

2009 SACME SPRING MEETING IS A MUST FOR ALL ACADEMIC CME PROFESSIONALS

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If you have resources to attend only one meeting this year, your best investment of time and money will be the SACME Spring meeting to be held April 23-26, 2009 in Rancho Mirage, California. Hosted by the Annenberg Center for Health Sciences at Eisenhower, all meeting activities will take place at the Annenberg Center, while social activities will be held at Rancho Las Palmas, the official conference hotel.

The program for the Spring Meeting will focus on leadership-preparing today's professionals to lead their organizations into the continuing medical education of the future. Interactive presentations, committee meetings, and networking will take place around the latest topics and research in the field of academic CME.

Front and center will be a three-hour interactive workshop "From CME to CPI: Are You Ready for the Change?" organized and facilitated by the steering Committee of the Annenberg Center for Health Sciences CME Leadership Initiative. Before long a new cohort of physicians will have been trained within a competency-based framework and will continue to manage their careers within this framework including maintenance of certification and maintenance of licensure. The need for skilled professionals who are able to assist physicians with their continuous performance improvement (CPI) will likely expand rather than diminish. However, the personal and organizational competencies required to be successful in the CPI era are likely to be quite different than those that have been cultivated and reinforced within the current CME context. Making the transition calls for deep, transformational change. Before we can change we

will have to take a hard look at ourselves, our organizations, and our traditional ways of thinking. We will need to consider what we need to start doing to remain relevant, and identify those tasks that currently consume our time and energy, but contribute nothing toward our future, and stop doing them.

During this workshop, participants will: (1) examine a vision for the future CPI role; (2) assess their current personal and organizational competencies in the context of what the future will require; and (3) examine the personal and organizational agenda for change within the framework of Kotter's Transformational Change, and Quinn's Deep *continued on page 2* ...

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SACME SPRING MEETING

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Change paradigms. Toward the end of the meeting, an additional hour will be set aside for participants to formulate concrete plans for personal and organizational change with coaching and input from faculty facilitators.

Also on the program is a session called “Developing, Disseminating, and Using Evidence: Partnerships for Effective Healthcare.” Consisting of moderated panel presentations with audience discussion, this session will: (1) summarize evolving national initiatives in CME as relevant to dissemination and use of evidence to advance healthcare; (2) introduce SACME members to the Effective Healthcare Program overall and suggest a range of opportunities in which they or faculty members at their institutions might participate; and (3) provide specifics about the AHRQ/SACME partnership in advancing specific information and dissemination initiatives and engagement of academic institutions in reaching into communities.

Another session on “Discovering and Disseminating CME as a Value Center: An Interactive Session” will provide ideas for deans and directors on how to position their CME offices within their institutions. The topic will be broached from

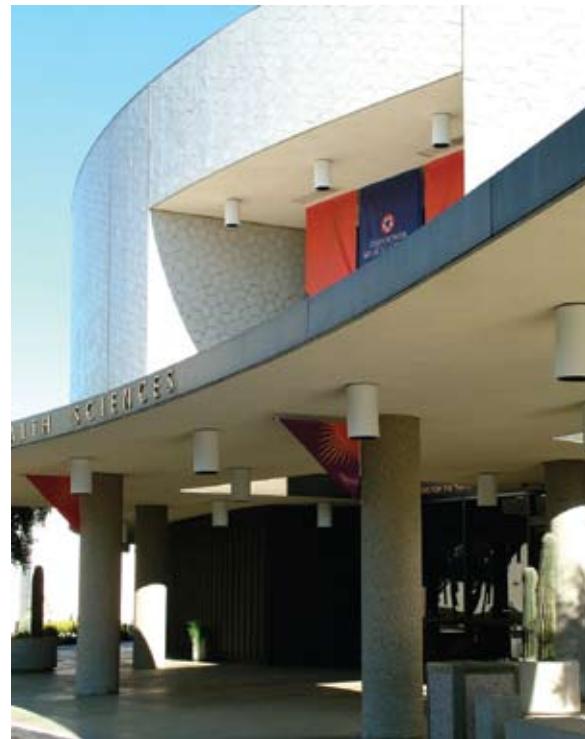
the perspective of the macro level of the institution and the micro level of the faculty.

The program will also include a robust research section that will be culled from abstracts submitted for RICME, best practices, and poster sessions. The RICME presentations will include a combination of work in very early stages, work in progress, completed studies, review papers, and issues and problems in CME research. Best practices presentations may include a wide range of topics including innovation and model approaches to educational program administration, planning, delivery, and evaluation.

Other sessions are in the planning stages as of this writing. The program will, of course, be rounded out with the highly acclaimed “Hot Topics” session, committee meetings, and opportunities for networking with new colleagues and long-standing friends.

Located ten miles from Palm Springs in the Coachella Valley, an area of great natural beauty, Rancho Mirage enjoys clear skies and abundant sunshine year round.

Keep checking the SACME website, www.sacme.org, for updates to the program. Make sure to register early to ensure a place for you at the table. You will not want to miss this meeting!



FROM THE PRESIDENT....

SYNERGY: A POSITIVE OR NEGATIVE EFFECT?

Melinda Steele, MEd, CCMEP

Have you ever undertaken a word study? I mean really delved into the meaning of words or groups of words? I was pondering the landscape of CME these days and began thinking about the “synergies” that were taking place. There are influences on and scrutiny of CME like never before. Just consider these for examples: the Revised Standards for Commercial Support, the Updated ACCME Criteria for Accreditation, the Senate Finance Committee Investigation of Industry Funding of CME, the Macy Foundation Conference on Continuing Education in the Health Professions, the IOM Committee on Conflict of Interest in Medical Education, the AAMC Task Force on Industry Funding of Medical Education.... I could go on, but I think we all see the picture and it makes one’s head spin if we think too long about it all!

As that word (synergy) played around in my head, I started to wonder about the origins and meanings of the term. So I did what anyone would do these days.... I went to Wikipedia and began my journey. As you might imagine, one thing led to another and I found myself wandering around the concept and other related terms in various resources.

Here is what I found out about synergy. It has its origin in the Greek, syn-ergo (συνεργός meaning working together) and is the term used to describe a situation where the final outcome of a system is greater than the sum of its parts. Would it surprise you to find that the Apostle Paul used the word in his Epistles (Romans 8:28; 1 Corinthians 3:5-9) to illustrate a dynamic conception of human, divine and cosmic cooperation? «I did the planting, Apollos the watering, but God made things grow... We are fellow workers (synergoi) with God; you are God’s cultivation, God’s building.»

A dictionary definition yielded this: “Combined effort being greater than the parts — the working together of two or more people, organizations, or things, especially when the result is greater than the sum of their individual effects or capabilities” Then I also found this: “Behavior of a system that cannot be predicted by the behavior of its parts.” Whoa! Does that sound like CME today or what?!

That last item hit home as I considered all the forces acting upon and around CME presently. With all the task forces, committees, working groups, and yes, even Senators, government committees and agencies scrutinizing every aspect of CME, conflict of interest, bias and industry funding, this unpredictable behavior of a system probably best describes current synergies around CME.

I had always thought of the term synergy in a more positive light. In fact, as I was doing this word study, I began to look at related terms to explore their meanings. These yielded more positive images. Here is a sampling of the related items I explored.

Teamwork — defined in Webster’s New World Dictionary as “a joint action by a group of people, in which each person subordinates his or her individual interests and opinions to the unity and efficiency of the group.” This does not mean that the individual is no longer important; however, it does mean that effective and efficient teamwork goes beyond individual accomplishments. The most effective teamwork is produced when all the individuals involved harmonize their contributions and work toward a common goal. In order for teamwork to succeed one must be a team player. A team player is one who subordinates personal aspirations and works in a coordinated effort with other members of a group, or team, in striving for a common goal.

Collaboration — a recursive process where two or more people or organizations work together toward an intersection of common goals. Collaboration does not require leadership and can sometimes bring better results through decentralization and egalitarianism. In particular, teams that work collaboratively can obtain greater resources, recognition and reward when facing competition for finite resources.

Strategic Alliance — a formal relationship between two or more parties to pursue a set of agreed upon goals or to

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FROM THE PRESIDENT *continued from page 3 ...*

meet a critical business need while remaining independent organizations. Partners may provide the strategic alliance with resources such as products, distribution channels, manufacturing capability, project funding, capital equipment, knowledge, expertise, or intellectual property. The alliance is a cooperation or collaboration which aims for a synergy where each partner hopes that the benefits from the alliance will be greater than those from individual efforts.

I suggest that with the unpredictable behavior of the current system creating “negative” synergy, SACME needs to take a leadership role to turn this concept back around into a positive synergy. To do so will require collaboration, teamwork and strategic alliances with all sorts of “partners.” (Now this started me off on another word study.... It could go on and on!) Here are a few positive terms to consider as we embark on this journey:

Partner — affiliate, team up, unite, connect, associate

Partnership — joint venture, enterprise, endeavor, undertaking

Collaboration — teamwork, partnership, group effort, association, alliance, relationship, cooperation

Collaborator — co-worker, colleague, partner, teammate, associate

During my term as SACME president, I have encouraged SACME to reach beyond our “society” walls and to build strategic alliances and partnerships with other organizations to change the spin of negative synergy. The possibilities are endless, and the outcomes are most likely beyond our wildest dreams. Already we are working with AAMC to jointly implement the biennial survey and several other projects. Several SACME members worked with the NC-CME to develop the first ever certification exam for CME professionals. Who would have thought a couple of years ago that SACME and AHRQ would be exploring partnerships to positively impact patient outcomes? And who could have predicted the richness of information to be generated at the Mayo Consensus Conference (a collaboration of the Mayo Clinic, SACME and ACCME)? And a successful project between SACME and the Alliance for CME on educating faculty on certified CME vs. promotion was just a pipe dream for some not that long ago either.

If I leave nothing more as a legacy of my term as SACME president, may it be the initiation of exciting strategic alliances, collaborations and partnerships leading to positive synergy for the CME Enterprise.

CME SOLUTIONS TO MANDATES FOR QUALITY AND SAFETY

By: Susan Pingleton, MD, Chief Learning Officer, University Healthsystem Consortium and Nancy Davis, PhD, Executive Director, National Institute for Quality Improvement and Education

The Accreditation Council for Continuing Medical Education (ACCME) has just surveyed the first cohort of providers under their new Updated Criteria for Accreditation. In order to qualify at Level 3, providers must demonstrate some degree of physician practice performance improvement as a result of the activity. Demonstration of physician performance improvement is not a new phenomenon; however, the definition and scope have clearly expanded.

Understanding not only the external imperatives for performance improvement, but also the genesis of those mandates seems warranted. This commentary will describe the forces culminating in the development of external imperatives

for quality and safety, as well as briefly describe the increasing number of new mandates for the future.

It is important to understand that the targets for external imperatives or mandates for quality and safety exist almost solely for physicians, hospitals, and health systems. In academic medical centers, schools of medicine are not the targets of this movement except as they relate to physician faculty accreditation and certification requirements for their educational programs.

External mandates for quality and safety are most commonly called measures in that something is “measured”. Two types of mandated measures exist, process and outcome measures¹.

Process measures are those which detail specific processes of care. For example, process measures for inpatients with community acquired pneumonia include assessment of oxygenation, smoking cessation, pneumonia vaccination status and the delivery of antibiotics within four hours of diagnosis. Outcome quality measures include the assessment of risk-adjusted mortality for specific diseases. Acute myocardial infarction mortality is an outcome process reported.

Currently, public reporting of both inpatient hospital process and outcome quality measure occurs. Centers for Medicare and Medicaid Services (CMS) report process and outcomes measures on the *Hospital Compare* website (www.hospitalcompare.hhs.gov). When accessing the website, a specific hospital's process and outcome performance can be compared to other hospitals in that state. Other outcomes of care reported on *Hospital Compare* include patient satisfaction.

CMS has also developed a program to link physician payment to performance through its program of Medicare Physician Quality Reporting Initiative (PQRI)². The PQRI project includes an incentive payment for eligible professionals (EPs) who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries. Currently this program provides incentive payment only for the submission of quality data, not the achievement of a specific performance level. PQRI includes both ambulatory and inpatient data.

How did we arrive at this current situation of mandated performance measures as well as pay for performance for hospitals and physicians? Clearly the cost of healthcare in the US is high. For 2003, US healthcare expenditures per capita (\$/yr) were \$ 5,635, compared to Germany and France at \$2,996 and \$2,903 respectively³. What does the US get for its money? According to the 2006 WHO World Health Report, US life expectancy is 78 years at birth, identical to the life expectancy of Cuba.

Variance of healthcare delivery is common in the US. Data from the Dartmouth atlas study show Medicare spending per capita in the US varies geographically⁴. Medicare spending ranges from a high of \$7,200 to \$11,400/case to a low of \$4,200 to \$5,800/case. What is responsible for this variance? It is clearly not the availability of data or evidence. From 1970 to 2005, randomized controlled trials and Medline citations

have increased two-fold and twelve-fold respectively. Clearly there is no lack of new evidence.

However, despite the wide and increased availability of evidence, adherence to evidence-based guidelines varies widely. The percent of patients in compliance with evidence-based guidelines can be as high as 79% in cataract patients to a low of 33% compliance with ulcer guidelines. Variance involves underuse in almost half of the guidelines and over 10% in overuse.

In this environment of high healthcare costs with little impact on longevity and a wide geographic variation in the costs of healthcare delivery, a seminal report was issued. In 2001, the Institute of Medicine (IOM) published "Crossing the Quality Chasm," which described the healthcare we have versus the healthcare we should have as not just a gap, but a chasm⁵. This report had specific recommendations which included safe, effective, efficient, personalized, timely and equitable patient care.

The IOM report changed the conversation around quality and patient safety. As a result, a broad group of stakeholders was enlisted including the federal government, the Joint Commission, regional coalitions, purchasers, payors and medical personnel. External mandates for quality and safety were developed at the national, regional, state and local levels. National organizations especially governmental agencies — Centers for Medicare and Medicaid services (CMS), quasi-government — Agency for Healthcare Research and Quality, and voluntary organizations develop quality and safety measures.

Currently, these organizations produce a large number of measures and more physician, hospital and health systems measures are sure to come in the future. Additionally, the quality movement has focused on physician practice improvement in the areas of continuing medical education, medical staff credentialing, maintenance of certification and licensure. Understanding the background of the national imperatives around quality and safety is important in our response to them.

The PI CME Solution

CME has responded to the call for improving healthcare through performance improvement. In addition to the ACCME's Updated Criteria, the AMA, AAFP and AOA *continued on page 6 ...*

CME SOLUTIONS TO MANDATES

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all allow for “enhanced” CME credit for Performance Improvement CME (PI CME). Based on a quality improvement model, PI CME requires assessment of current practice based on evidence-based measures, implementation of interventions for improvement, and remeasurement to analyze and reflect on improvement. This new format moves CME to continuous performance improvement.

Maintenance of Certification (MOC) requires on-going self assessment and life-long learning (Part 2) and demonstrated performance improvement in practice (Part 4). Academic CME professionals should recognize these requirements and how they might integrate them into their CME programs. This will require new skill sets for CME professionals. They must be familiar with performance measures and the data to assess them. Educational activities should be developed as

interventions along with systems-based process tools that actually improve practice. CME should be more focused at the point of care and be tied to performance. Collaboration with healthcare quality improvement professionals will ensure on-going, high quality continuous performance improvement initiatives for physicians.

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FOUND IN TRANSLATION: EXPANDING OPPORTUNITIES FOR CME

Michael Fordis, MD and Melinda Steele MEd

In the February 2007 issue (Vol. 20, No. 1) of *INTERCOM*, Dr. Kenneth Fink, Chief Medical Officer of the Centers for Medicare and Medicaid Services for Region X, noted that for clinical service quality improvement to be influenced by ongoing physician education, “... the CME intervention would need to be effective for transferring the new knowledge, and the system or organization in which health is delivered would need to enable the application of the new knowledge in clinical practice.”^{1, p.1} At the conclusion of his article Dr. Fink emphasized the importance of effectively and efficiently translating knowledge into practice, and that “CME has an opportunity, and perhaps a responsibility, to evolve accordingly and help providers improve the health outcomes of their patients.”^{1, p.2}

In the “From the President” column of the same issue of *INTERCOM*, my commentary was entitled “Lost in Translation: Tales of the Invisible Plan.” The column noted the absence of any substantive role for CME in any of the published proposals for the first 12 awards made by NIH in support of the major federal initiative (about \$100 million committed in 2006) entitled Clinical and Translational Science Awards (CTSA).² Three of the proposals failed

to mention CME in any way, and in the others CME only appeared by way of “wrapping in credit” some of the activities that might be conducted through the CTAs. The invisibility of CME in the CTAs posed the specter that, as progress was made to advance translation sciences through programs like the CTSA, CME—a function that should be all about translation of research into clinical practice—might indeed be “lost in translation.”²

In the two years since the pieces cited above were published, new opportunities have begun to coalesce around a substantive role that SACME might play in shaping the manner in which nationally identified needs can be met through the integration of high levels of evidence into the development of our educational activities. One such opportunity relates to a new relationship between SACME and the Agency for Health Care Research and Quality (AHRQ). The AHRQ mission is “to improve the quality, safety, efficiency, and effectiveness of health care for all Americans.”³ An important component of AHRQ’s efforts to carry out this mission involves operation of the Effective Health Care (EHC) program. The EHC program “focuses strategically on comparing the outcomes, clinical effectiveness, and appropriateness of pharmaceuticals,

devices, and health care services.”⁴ The work of the EHC program is carried out through AHRQ support of:

- 14 Evidence Based Practice Centers (EPCs) that are responsible for conducting comprehensive research reviews and synthesizing the evidence in the form of comparative effectiveness reviews (CERs).
- 2 academic networks that are directly involved in conducting research on clinical effectiveness:
 - 13 Centers that are part of the Developing Evidence to Inform Decisions and Effectiveness (DEcIDE) Network.
 - 14 Centers for Education and Research on Therapeutics.
- The John M. Eisenberg Clinical Decisions and Communications Science Center, which serves as the translation and dissemination arm of the EHC program and has traditionally translated complex scientific information gathered and created by AHRQ into short, plain language materials.

SACME is well positioned to assume a prominent role in working with AHRQ to foster more effective integration of the important findings from CERs and other AHRQ supported research into CME initiatives. CME providers have always had a responsibility for translating the best available evidence into the educational activities that they conduct. This responsibility was codified with the 2002 release of the ACCME standard for validation of content.⁵ However, this standard invites consideration that the evolving role for the CME provider might well extend beyond processes for ensuring content validation. In the future, one can envision CME providers serving as translation advisors to support faculty by assisting in the identification of quality evidence relevant to learner needs and, when available, sharing and expanding upon educational tools that facilitate the translation of that evidence into the instructional setting.

At the SACME Spring 2009 Meeting we will have an opportunity to explore new partnerships in translational science. The meeting will feature a session titled *Developing, Disseminating, and Using Evidence: Partnerships for Effective Healthcare*. Dave Davis, AAMC Vice President, Continuing Health Care Education and Improvement, will offer a *Brief Introduction to Evidence, Its Development and*

Use: Implications in Light of the Transformative National Initiatives Underway in CME. This will be followed by a presentation by Jean Slutsky, Director of the AHRQ Center for Outcomes and Evidence (COE) on *The Effective Healthcare Program at AHRQ: National Initiatives to Develop and Share Evidence for Advancing Healthcare Quality*. Michael Fordis, Director of the John M. Eisenberg Clinical Decisions and Communication Science Center will then focus on SACME member engagement in *Translating and Disseminating Evidence for Use: Engagement in AHRQ’s National Initiatives to Advance Effective Healthcare*.

The session will include open discussion of how SACME may proceed in building a sound and productive partnership with AHRQ in advancing the agenda of quality health care. This discussion will provide opportunities for SACME members to express views about SACME’s role in translational science, as well as to indicate how members as representatives of their respective institutions or as individual research, clinical, and/or teaching professionals may become involved.

Work is already underway in advancing an AHRQ-SACME partnership. SACME has established a Task Force to explore pathways, methodologies, educational tools, and evaluation approaches that can accelerate member engagement in translation initiatives involving AHRQ research. Serving in the important role of guides in incorporating into CME activities the latest and best evidence on comparative effectiveness of drugs, devices, and health services is a good fit for SACME members. SACME can “find” itself in translation; but we need your help to do it. We hope to see you at this session of the SACME Spring meeting.

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1,600 GUIDELINES IN 17 MINUTES: A PRACTICING PHYSICIAN'S VIEW OF CME

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The view from my office has changed drastically over the past 20 years since beginning my internal medicine practice. However, certain aspects of the practice have remained the same. 50% of American College of Physician internists are in practices with < 4 doctors and 25% are in solo practice. For non-board certified physicians these numbers are probably higher. The average time allotted for an office visit remains 17 minutes (longer than in Europe). Most physicians in practice have limited resources and do not have a quality improvement team, human resource department, or staff development department. Their staff is often limited to 1 medical assistant and a receptionist.

What has changed is the number of tasks universally agreed upon to be completed and the number of treatments available. The average medicare patient has 6 comorbid conditions and is prescribed 10 prescription medications. During the typical brief visit, the physician is expected to screen for substance abuse, domestic violence, household/occupational safety, osteoporosis, depression, and cancer; assess medication adherence, and health literacy; practice motivational interviewing; counsel and educate the patient regarding the risk/benefits of cancer screening, diet, exercise, and complementary and alternative medications; as well as their prescribed medicines. All of these are laudable goals, but by no means represent a complete list. These are but only a few of the 1,600 guidelines I am held accountable for and soon to be publicly reported and used for pay for performance.

All this, while I am told that an “annual physical” is not effective and usually not reimbursed; this is the expectation, even before I ask the patient the reason they made the appointment to see me.

For every 4 hours of patient visits, 2 hours are required to perform clerical work: documentation — review and sign home health, handicapped parking, return to

work, FMLA forms; request preauthorization for radiology, consults, procedures, specific non-formulary drugs; review labs/tests and notify patients of normal and abnormal results; and coordinate the health care of complicated patients; all of which is uncompensated and rarely delegated. Upwards of 100 pieces of mail per day are sifted and sorted; a large portion of it is advertising for CME programs. At the same time, the hospitalist movement has distanced many physicians even further from traditional hospital-based CME, leaving the community practitioner increasingly isolated and overwhelmed.

The sheer volume of available medical knowledge is enormous. The *Journal of the Medical Librarian Association* reported in 2004 that 620 hours are required to read the more than 7,000 articles which a group of experts identified as potentially relevant to primary care /month (there are 720 hrs/month). The information explosion in medicine is exciting as well as challenging. In diabetes alone, we have 7 classes of medicines and 30 drugs to treat diabetes, yet less than half of Americans reach diabetic goals, a truth across all types of practices — rural/urban, small/large, academic/community, electronic or paper-based.

Maintenance of Certification and/or Licensure remains a priority to practice medicine. The P4P (pay for performance) programs, quality improvement initiatives provided by each of the dozens of insurance companies are varied, time consuming, often redundant, and requisite to participation. Rarely do these result in a change or improvement in my delivery of care, but rather justify a change in payment level.

We all aspire to practice evidence-based medicine according to guidelines and meet every patient’s need at every level and we need help. Determining which CME programs are

developed and funded primarily to introduce a new drug, a new procedure, or a new subspecialist is time consuming and challenging. CME opportunities are often not what I need, but rather what someone wants me to know; and not with the patient's ultimate best interest as their number one priority.

Quality CME educators place the needs of the attendees first and foremost and provide not only what knowledge is needed, but address *how* that knowledge may be applied in real practice. Suboptimal patient care is not always due to knowledge gaps, but often the lack of systems. Just as the primary care physician is expected to do more in less time as well as demonstrate improved outcomes, CME faculty must be trained in QI/PI and incorporate practical solutions to translate knowledge into practice, in the same amount of time. If not qualified to address both the "what *and* the how," the faculty member should share the podium with a "real doc," an expert with practical solutions to system redesign and team-based approaches to improving patient care. Just as every lecture on every disease begins with the prevalence of the disease, every program should end with real world solutions to translate the knowledge into practice.

Programs designed for a physician's office staff or a web-based program to introduce this team-based approach are greatly needed. How does a physician who is just learning the world of quality improvement and team building teach someone else? For example, concurrent lectures for the office team to introduce the concept of PDSA would be welcomed.

Effective CME educators understand that the primary care audience does not have the luxury of a narrow area of focus as does the specialist. The complete physician (internists and family practitioners) cares for the complete patient and does not have the luxury of treating only 1 part of the patient. When the subspecialist (often the subsubspecialist) delivers a lecture intent on demonstrating the depth and breadth of his/her own narrow focus (teaching by trials) with the expectation that the audience aspire to achieve the same level of expertise, he/she risks leaving the primary care physician feeling unqualified, demoralized, and frustrated. Self-promoting and impressing rather than informing and empowering should not continue in certified CME. The

most effective faculty understand their audience's broad needs, place their specialty in perspective as only one of 25, and recognize and respect the challenges the primary care physician faces.

As was mentioned at the CME Summit in Chicago 2008, just as health care should be patient centered, medical education should be physician-centered. I need a physician centered educational home. I don't know what I don't know. Over the course of a specified time, a review all of internal medicine must occur. Perhaps a "survey course" using a variety of sources: point of care, lectures, national meetings, podcasts, journals, self-study, yet coordinated to avoid gaps and redundancy is needed. One size does not fit all and each part of each day affords different education opportunities. National meetings serve to reenergize as well as educate. Competency based education allows educational programs to be tailored to each individual and avoid redundancy. Programs should be coordinated to meet the myriad requirements by insurance companies, CMS, Maintenance of Certification, and Maintenance of Licensure to ultimately improve patient care.

Physicians rely on and trust national membership organizations, universities, and other accredited CME providers for quality education now more than ever. We expect unbiased, quality programs that will improve knowledge and narrow the gap between what we all agree should be done and what is actually being done. Successful CME programs of the future will incorporate not just "what to do" but "how to do it."

"A little knowledge that acts is worth infinitely more than much knowledge that is idle."

— Gibran

For up-to-date information
on SACME activities
visit us often at
<http://www.sacme.org>

NEWS FROM THE AMERICAN MEDICAL ASSOCIATION

By Alejandro Aparicio, MD, FACP

By the time you read this column, written in the last few days of 2008, we will be well into 2009. It is our hope that the promise of a new year and our wishes for health and happiness are already being realized for all of you.

The work of the AMA's Initiative to Transform Medical Education (ITME) continues in 2009 with a concentration on physician re-entry, self assessment and lifelong learning, and the medical school admissions process. Physician re-entry issues were discussed at both an Invitational Conference on Physician Re-Entry, held in September 2008, and in an AMA Council on Medical Education Report made to the AMA House of Delegates at its Interim Meeting in November 2008. Reports on the invitational conference will be finalized in 2009 and there will be an additional report to the House of Delegates by the Council on Medical Education at the November 2009 Interim Meeting. Re-entry is defined as, "a return to clinical practice in the discipline in which one has been trained or certified following an extended period of clinical inactivity not resulting from discipline or impairment." This re-entry effort may help provide a path for physicians to reintegrate themselves into the practice of medicine, and may be able to bring additional physicians into the workforce that might otherwise be lost to the profession. This is particularly important in the current climate, which sees a worsening physician shortage and an increasingly aging population in need of more physicians to care for them. In addition, the AMA Council on Medical Education will present a report on Physician Lifelong Learning to the House of Delegates at its June 2009 Annual Meeting. A third report on this topic is scheduled to be presented to the House of Delegates at the 2010 Annual Meeting. Re-entry and lifelong learning are both issues that should be of special interest to the CME community, particularly to those at medical schools. All Council reports are available at the AMA website (www.ama-assn.org).

It is also expected that the Council will present a report on Industry Support of Professional Education in Medicine to the House of Delegates at its June 2009 Annual Meeting.

This report will be coordinated with a similar report by the Council on Ethical and Judicial Affairs (CEJA), expected to be presented at the June 2009 meeting as well.



The Division of CPPD continues to disseminate information about approved CME learning formats, particularly PI CME, through a variety of forums. One effective mechanism has been the periodic presentation of webinars that address the potentially significant impact of PI CME on patient care. Webinars allow us to target specific types of CME providers and facilitate the use of provider-specific examples.

The 19th Annual Conference of the National Task Force on CME Provider/Industry Collaboration was held in Baltimore in October 2008. More than 650 participants attended excellent breakout, case study and plenary sessions on topics ranging from regulatory guidelines and letters of agreement to instructional design principles and grant application procedures. Among the outstanding presentations was a memorable key note address, "The Important Role of CME in Impacting Care," by Norman B. Kahn Jr, MD, Executive Vice President and Chief Executive Officer, Council of Medical Specialty Societies. Also at the conference, the "Get the Facts" Campaign of the National Task Force was launched. The campaign is an effort to educate individuals from both inside and outside the CME community about topics related to CME through the dissemination of fact sheets that aim to provide unbiased information. Fact Sheet 1, "Continuing Medical Education: Providing Valid and Independent Evidence for Clinical Decisions," and Fact Sheet 2, "Continuing Medical Education: Addressing Conflict of Interest (COI)," were well received. Additional fact sheets will be distributed in the future. The 20th Annual Conference of the National Task Force will take place, again in Baltimore, October 14-16, 2009. The chair of the conference is our own Melinda Steele, MEd. For copies of selected presentations from the 2008 conference, and for copies of the Fact Sheets go to www.ama-assn.org/go/cmetaskforce.

LISTSERVE POLICIES AND GUIDELINES

By David Pieper, PhD, Chair of SACME Communications Committee and SACME Listserve Manager

The SACME listserve is one of the most valued and valuable features of SACME membership. Policies have been put in place that were designed to maintain its quality and usefulness to SACME members.

Surveys destined for the SACME listserve must be sent for review and approval to the SACME Communications Committee. Some of the criteria considered by the committee include:

- Request must come from a SACME member
- If the survey is part of a research project, IRB approval must be obtained
- The survey and its results need to benefit SACME
- Requester must agree to submit a summary of the results to SACME

Please send your surveys to dpieper@med.wayne.edu and they will be forwarded to the Communications Committee for approval. Once approved, a sentence should be added to the survey stating that “The request to post this survey was submitted to the SACME Communications Committee and approved for distribution”.

Only notices of events or resources sponsored or co-sponsored by SACME can be approved for distribution through the SACME listserve.

Remember that all replies to the listserve are sent to all members, not just the original sender. If you want to reply only to the sender, you must forward your email to that person’s email address. Also of note, automated “out of office” messages are sent to the entire listserve, so we request that you deactivate your postings to the listserve if you will be using this tool.

All of these policies, plus more details and tips, can be obtained on the SACME website: www.sacme.org.

THE GOOD NEWS

By Todd Dorman, MD, FCCM

Continuing Medical Education as a formal structure in healthcare education is the youngest of all the medical education domains. Medical student education and graduate medical education have histories that predate CME by more than 100 years. As the relative new kid on the block, it should not be unexpected that our field is less developed. That lack of development and, in particular, the paucity of solid research in CME has, in recent years, led to concerns about our benefit to the profession and our integrity.

CME, however, has been on an exponential course of performance improvement. New forms of certified CME that address provider needs at the point of care and that underpin performance improvement projects have been launched. A focus on needs assessment and gap analysis linked to outcomes evaluations has taken root and we are beginning to see results. New lenses through which we view relationships, conflict of interest, and the potential for bias have been adopted. The American College of Chest Physicians is releasing guidelines for effective CME in March 2009 and a more mature CME system is now establishing a national research agenda.

This article serves as call to all SACME members to submit material to a new column in the INTERCOM titled “The Good News,” which is dedicated to CME successes. We are especially interested in hearing about successes with gap analysis, innovative instructional design, outcomes analysis, conflict management, and/or research. We invite you to share your accomplishments in CME with us. Please send your submissions, approximately one page in length, describing your success stories to Melissa Newcomb at Melissa_newcomb@urmc.rochester.edu.

For assistance with the SACME Listserve, such as receiving the messages in alternate formats, please contact the Executive Secretariat at sacme@primemanagement.net or the Listserve Administrator at dpieper@med.wayne.edu.

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The views expressed in *INTERCOM* are those of the authors and are not intended to represent the views of SACME or its members.

SACME Listserve: sacme@lists.wayne.edu.

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UPCOMING EVENTS

2009 SACME Spring Meeting

April 23-26, 2009

Annenberg Center for Health Sciences at
Eisenhower

Rancho Mirage, CA, USA

www.sacme.org

MedBiquitous Annual Conference 2009

April 28-30, 2009

Sheraton Baltimore City Center

Baltimore, MD, USA

www.medbiq.org

SACME 2009 Summer Institute for CME

Research

June 13-17, 2009

University of Toronto Conference Center
Toronto, ON, Canada

www.sacme.org

See also *News & Events* at www.sacme.org