# CMEBRIEFING®

NEWS, OPINIONS, AND PERSPECTIVES IN CONTINUING MEDICAL EDUCATION • DECEMBER 2003–FEBRUARY 2004

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***The resources we have in CME***

*GAME—Helping us understand CME around the world*

*JCEHP—Helping us recognize the influence of education on competence*

*AAFP—Helping us implement evidence-based CME*

## A United Nations of CME

The initial idea sparked about a decade ago: a loosely knit group of CME professionals from different countries were recognizing important CME trends internationally, but there was no avenue or organization for collaborating on those trends, or learning more about them. Although the already established Alliance for CME always had an international subcommittee, it was agreed at the time that the issues and interest in international CME were outgrowing what existed to address them.

With this came the formation of GAME, the Global Alliance for Medical Education. Christopher West, founding director, officer, and immediate past president of GAME (also chairman/CEO of Pegasus Healthcare International, Montreal, Canada), and other directors and officers have been working hard — with a good deal of success — to increase the percentage of non-North Americans within the organization so that it becomes “a United Nations of CME in the truest sense.”

### Refining the Mission of GAME

As it was set up initially, GAME found itself trying to be all things to all people, which necessitated a chiseling of the mission about 2 years ago. The focal point for the organization is to provide an international forum where thought leaders can network and share innovative ideas in CME. (*See More About GAME*, in this article.)

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## The Journal of Continuing Education in the Health Professions: Looking at Education and Its Effects

***Evidence of a commitment to change translating into actual practice was demonstrated in a study of 207 Canadian-based family physicians participating in a CME program. The program consisted of monthly learning groups (small, interactive groups) where physicians received case-based educational modules with or without personal prescribing feedback. About half (91) said they would make changes in their practices, and 71% of those were directly related to prescribing. Objective evidence of prescribing changes was provided by a pharmacy registry that was analyzed 6 months before and after the program. Those who expressed a commitment to change were more likely to change actual prescribing practices. Further study of this “commitment to actual practice” process is needed.***

Source: Wakefield J, Herbert CP, Maclure M, et al. Commitment to change statements can predict actual change in practice. *J Contin Educ Health Prof.* 2003;23:81-93.

This is just a small sampling of the information available through *The Journal of Continuing Education in the Health Professions*, now in its 23rd year of publication. In an interview with Paul Mazmanian, Associate Dean for

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CMEBRIEFING®

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

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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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# FOR YOUR CALENDAR

## UPCOMING CME MEETINGS FOR CME PROFESSIONALS

### Alliance for Continuing Medical Education "29th Alliance for CME Annual Conference"

*January 21-January 24, 2004*
*Atlanta, GA*

**For more information, contact:**
Alliance for Continuing Medical Education
**Phone:** 1 (205) 824-1355
**Fax:** 1 (205) 824-1357
**Website:** www.acme-assn.org

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### North American Association of Medical Education and Communication Companies (NAAMECC) Education Program

**"We Can MECC a Difference: Effectively Responding to a Difficult Regulatory Environment"**

*January 23, 2004 (during the Alliance Annual Meeting)*
*Atlanta, GA*

**For more information, visit:**
**Website:** www.naamecc.org

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

*May 16-9, 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

### 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

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

*April 18-19, 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

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### 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
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# A United Nations of CME

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The idea for GAME members is to greatly accelerate knowledge transfer and collaboration on international CME opportunities. "The world is becoming a smaller place in CME, and this is the way to ride that wave," said West. GAME is also a networking institution and a resource gold mine for its members.

### Is CME Really That Different "Over There"?

The answer is yes. West explained, "The culture of CME differs a lot from continent to continent, from country to country, and even from region to region within countries." But there are some common threads.

One trend that GAME has been watching closely is the *overall* trend toward mandatory, accredited CME all over the world — an issue that is addressed in much of GAME programming.

Although not necessarily true in southern Europe, most of northern Europe now has some form of mandatory CME. In other words, physicians need to obtain a certain number of credits within a prescribed period of time to keep some sort of licensure or other privileges as a physician.

West suspects this will affect anyone in the business of CME, whether from the academic, nonprofit, commercial, or industry side of CME.

### In Search of the Holy Grail

Providers looking to cross borders with CME are asking, "Can I develop a program that would work in many

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## More About GAME

GAME provides an international forum where thought leaders network and share innovative ideas in CME.

### History of the organization

Established in June 1995, originally under the name *International Alliance for Medical Education*, GAME was launched in a manner similar to the beginnings of the Alliance for CME in 1975, and shares the same "founding father," Lewis A. Miller of Intermedica, Inc., Norwalk, Connecticut. Initially an informal organization was created, which after several years grew into a more formal structure, with more than 100 members today.

### GAME objectives

- To learn and share market experiences in the continuing globalization of physician and consumer education
- To meet possible new education and/or business partners
- To learn from experts about new trends affecting CME
- To recognize leaders in the field with an awards program

### Representative membership

- Educators based in medical schools, medical specialty societies, national medical societies, and medical education companies
- Managers from these same groups, plus government, accrediting, and regulatory agencies
- Marketing people from medical communications companies, medical schools, and medical societies
- Pharmaceutical company managers with responsibility for education

### Organization scope and reach

Countries represented in GAME are the United States, Canada, Mexico, Colombia, Brazil, Argentina, Spain, Italy, Germany, the United Kingdom, Japan, Australia, and Pakistan. GAME welcomes members from any country and any segment of the medical and health education community.

### Member benefits

- Exchange of information on trends in CME and health education around the world
- Opportunity for interchange with other members
- Access to an Internet Website for discussion groups
- Entry to the Members' Zone of the GAME Website: membership directory, meeting minutes, presentations from meetings (when available), reference databases, CME news internationally
- Newsletter and e-mail bulletins
- Reduced fee for the annual meeting

### Why join?

Not only to take advantage of member benefits, but also to explore opportunities to work with others in various parts of the world and to extend capabilities in content development, program organization, use of technology, or marketing. Many members have developed relationships that optimize individual resources, to ultimately benefit the education of physicians and patients in other countries.

***Visit* www.game-cme.org *for more on GAME.***

## The Journal of Continuing Education in the Health Professions

*Continued from page 1*

Continuing Medical Education at Virginia Commonwealth University in Richmond and editor of *JCEHP*, *CME Briefing* learned just how valuable this resource can be.

### The Start of Something Big: *JCEHP* Is Established

Speaking about the mid 1970s, Mazmanian recalled, “People who were responsible for planning educational activities for physicians were looking for one another.” And as they sought each other out, specialized groups started forming. In the medical school arena, the Society of Medical College Directors of Continuing Medical Education (now the Society for Academic Continuing Medical Education) was formed, and in that same year, the Alliance for Continuing Medical Education was established as a forum for planners from hospitals, specialty societies, professional societies, and other organizations interested in knowing how to run a program of continuing medical education. Likewise, the Association for Hospital Medical Education represented those in graduate medical education with an interest in CME.

***There were limited opportunities to add to the body of knowledge involving physicians, healthcare practitioners, and their ongoing education, growth, and development.***

At this time, however, those who were interested in research in CME had very few vehicles at their disposal for reading or for peer-reviewed publication of their work. “There were limited opportunities to add to the body of knowledge involving physicians, healthcare practitioners, and their ongoing education, growth, and development,” said Mazmanian. “Most of the interest was focused on undergraduate medical education, with limited appreciation for residency training or continuing medical education,” he explained.

That is until *JCEHP* was established. The journal is owned by the Alliance for Continuing Medical Education and the Society for Academic Continuing Medical Education (both since 1984), and by the Council on Continuing Medical Education of the Association for Hospital Medical Education (since 1996). Over the years, subscribers have increased from a very few located in the United States and Canada to several thousand distributed throughout nearly every continent. The journal is published quarterly by BC Decker, Hamilton, Ontario.

**Table 1. Topics of Special Interest in JCEHP***

- Continuous quality improvement
- Health policy
- Professional performance
- Competency assessment
- Cognition and aging
- Practice-based learning and improvement
- Knowledge translation
- Distance learning
- Patient education
- Disease management
- Team learning

*Journal contents are abstracted and/or indexed in *Abstracts of Health Care Management Studies; AgeLine; Cumulative Index to Nursing & Allied Health Literature; Current Index to Journals in Education; Index Medicus;* and *MEDLINE*

### About *JCEHP*

The mission of the journal is to promote lifelong, continuous learning in the health sciences professions, and in fulfilling its mission, it serves two major audiences: those who design, implement, or evaluate programs for learning and behavior change, and those who develop policy involving continuing education. The journal concentrates on several topics of special interest (Table 1).

“There has been a shift in our content,” said Mazmanian, “away from planning reports and theoretical models that help leaders administer CME, to studies that address the influence of education on competence, including knowledge, skills, attitudes, and patient outcomes.” The number and content of published articles continue to be dominated by studies involving physicians. Certainly the time is right for this shift, given the changing CME environ-

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## The Journal of Continuing Education in the Health Professions

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ment and its emphasis on improvement in healthcare outcomes and maintenance of physician competence.

"Where once the discussion focused on the influence of regulation and policy on planning, financing, and administering CME," Mazmanian noted, "journal content has taken a turn toward interpreting the results of studies to inform policies and regulations that govern CME."

Other changes for the journal include a growing international audience of readers and contributors, and a website (www.jcehp.com) that in time will serve as a platform for electronic interaction with subscribers.

Associate and consulting editors for the journal, an impressive listing of "people in the know" in CME, serve as peer reviewers and editorial policy consultants. It was the associate editors who decided recently that carefully researched narratives on contemporary issues should become a larger part of the journal.

**What Readers Will Find in *JCEHP***

*JCEHP* offers its readership content that addresses theoretical foundations, original research, and innovations in continuing education, as well as book reviews. In addition, a Cochrane Collaboration abstract is presented twice yearly, with commentary by a noted leader in continuing education. "In that way," said Mazmanian, "the results of meta-analyses and reviews of randomized controlled trials generated by Cochrane research analysts are interpreted for value in day-to-day CME practice."

Each article appearing as a theoretical foundation, original research study, or innovation also includes a text box of Lessons for Practice. "The purpose," explained Mazmanian, "is to focus the attention of authors and readers on the relationships of theory and research to practice, and what those relationships mean to planners, policymakers, and learners, especially because our field is dominated by day-to-day practice."

Given its content, focus, direction, and long-standing history, those involved in CME should consider *JCEHP* as a useful resource and aid in their work. To learn more about becoming a subscriber and/or contributor to *JCEHP*, visit the journal website at www.jcehp.com.

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### Straight From the Editor

**Why the CME Professional Should Read *JCEHP***

- If you want to know about the implications of cognitive aging on the education and performance of physicians, *JCEHP* can inform.
- If you want to know how physicians are using on-line CME and the Internet, read *JCEHP*.
- If you want to learn how to measure changes in knowledge or performance, *JCEHP* has a long history of articles to advise you on how to—and how not to—do that.
- If you want to understand how to overcome barriers to change in practice, look to *JCEHP*.
- If you want to assess the relative value of use of an audience response system in CME, *JCEHP* can offer insights.
- If you want to know about the development of CME in Greece, Kuwait, Lebanon, Spain or the United Arab Emirates, *JCEHP* can help.
- If you are looking for basic tools to use in evaluating CME and clinical performance in systems of care, *JCEHP* has it covered.
- PLUS, *JCEHP* is the only journal in *Index Medicus* devoted solely to continuing education in the health professions!

# Reality Check: Update on AAFP and Evidence-Based CME

Coming up on the 2-year mark since the official start of the American Academy of Family Physicians' evidence-based (EB) CME initiative, Nancy Davis, AAFP's Director of CME, provided *CME Briefing* with a reality check and update on this ambitious endeavor.

**Working From the Inside Out**

Change can be good but as AAFP learned, change can be slow. "Unfortunately, things are not moving as quickly as we would like," said Davis, "but we have seen progress, especially internally." At least 60% of the CME programming now produced by AAFP is EB CME, and internal training and promotion are at the heart of this shift.

"We have done a lot of training of our staff and the faculty, to help them understand the evidenced-based medicine concept and the criteria that we set up for evidenced-based CME credit," said Davis. In fact, AAFP is doing what they recommend other providers do, and that is to start with faculty members who have a good understanding of evidence-based medicine and start with topics that lend themselves well to EB CME. "This is certainly the approach that we've used at AAFP," Davis emphasized.

**AAFP: Helping Others Follow Suit**

But AAFP is still aiming to not only foster the use EB CME internally but make it a standard for other provider groups as well. David Baldwin, MPA, AAFP's Manager of CME Accreditation, and Davis speak around the country for AAFP to help provider groups acclimate to the intricacies of EB CME, which according to Davis, "has helped raise awareness of EB CME and it helps provider groups understand how to start integrating evidence-based medicine into their CME programs."

AAFP has seen much more enthusiasm and a positive response to the concept of EB CME among other providers than they had seen early on. But the continuous and intensive support that AAFP gives itself—accounting for the rise in EB CME seen at AAFP—is logistically not available to other providers and may explain the slow uptake of EB CME by provider groups outside AAFP.

One solution is AAFP's more user-friendly website at www.aafp.org, CME Accreditation, Evidence-Based CME. AAFP has also added a listing of practice recommendations that have been approved for EB CME credit. Davis noted, "Providers and faculty can go to that site and see practice recommendations that have already been approved through our system. We have had a lot of positive feedback from providers and faculty on this."

**EB CME: Ensuring Sound, Valid Content**

Perhaps the best support for the use of EB CME comes from the Accreditation Council for Continuing Medical Education (ACCME) and its guidelines on content validity for CME. "If you follow an evidence-based medicine approach for CME," noted Davis, "you can be sure your content will be valid and sound."

EB CME can also ensure a neutral approach to CME—the best defense against the potential for commercial bias. "There is always the issue of commercial bias in CME," explained Davis, "but if one follows an evidence-based approach, it can alleviate that, because you are looking at what the best evidence shows for a clinical question or issue."

**Change Is Coming—Slowly but Surely**

Signs of change within the CME community in terms of EB CME were apparent at the 2003 Annual Conference of the National Task Force on CME Provider/Industry Collaboration, at which AAFP held a breakout session on the emergence of EB CME. "We had a full house at the breakout, and I saw that meeting as a real turning point in provider attitudes," noted Davis.

In the past, AAFP was hearing a good deal of provider pushback on the subject of EB CME: *This takes too much time. We don't know how to do it. Faculty members don't understand it.* But the 2003 breakout session was the first time that almost all the response was positive. Davis and AAFP are now hearing: *This is the right thing to do*, and *Tell us how we can integrate evidence-based medicine into our planning early on.*

**Achieving Success With EB CME**

And here lies one of the AAFP's biggest tips on successfully incorporating EB CME into CME programming: early planning.

*Continued on next page*

## Using the Right Approach for EB CME

Working backwards doesn't work. A challenge for providers is convincing faculty to start with the evidence and develop an EB CME presentation around it, rather than working backwards with an existing presentation and trying to retrofit it to the evidence. Proactive planning with faculty can help providers address this challenge.

## A United Nations of CME

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countries — for example, that could work in North America and in Europe?" or "Is there a valid platform that could serve different countries and different regions?" In essence, everyone is looking for the Holy Grail in global CME — a global standard in medical education internationally.

However, providers from different countries who want to collaborate cannot assume that the North American model, for example, will easily translate in Spain, Italy, France, or the United Kingdom. And there are other examples of differences in CME outside North America. Some countries outside the United States are not sure that the pharmaceutical industry should have any involvement in CME at all, either as a supporter or partner.

All this means that there is no "tip sheet" on how to conduct a CME-certified activity internationally. "There is no easy recipe for that," cautioned West.

### How GAME Can Help

But where GAME can contribute in international CME is critical. For providers who want to know more about what is happening in CME internationally, or where to go to get more precise information on CME internationally, as well as who to interact with in the various countries, GAME can offer solutions.

The long-term trend in international CME will be toward finding more similarities than differences in international CME, and according to West, this is the broader end of what GAME can provide to its membership. For example, attendees at the 2003 GAME annual meeting in New York heard a remarkable address on the first experiment in global medical education standards, given by Dr Hans Karle, president of the World Federation of Medical Education, University of Copenhagen, Denmark.

"GAME can provide that big picture of where international CME is headed," West explained. At the other end of the spectrum, GAME offers expert speakers/panelists at its annual meetings who provide snapshots of the current situation in international CME, as well as the pitfalls and opportunities, country by country and region by region around the world. GAME's annual meeting also offers practical workshops on how different countries are conducting CME.

***The long-term trend in international CME will be toward finding more similarities than differences in international CME, and according to West, this is the broader end of what GAME can provide to its membership.***

GAME is planning its first small-scale European meeting, which will help the organization plant deeper roots in the international CME community. In international CME, it's the only GAME in town!

## Reality Check: Update on AAFP and Evidence-Based CME

*Continued from previous page*

"By starting early on in the planning process," explained Davis, "providers have something specific to talk to faculty about." Early planning allows time for the provider to conduct literature searches of the evidence-based medicine sources as they are planning, and then to discuss those sources and process recommendations with the faculty. It also allows time to introduce the faculty to the plan for using EB CME. "Planning committees are being proactive, talking to faculty up front about that type of approach," said Davis.

### What's Next for AAFP

As it now stands at AAFP, in order to be eligible for evidence-based CME credit, the evidence-based medicine source has to be a comprehensive, systematically reviewed source. But Davis wants to address this at AAFP's next Commission on CME to be held in January 2004.

"My goal ultimately is to have all CME be evidence-based," said Davis, "and that any type of evidence can be used, as long as it is the highest strength of evidence available and that the learner knows the type of evidence it is." This is to account for those topics in medicine for which there is yet no systematically reviewed evidence.

"We are hopeful that we can find a way to make the system less restrictive and open it up to any type of evidence—as long as it is the highest level of evidence for that particular topic area."