AND MANUFACTURERS OF AMERICA; OIG = OFFICE OF THE INSPECTOR GENERAL.

no difference between the needs of the physician leaders and nonphysician leaders in this regard. They both need the same thing—a need that this conference clearly satisfied.

Helping Leaders Improve and Expand the World of CME

The 4-day conference, *CME Leadership in the 21st Century*, held in September 2002, brought together potential and future leaders in CME to prepare them for the challenges ahead. Green served as cochair, with Bellande, Kopelow, and Kristofco (among others; see *Leadership Conference Faculty*, page 7) serving as faculty members. The conference utilized group discussions, panel debates, case-study workshops, and mentoring sessions on topics that included the healthcare environment, physician learning, and the future CME system. The conference was cosponsored by the Duke Office of Continuing Medical Education and Thomson Professional Postgraduate Services®, Secaucus, New Jersey.

Green, along with cochair Marty Cearnal, President and Chief Execu-

tive Officer, Thomson Physicians World, wanted the conference to be real-world oriented—practical, pragmatic, and applicable. Green administered a leadership challenge form up front for participants to identify their greatest obstacles. Participants were encouraged throughout the program to keep their leadership challenge top of mind and to think about how they would apply what they were hearing at the sessions to their challenge. An implementation plan, also a requirement for participants, asked them to state what they gained from the meeting and how they would be applying it “back home.” Participants have also agreed to take part in an evaluation 3 to 4 months after the program.

The real value of the conference, noted Bellande, was that it made the participants aware of the scope and significance of the changes facing CME, and it provided an opportunity for experts to present the new vision of CME and the implications of that vision. (See *Synergizing Resources for a Better CME*, page 5.) According to Bellande, “The meeting will send forth a

cadre of new leaders to help us move the profession forward and help their colleagues better understand how CME is changing, in what direction it is changing, and the new skill set that leaders must possess.” (See *Leadership Skill Set for a Future CME*, page 7.)

Adding to the meeting dynamics was a good cross-section of participants. Said Kristofco, “The cross-section made a difference, because participants could appreciate other dimensions of their concerns.”

“Taking the time to find out about all of the players in the CME arena” is an important aspect of successful leadership, noted Maureen Doyle-Scharff, conference participant, and Director of Professional Affairs, Pharmacia, Washington, New Jersey. Doyle-Scharff is head of a division that works closely with professional associations at the national and state levels in supporting medical education for their members. Pharmacia was one of the supporters of the Leadership Conference, which is not surprising given its history in CME. Noted Doyle-Scharff, “Pharmacia, our legacy company The Upjohn Company, and Searle take pride in being some of the forerunners in defining the role of industry in working with accredited CME providers.” (See *Achieving Success in the Partnership of Industry and CME Providers*, page 6.) Pharmacia also supports other CME-related endeavors.

For Doyle-Scharff, the valuable aspect of the conference was the opportunity to hear from her mentors and, for her own professional development, verification that she is on the right track in her thinking about CME. For Mila Kostic, Director of Continuing Medical Education at the University of Pennsylvania School of Medicine, Philadelphia, this was a rare opportunity to exchange experiences and ideas with colleagues and faculty in a small group setting.

In talking about what the Leadership Conference achieved, Kopelow said, “Maybe we have germinated conceptually the development of the

CME professionals, and it will spread.” And perhaps it should. In a March 2002 Task Force Report, the Council of Medical Specialty Societies noted 16 recommendations for the repositioning of CME to be in line with the maintenance of physician competence. One of those recommendations is: The CME enterprise should encourage the development of educational opportunities for CME providers to engage in continuous learning and professional development, to acquire the skills and competency necessary for effective implementation of the new system proposed herein. “The Leadership Conference,” said Kopelow, “was exactly the implementation of that recommendation.”

Under the New System, Should CME Leaders Be Certified?

“The leadership in CME,” Kostic noted, “is facing increasing demands, and these changes require constant personal and professional improvement and growth.” With such a heavy focus on CME leadership skills and abilities in the new CME system, an obvious question arises: Should CME leaders be certified?

Bellande has asked this question before, specifically in a 2-year study conducted among the membership of the Alliance for CME. In assessing the data, Bellande and the Alliance learned that those with less experience, lower education levels, and shorter tenure placed more value on certification for themselves than those with more experience, education, and

Synergizing Resources for a Better CME

Mila Kostic, *Director, Continuing Medical Education, University of Pennsylvania School of Medicine*

With previous CME experience in medical education and communication, I recently assumed responsibility for leading the CME office of the University of Pennsylvania Medical School. My challenges are no different than those we all face at this time, most importantly, how to motivate stakeholders around me to change the ineffective and inefficient practices in CME, and how to energize physician educators in a large health system to become partners in developing meaningful, engaging, highly targeted CME offerings that make sense for today’s diverse group of practicing physicians. An even greater challenge is how to integrate this so that the CQI department (continuous quality improvement), P&T Committee (Pharmacy and Therapeutics), educators, researchers, and clinicians start communicating effectively.

One of the roles I see for our CME office is to be a cohesive element in this patchwork, because isolated CME offices (of whatever background) cannot do it alone anymore. It takes expertise from a number of different fields to develop a CME system that will truly serve physicians. This system should accommodate individualized educational needs and learning preferences, which means we need to start with individual assessment of a physician’s skills and competencies and offer a multitude of educational interventions in a variety of formats that can translate into more effective targeted education, and increase the quality of healthcare at all levels.

The solutions are in partnerships, and the leaders in the field must have the vision and talent to synergize the resources. It will take regulatory and government healthcare agencies, specialty boards and societies, academic medical centers, large healthcare systems, the pharmaceutical industry, communication companies, publishers, individual researchers and clinicians, and interactive learning systems, among others, to make the qualitative leap.

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tenure. When respondents were asked if they were willing to invest the time and money needed for certification, the level of interest fell dramatically. "From the association perspective," Bellande said, "we did not see the need to pursue certification, given the lack of evidence from the data."

The process of certification itself comes with its share of problems, as noted by Kristofco, who also is not convinced that a certificate or designation program could add value in this arena or encompass a broad enough spectrum to prepare people for their responsibilities and challenges.

But both Bellande and Kristofco agree that if a designation program of some kind were to be instituted, a program like the Leadership Conference has the energy it takes to serve as a centerpiece program. The conference went well beyond that of passing along interesting information or discussing the requirements for job performance.

Paralleling what is going on now at the graduate medical education level, the model for such a designation program would:

- Identify the core competencies of the CME provider
- Define the skill set for CME providers across different venues
- Develop provider-specific curricula based on the skill sets
- Recognize competence of CME providers

Bellande noted, "Once we have identified, created, and defined the elements toward recognition, then certain types of education experiences could be applied to different areas, where applicable, and this includes the Leadership Conference."

A Future for the Leadership Conference Begins

Despite the uncertainty of a formal certification program for CME professionals, the future for the Leadership Conference is strong. Plans to repeat

the conference are already in place, with a new date set for October 2003. (See *For Your Calendar*.) An extensive debriefing at the first conference is helping to guide some revisions to the program that can enhance the experience. The cosponsors are considering longer times for participant sessions with their personal mentors, and a slightly different format for case studies, where team members remain the same throughout the conference. Also under construction now is a website that will serve not only as an information resource for future conferences, but also as a source for presentations made by faculty, and a place where alumni of

the conferences can continue dialogue and exchange.

After attending the conference, Kostic noted, "I learned that those of us in CME have an important role to play in one of the biggest problems facing our society—the improvement of the quality of healthcare. We now have an opportunity to become leaders and promoters of the desired change." Bellande voiced what everyone involved with the conference knows to be true as they face the new vision for CME. In terms of cultivating the next generation of CME leaders, "The time is right to pursue this." *CME Leadership in the 21st Century* will be part of that pursuit.

Achieving Success in the Partnership of Industry and CME Providers: A Conversation With a Member of Industry

Medical education is true learning where those who attend gain knowledge, apply it to their profession, and then continue to practice it. It is reinforced by various programs that they participate in, or reminder systems that are put in place, so that their behavior changes for the better, which ultimately manifests as better patient care and better patient outcomes.

Maureen Doyle-Scharff, Director, Professional Affairs, Pharmacia

The greatest challenge for the CME provider and industry supporter working together is a true appreciation for the partnership and for the worlds both entities work in. Many companies within industry have become so conservative that they are almost paralyzed. We are losing creativity. In the past we took "creativity" too far, at the expense of good, solid education. It was short-term gratification versus an investment in the education of those we are trying to reach. But you can be creative and innovative, and still work within the guidelines and standards. The perception is that in order to do this well, the CME provider and industry supporter "boxes" don't overlap, but they in fact do overlap considerably.

We need to change the paradigm of using medical education as a means to bombard physicians with information we want them to know, and shift it to providing them with information that truly meets their needs and positively impacts patient care. The worst-case scenario is that, if we cannot self-regulate, the government could (and some might say should) get involved. Government regulation and oversight are likely to negatively affect the ability of physicians who are seeking information to improve themselves and their practice. Innovation—and patient care—would ultimately suffer.

Leadership Skill Set for a Future CME

CME seeks new kind of leader for successful future. Must be:

- Attuned to what's happening in the healthcare environment in which the physician works
- Knowledgeable about all the players in the arena
- Informed on the politics and financing of healthcare
- Familiar with the research on how physicians learn and change behaviors
- Analytical, with an ability to draw conclusions from research findings
- Able to think "outside the box" and collaborate with representatives from credentialing, quality assurance, and quality improvement
- Computer literate, and informed about information technology and online education
- Intellectually curious
- Innovative
- Flexible to change
- A risk-taker
- A good listener
- Open-minded
- Enthusiastic
- Supportive to colleagues as they deal with change
- A tough critic of their own performance

"With this new vision of CME, we have to look at the competency of CME providers. To do this, we need a concerted effort to define a new skill set."

Bruce Bellande, PhD
*Executive Director,
Alliance for CME
Leadership Conference Faculty Member*

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TRUE OR FALSE?

A survey conducted by the AMA found that nearly two thirds of physicians access the Internet daily.

Answer: True.

Read more about the AMA survey on physicians' use of the Internet at:

The AMA's website:

<http://www.ama-assn.org/ama/pub/article/1616-6473.html>

The Alliance for CME website:

www.acme-assn.org, under Resources, *Almanac* Newsletter—2002 archives, October 2002 issue

Online Programs That Are Making a Difference

Excellence in online CME was recognized at the November 2002 *Forum in Healthcare Strategists' Internet and Technology Conference*, when the winners of the Third Annual eHealthcare Leadership Awards were announced. The Leadership Awards are presented by *eHealthcare Strategy & Trends*, a monthly publication and online resource for Internet news, trends, and technology that considers the perspectives of both Internet authorities and healthcare practitioners.

There were more than 1,000 entries for this year's awards from a variety of healthcare entities, including hospitals, healthcare systems, centers of excellence, medical practices, health maintenance organizations, professional societies, communication/education companies, pharmaceutical companies, and business improvement initiatives. Eighty judges evaluated entries in several award categories.

Winning the platinum award—the highest honor—in the group classification for Physician/Clinician-Focused Site were the following:

Award category: **Best Health/Healthcare Content**

Criteria: Extensive, balanced, up-to-date, well-organized, credible material that can be tailored to individual needs

Organization/site: MDLinx Inc., for MDLinx.com

Award category: **Best Interactive Site**

Criteria: Focus on the site's interactive features and technologies in the delivery of healthcare information; in establishing ongoing relationships via personal Web pages, e-newsletters, e-mail alerts; and in facilitating community groups

Organization/site: Temple University School of Medicine, for gastrotherapy.com

Award category: **Best Overall Internet Site**

Criteria: Delivery of strong health content, interactivity, medical care support, strength of site design, and ease of navigation

Organization/site: Salu, Inc., for salu.com

Award category: **Best Site Design**

Criteria: Engaging design that facilitates access to key site information and with excellent usability

Organization/site: National Lipid Education Council™, for lipidhealth.org

Be sure to visit these sites and see what makes them powerful online resources in healthcare, and winners in online CME.

A Website With a Winning Design

The National Lipid Education Council™ (NLEC®) was established in 1995 to increase awareness among clinicians of the diagnosis, treatment, and management of lipid disorders, and the importance of treating to target guidelines to help control dyslipidemias and their consequences. Educational guidance and direction for the initiative are provided by a Steering Committee of physicians representing the areas of cardiology, endocrinology, family medicine, preventive medicine, women's health, pharmacology, and lipoprotein research. Since its inception, the NLEC has reached many thousands of physicians through a variety of educational activities, formats, and venues, including lipidhealth.org, an online resource for healthcare professionals and winner of the 2002 eHealthcare Leadership Platinum Award for Best Site Design.

The NLEC and its website are sponsored by Thomson Professional Postgraduate Services® (PPS), Secaucus, New Jersey, and supported by an unrestricted educational grant from Pfizer Inc. The site offers cutting-edge CME activities, including virtual and interactive case studies. Incorporation of interactive diagnostic tools in the case studies (such as angiogram, chest x-ray, intravascular ultrasound, echocardiogram) offer real-life learning experiences for users, more so than other CME

courses, as noted in the feedback from those applying for CME credit.

Those who prefer traditional CME offerings can access the *LipidManagement*TM newsletter, a publication of the NLEC. Also on the site is an extensive library of more than 300 downloadable slides based on the latest research and guidelines on lipids and cardiovascular disease; updates from the current clinical literature; related links to medical societies, web-based journals, and more; and patient-education materials. The site also includes listings of NLEC events and other medical meetings.

Design considerations for the site included maintaining cohesiveness across the elements of the site, simple navigational aspects, and the ability to access maximum information with a minimum number of clicks. Together, these features are working to make this a valuable resource for clinicians. The site has 22,000 registered users, with more than 6,500 new registrants in the past year. In September, more than 35,000 user sessions were reported, and the number is climbing.

Organizers of the site at PPS will continue to build on success. Looking ahead, the site will offer more interactive features within the case studies, it will incorporate "webcasts," and it will include a mechanism for users to "build" their own presentation by clicking on slides in the slide library.

News From NAAMECC

Noteworthy news and updates from North American Association of Medical Education and Communication Companies, Inc. (NAAMECC) President, Jacqueline Parochka, EdD

Board of Directors Expanded

As NAAMECC continues to grow with new members, so does its governing board. At the September 2002 General Meeting, NAAMECC announced the new members of its Board of Directors:

Kurt J. Boyce

*Healthways Communications Inc.
(2 years*)*

James T. Magrann

Lippincott Williams & Wilkins (3 years)

Robert F. Orsetti

*University of Medicine and Dentistry of
New Jersey (1 year)*

Eric D. Peterson

CoMed Communications, Inc. (2 years)

Jane Ruppenkamp

*Strategic Implications International
(3 years)*

*To begin an orderly rotation of Board members, those members elected in 2002 will serve different staggered terms, as determined by random lot.

Become a Member of NAAMECC

The 2003 NAAMECC membership dues are \$1,200 for new members. You and the organization can benefit by your membership! Join today by contacting:

Jane Ruppenkamp

Chair, Membership Committee
Phone: 1 (703) 821-8400
jruppenkamp@SIWEB.com

Now Online

Visit www.naamecc.org to learn all about the organization or to become a member.

Next Up for NAAMECC

NAAMECC will host its interim meeting on Friday, January 31, 2003, in conjunction with the Annual Alliance for CME Conference, to be held at the Hyatt Regency in Dallas, Texas. The Educational Session of the evening program, which will consist of two panel discussions, including a discussion of the Office of the Inspector General (OIG) Draft Guidance, is open to nonmembers for a nominal charge. For additional information, visit the NAAMECC website or contact:

Rick Rodes

Chair, Program Committee
Phone: 1 (215) 283-5374
rrodes@edcomm-pdi.com

January 31, 2003

7:00–8:30 AM

NAAMECC Board of Directors Meeting

Evening

NAAMECC Association Meeting

5:30–6:30 PM Educational Session

6:30–7:00 PM Business Meeting

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tice increases screening for domestic violence and provides more domestic violence resources to patients. Site visits will be repeated at 6, 12, and 18 months. A study will also be conducted in two smaller cities to see if a community-wide online CME program increases use of local domestic violence resources.

Harris' ultimate goals are to develop an online CME program on domestic violence issues that improves patient health outcomes and has demonstrable benefits that would appeal to organizations with similar interests. In the future, the data may also be used in working with a health maintenance organization, hospital system, or physicians' group to incorporate the program into an overall quality improvement initiative, making online CME an important part of the solution to the problem of domestic violence.

To read more about improving physician skills and confidence with an interactive, case-based, online program in domestic violence, see:

Harris JM Jr, Kutob RM, Surprenant ZJ, Maiuro RD, Delate TA. Can Internet-based education improve physician confidence in dealing with domestic violence? *Fam Med.* 2002;34:287-292. *Methods for Continuing Medical Education* section.

FOR YOUR CALENDAR

Upcoming CME Meetings for CME Professionals

28th Alliance for CME Annual Conference

January 29–February 1, 2003
Dallas, TX

For more information, contact:
Alliance for Continuing
Medical Education

Phone: 1 (205) 824-1355
Fax: 1 (205) 824-1357

The 14th Annual Conference of the National Task Force on CME Provider/Industry Collaboration

September 8–11, 2003
Chicago, IL

For more information, contact:
Regina Littleton

Phone: 1 (312) 464-4637
Email: regina_littleton@ama-assn.org

Interim Meeting of the North American Association of Medical Education and Communication Companies, Inc. (NAAMECC)

January 31, 2003
Dallas, TX

For more information, contact:
Rick Rodes
Chair, Program Committee

Phone: 1 (215) 283-5374
Email: rrodes@edcomm-pdi.com

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