The Society for Academic Continuing Medical Education
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INTERCOM

THE SOCIETY FOR ACADEMIC CONTINUING MEDICAL EDUCATION

SACME Annual Spring Meeting

"Leading for Success in Turbulent Times"

Mila Kostic, FACEHP
SACME Program Chair
Director, Continuing Medical Education
Perelman School of Medicine at the
University of Pennsylvania

Most of us are ready to leave this long, snow- and ice-drenched winter behind. Before you know it, spring will welcome us with its long warm days bathed in the sun-lit Southern Florida.

Planning the Spring Meeting 2015 was particularly rewarding because our program is CME–certified and hosted by the *Center for Advanced Medical Learning and Simulation (CAMLS) at the University of South Florida Health.*

Educational needs and interests of professionals in the continuing education for the health professions field were considered in developing this program. Physicians and other clinicians, educators, researchers, accreditors, administrators, quality and safety specialists, patient advocates, technology experts, instructional designers and others who are members of the Society for Academic Continuing Medical Education (SACME) and those who have similar or aligning professional interests will find this a worthwhile learning and networking opportunity.

The program will center on several larger themes of leadership, advances in the use of simulation in continuing education, the modern approach to the science of teaching and learning and interprofessional team efforts in teaching and faculty development in quality and safety. A number of expert lead discussions

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will be interspersed with research, best practice, and poster presentations from accepted abstracts. Expert faculty will inspire you daily, to mention a few, Deborah Sutherland, PhD, the Associate Vice President, USF Health and Associate Dean, at the Morsani College of Medicine, Continuing Professional Development will deliver this year's Barbara Barnes Plenary on the topic of *Change Management in the Context of CME to CPD*. Peter J. Fabri, MD, PhD, FACS will review the Role of Health Care Engineering in Improving Healthcare and How to Teach it and Ajit K. Sachdeva, MD, FACS, FRCSC, the Director of the Division of Education, American College of Surgeons will lead the section on the Advances in the Use of Simulation in CME/CPD. SACME members and other conference participants will have a rare opportunity to meet Graham McMahon, MD, MMSc the new ACCME President and CEO.

You will be able to choose from several high-quality workshops, such as *Engaging Research in Your Day-to-Day Work, Using Learning Management Systems to Support CME/CPD Program, Facilitating Effective Performance Feedback for Physicians, Development of Assessments and OSCEs, Utilizing Standardized Patients as Evaluators, and Faculty Development in Interprofessional Education.*

Emphasizing the scholarly focus of the Society throughout the program, we will also devote time to conversations with colleagues from award-winning and SACME funded research projects, enjoy the RICME presentations and spend time reviewing the record number of poster presentations we received this year.

Everyone is invited to engage in the working sessions of the open committees throughout the conference and enjoy optional activities such as tours of the CAMLS and other more leisurely options reserved for Friday afternoon.

Get ready for an exciting and interactive program filled with opportunities to learn about the latest research in our field, share in best practices, acquire new skills in our workshops, contribute in small groups, catch up with old friends, and meet new colleagues and future mentors.

For additional details, full agenda, accommodation information and to register please visit the SACME website at www.sacmespringmeeting.org. Early registration is recommended, and the discounted room rates are limited, so please make your plans today.

I look forward in seeing you soon in Tampa, because this meeting would not be the same without you!

President's Column

By Ginny Jacobs, M.Ed., MLS, CCMEP

> ***"It's not enough to be busy, so are the ants. The question is…..what are we busy about?"***

- Henry David Thoreau

In preparing for the "Strategic Repositioning of CME/CPD" session which was held at the SACME meeting in Chicago in November, 2014, we asked individuals (via an email survey) to consider the following question --

"How you would describe your work group's level of preparedness to address the shifting needs of the healthcare field?"

A majority of those responding to the pre-session survey (72% or 31 of 43 respondents) felt they were either 'somewhat prepared' or 'well-prepared', and it was insightful to see what they shared when asked --

"What do you consider to be the key ingredient or secret to success?"

I believe there is value in more-closely reviewing those responses and further examining what clues they may offer as we seek to improve our current complex (I will even go so far as to add hectic, and - at times - confusing) work environment. Here is my summary of the seven major themes that emerged from the 'secrets to success' responses that were gathered:

STRATEGIC ALIGNMENT

- Establish a strategic position within the organization

- Align CME/CPD goals with those of our Quality Improvement and Patient Safety offices
- Communicate an established Value Statement with strategic dashboard data and plan in support of the institutional goals
- Work hard to form strategic relationships within our institution -- spend time working on activities that are aligned with strategic priorities

COLLABORATION/PARTNERSHIPS

- Promote collaborations across our integrated health system
- Seek collaborations in an unrelenting fashion -- create opportunities
- Partner with the academic departments who can best describe their needs
- Form coalitions with communities, public health, and professional societies
- Partner with community hospitals to accredit CME

LINKS TO IMPROVEMENTS IN PATIENT CARE / EMPHASIS ON MEASUREMENT/OUTCOMES

- Communicate and promote a focus on improving care to patients and public health
- Find ways to be 'connected' to multiple stakeholders who value quality, patient-centeredness, and efficiency in healthcare
- Guide the transition of CME/CPD toward more emphasis on assessment (measurement), improvement, and reporting of change in practice performance and patient outcomes

INTEGRATION INTO THE BROADER SYSTEM

- Pursue QIE and interprofessional projects
- Find ways to fully integrate into the system
- Connect CME/CPD with the broader medical education landscape
- Reach out to new audiences who might embrace (i.e. pay for) CME/CPD (e.g. patient safety training in the hospital and simulation education for community physicians)
- Promote integration of QI, CME, GME and Pay for Performance

LEADERSHIP SUPPORT

- Informed leadership committed to the process of change and focused on improved healthcare and patient outcomes
- Regular communication with key personnel and leaders in the health system
- Ensure CME/CPD is recognized by the highest levels of the organization as a key factor in successfully navigating the transition to new models of care delivery
- Facilitate ongoing enhancement of the education and educational research conducted in CME/CPD

STAFF SKILL SET

- Talented team of CME/CPD professionals who possess the following traits:
  - Well-trained, flexible/resilient, dedicated staff
  - Hard-working with good attitudes and a willingness to learn
  - Accountable - take ownership in their work
  - Professionals who possess solid educational consulting skills
  - A team capable of making connections to the broader healthcare system and comfortable with a changing environment
  - Able to work in an interprofessional, cross-continuum community to help identify and address common issues and challenges
  - Shifted away from "meeting planning" to a focus on strategic partnerships with educational partners

OPERATIONAL ELEMENTS & EFFICIENCIES

- Openness to new ideas

- Well-defined processes – that helps to accommodate shifts that occur
- Ability to drum up additional revenue sources / adequate resources to fund CME/CPD
- Bring a high level of awareness of the bigger picture
- Able to reach out to a community of fellow CE professionals for advice and assistance

Questions for Reflection:

- How linked is your CME/CPD unit with your institution's strategic goals and priorities?
- Are your group's efforts well-aligned with your institution's overarching strategic priorities?
- How often are patient outcomes central to the projects that you pursue within your group?
- Have you been able to freely pursue activities that you expect would result in a much greater impact on the institution's ability to achieve its strategic goals?
- Do you ever find that you are too busy or unable to devote additional resources to new educational and/or quality improvement activities? (even though those activities are directly aligned with the institution's overarching strategic goals)
- Does your unit's current funding model ever stand in the way of pursuing new, innovative activities?

Michael Porter, a leading authority on competitive strategy and a Professor at the Harvard Business School, has noted that….. ***"The essence of strategy is choosing what not to do."***

How many of us continue to invest significant energy and resources into educational activities that we know are not core to addressing the strategic imperatives of our health system? Therein may lie one of the key elements to implementing a successful strategy for our CME/CPD work units. What activities should come off the list in order to free up the necessary resources to ensure our pursuit of those efforts that are strategically aligned and capable of greater impact?

The founder of modern management, Austrian-born American management consultant, educator, and author, Peter Drucker, had a way of systematically addressing these complex concepts.

> ***"There is nothing so useless as doing efficiently that which should not be done at all."***

In these days of scarce resources and competing demands, CME/CPD work groups need to leverage their unique skill set, apply their expertise and do everything possible to ensure they are strategically aligned within their organization.

In the survey referenced earlier, we asked the following question……

> **How would your institution's leadership describe your work group's current contribution toward achieving the institution's overall strategic goals?**

The responses compiled from the group were distributed as follows:

Central to the effort – Involved in key decisions	**25%**	(11)
Occasionally helpful / supportive	**44%**	(19)
Pursuing a parallel path, but not directly linked	**16%**	(7)
Detached or unrelated	**7%**	(3)
Let me think….do we have a CME/CPD function?	**7%**	(3)

How would your institution's leadership respond when asked about your CME/CPD work group?

Can we afford to be viewed as anything but 'central to the effort'?

These are definitely not simple issues; however, I believe our collective goal is to be linked and (at minimum) supportive of the overarching strategic initiatives within our institution. We need to be seen as able to leverage skills and data in such a manner that we effectively link education to quality initiatives. Better yet, we would be viewed as central to the effort.

It is the goal of the Society for Academic Continuing Medical Education (SACME) to provide a forum for continually addressing these important issues and helping its members develop effective strategies to enhance CME/CPD's contribution to the institution's strategic goals.

We expect to bring further ideas on this topic forward at the Spring SACME meeting in Tampa and we look forward to your engagement in this crucial conversation.

Update on SACME's Vision, Mission, and Guiding Principles

Thank you to our members who answered the Call for Comment to help refine SACME's vision, mission, and guiding principles. We appreciate the thoughtful comments and suggestions. Included is a brief overview of the timeline and multiple stages involved in this effort.

SACME leadership outlined a new Strategic Agenda to members beginning in 2012 with significant progress made in 2013. During 2014 SACME leadership, committee members, and past chairs continued discussions on our strategic goals and direction. A refined Vision, Mission, and Guiding Principles came out of those discussions with a draft presented to members in December 2014. Membership feedback on this draft has been vitally important as changes directly affect SACME's strategic goals, committee structure, and future direction. An update on this journey will be shared during the SACME Spring meeting in Tampa.

SACME: Our Vision, Our Mission, Our Guiding Principles

Our Vision:

To be the premier academic continuing medical and interprofessional education society that advances the field of continuing education in the best interest of patients and communities.

Our Mission:

To promote the highest value in patient care and health of the public through the scholarship of continuing medical and interprofessional education.

Our Guiding Principles:

SACME is committed to the following actions

1. Advance the theory and evidence to improve continuing education of clinicians, educators, and researchers.
2. Study the planning, implementation, and evaluation of continuing education programs and activities.
3. Collaborate to solve complex challenges facing leaders, clinicians, educators, and researchers in the field of continuing education.
4. Support scholarship and dissemination of continuing education, including discovery, integration, application, and teaching.
5. Guide the development of an interprofessional infrastructure necessary to improve continuing education to better serve patient care.
6. Address the full range of professional competencies required for excellence in clinical practice and education.

Multi-Specialty Portfolio Approval Program Update

By David Price, MD, FAAFP, FACEHP

Director, Multi-Specialty Portfolio Approval Program

American Board of Medical Specialties

Dear Fellow SACME Members:

No doubt you have heard about the ABIM announcement on February 3 announcing changes to their MOC Program. This major step provides ABIM an opportunity to restructure their program based on input from internist and the healthcare community. It clearly demonstrates that ABIM is serious about listening and improving their program.

Many of you have inquired about how this announcement will impact the ABMS Multispecialty Portfolio Program. As you know, many of the expressed concerns about MOC relate to the relevance and burden of MOC requirements for busy practicing physicians. The Portfolio Program exists in large part because it is a mechanism for physicians to receive MOC credit for the meaningful, relevant work they do in their practices, on behalf of their patients, supported by their organizations. The program benefits patients and participating organizations by aligning organizational quality improvement activities designed to improve patient care with the expectation of continuous board certification. Those of you participating in the program know how much your work means to your patients, your physicians, and your organization.

ABIM diplomates will continue to receive MOC points for engaging in this work – the work that many of them are doing every day. My message to ABIM diplomates in Portfolio Program organizations: "You're doing the work – why not get credit for it!" Furthermore, I believe that the opportunities and challenges identified by Portfolio Program organizations will be helpful to the ABIM as they re-examine their system, and to all participating ABMS Member Boards as they continue to evolve their MOC programs. In fact, ABIM has already asked us to participate in discussions to help them improve their MOC process.

I also believe this situation highlights the very important role that SACME members can play in the physician quality movement, and in helping MOC evolve. I hope over time to engage many more SACME member organizations as Portfolio Sponsors, and I look forward to an ongoing dialogue with you about how we can study MOC in order to continuously improve it.

ABMS Building Increased Relevance into MOC Program

By Mira Irons, MD, ABMS Senior Vice President, Academic Affairs

The American Board of Medical Specialties (ABMS) is committed to improving the value of the ABMS Program for Maintenance of Certification® (ABMS MOC®) for diplomates by enhancing the program's relevance to practice while mitigating burden. To that end, the following is a summary of activities underway.

Increasing Access to Practice-Relevant MOC Activities

In an effort to provide diplomates as broad a set of practice-relevant options for fulfilling the requirements of the ABMS MOC Program as possible, ABMS launched two Calls for MOC Activities, one related to patient safety activities and a second to system-based practice, and interpersonal and communication activities.

The goals of this initiative are to:

- Provide a mechanism for identifying continuing medical education (CME) and quality improvement (QI) activities and resources that reduce burden and improve relevance for diplomates fulfilling their MOC requirements.
- Provide an opportunity to identify MOC activities that may be appropriate for multiple specialties and/or practice settings.
- Simplify the approval process by allowing the Member Boards Community to advance the adoption of MOC activities that meet the needs of their diplomates.
- Facilitate continuous QI, and tracking real time approvals, system improvements, and additional feedback mechanisms to educational stakeholders.

To date, the ABMS Calls for Activities have resulted in:

- 27 unique MOC activity approvals
- 13 unique activity submissions (several submissions contain multiple modules per submission and eight of the 13 were approved by more than one Member Board)

The approved activities will be shared with the diplomates through an ABMS MOC activity platform coming soon.

Fostering Innovation in External Assessment

ABMS has commissioned an External Assessment Task Force to explore opportunities for innovation in Member Boards' external assessment practices and methodologies, and to disseminate best practices in the development and implementation of rigorous alternatives to currently constructed MOC examinations. The 19-member Task Force has completed phase 1 of its charge, which included conducting a comprehensive assessment of the current practices and innovations mapping to the 2015 Standards for the MOC Program and identifying innovative methodologies being used by Member Boards to evaluate core competencies. In phases 2 and 3, the Task Force will form work groups to examine issues such as what the core purpose of external assessment should be, how to improve relevance to physician practice, and how best to integrate core competencies within external assessments.

Addressing Relevance with Multi-Specialty Portfolio Approval Program

Last year, the Multi-Specialty Portfolio Approval Program (Portfolio Program), which began in 2009, transitioned to ABMS. The Portfolio Program offers a streamlined approach for health care organizations to support physician involvement in organizational QI initiatives and provide physicians from multiple specialties the opportunity to receive credit in their ABMS Programs for MOC. It promotes organizational effectiveness and efficiency through team-based QI initiatives that are directly related to physicians'

practice and influences the care they deliver. In doing so, the Portfolio Program delivers a more meaningful, relevant MOC experience for physicians that can be emulated in integrated multi-specialty systems across the country. The total number of Portfolio Sponsors is now 35. Additionally, 60 organizations are engaged in the application process to become sponsors and 100 (including several medical specialty societies) are actively exploring the option. Approximately 880 QI efforts have been approved through the Portfolio Program. More than 8,000 physicians have received credit for MOC Part IV activities from their Member Board for participation. Currently, 19 Member Boards participate in the Portfolio Program.

Encouraging Research through Visiting Scholars Program

Last year, ABMS launched its Visiting Scholars Program intended to help early career physicians and scientists develop their research skills and scholarship by engaging in a research project related to the ABMS Program for MOC. The goal of the one-year, part-time program is for the scholars to present their research at an ABMS conference and ultimately publish in a peer-reviewed journal; contribute to the scholarship about innovations/best practices of continuous professional development, assessment, QI, and health policy; and familiarize themselves with health policy and the external environment in which continuous certification occurs. The five current scholars are working on projects that build on existing research at their institutions and generate MOC-related data, tools, and activities. The Scholars Program is open to junior faculty including assistant professors and instructors, fellows, residents, medical students, public health students, graduate students, and PhDs in health services research and other relevant disciplines. New this year, Member Boards will have the opportunity to sponsor a scholar to focus on specialty-specific research. ABMS will begin accepting applications in March for its 2015-16 class of scholars.

Understanding Needs and Characteristics of Diplomate Cohorts

Last year, ABMS commissioned three committees to examine issues, challenges, and opportunities facing Board Certified military physicians, physician scientists, and physician executives when engaging with Member Board MOC programs. Through these committees, ABMS intends to model a process to assist Member Boards as they seek to better understand the ways in which physician characteristics, work context, and continuing professional development needs may impact diplomates as they engage with Member Board MOC programs. The Special Committee on Military Physicians met twice last year and is slated to issue a report early this year. The Special Committee on Physician Scientists met last October and will meet again in February. The Special Committee on Physician Executives will be convened this spring.

Learning from Teaching—Moving Beyond Credit: An Approach to Faculty Development

By Carol Goddard, Association of American Medical Colleges

Developed in partnership with the American Medical Association (AMA), Learning from Teaching allows *AMA PRA Category 1 Credit*™ for learning activities related to teaching in undergraduate and graduate medical education—important especially to volunteer faculty. This move from self-reported C*ategory 2 Credit to Category 1 Credit* for activity documented and vetted through the CE unit has proved an asset to many.

Beyond the credit component, there is increasing interest and usage by institutions implementing the activity captured by Learning from Teaching for preceptor professional development and other value outcomes. These include changing teaching and engagement processes, assessment tools for clerkship and program directors, and helping to highlight part-time, volunteer faculty as a visible asset to the institution. These advances (and some of the challenges in implementing Learning from Teaching in institutions) are highlighted in a webinar accessible from the AAMC's Continuing Education & Improvement Learning from Teaching webpage (https://www.aamc.org/initiatives/cei/learning).

Harrison Survey Update

By David Davis, MD

Association of American Medical Colleges

The sixth annual report of the AAMC/SACME Harrison Survey reveals numerous strengths of and opportunities for the continuing medical education (CME) unit within an academic medical center (AMC). The report outlines the strengths of academic CME units—including their potential to assist the AMC in achieving its mission and improving patient care—and summarizes the challenges to academic CME units, providing six possible strategic improvement goals for consideration.

In 2013, the survey was redesigned to better understand the placement and alignment of the CME unit within the AMC, providing a better picture of its impact on both the internal and external audience, and on the community it serves. These findings help the CME unit to target and create a focused, integrated, and effective continuing education/professional development presence in the AMC.

Over a six year period, the CME community has seen an increased focus on faculty development, more linkages with programs such as quality improvement and patient safety, a greater use of effective educational methods, and more fiscal stability. For questions or archival copies of the survey, contact David Davis, Senior Director of Continuing Education and Performance Improvement (ddavis@aamc.org).

Next Survey (now biennial)

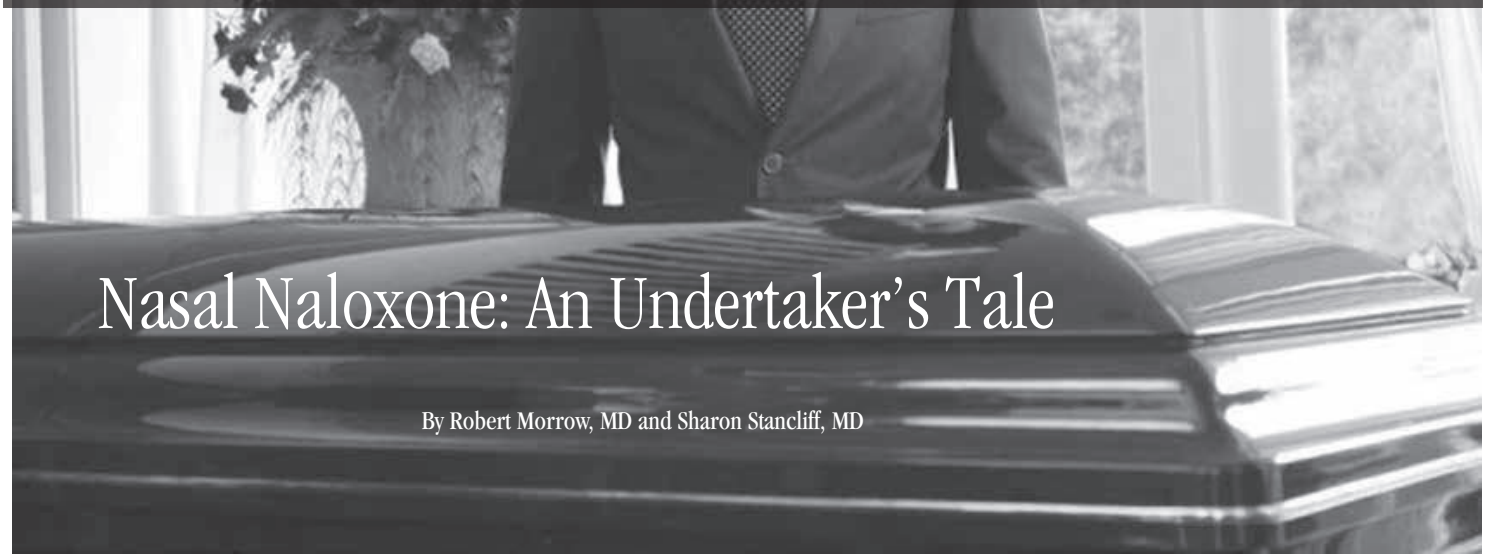
Survey Launches Oct/Nov 2015
Survey Closes Jan 2016
Survey Report Draft March 2016
Survey Report Final April/May 2016

Current Survey Writing Group

Lois Colburn, University of Nebraska, chair (SACME)
Ginny Jacobs, University of Minnesota (SACME)
Jack Kues, University of Cincinnati (CEI)
Connie LeBlanc, Dalhousie University (SACME)
Chitra Subramaniam, Duke University (CEI)

To access the current AAMC/SACME Harrison Survey, visit the AAMC Continuing Education & Improvement webpage at **www.aamc.org/initiatives/cei/** and you will find the survey report link in the lower left corner of the screen, or at SACME's web site at **http://www.sacme.org/Publications.**

Dr. Bob Morrow has been a SACME member for 12 years. He co-authored this article for the New York State Academy of Family Physicians Journal Winter 2015 issue. We believe it was both interesting and relevant to the work of the SACME community and would like to express our gratitude to Dr. Morrow and his co-author Dr. Sharon Stancliff for sharing it with us.



Nasal Naloxone: An Undertaker's Tale

By Robert Morrow, MD and Sharon Stancliff, MD

"Why are these fingers twitching on my left hand? My hand and arm are fine-- I'm fine. What 's wrong?"

Ms. T, who is a long term patient I know well [I thought], seems worried a bit out of proportion to her symptoms. Her symptoms have been stable but annoying for months. Her exam is normal. A recent brain image done elsewhere is normal.

"Is something bothering you, or someone?"

"I'm stressed, yeah."

"What's stressing you?"

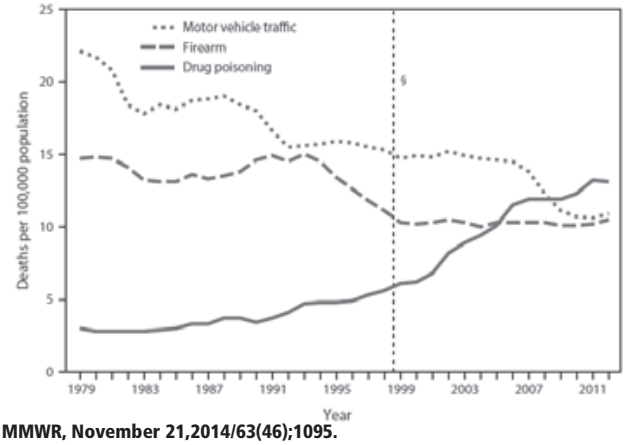
Several backs and forth, more prodding from me, then: *"My daughter. She's out of rehab but I think she's back on heroin."*

First déjà vu for me. Heroin, the scourge of my internship in the ED of the 70's, people dead and blue, young adults in great health now dead. Waking them from death with the new wonder drug, naloxone by intravenous. When I could find a vein. What a wonderful thing to save a young life so easily!

I now know of the return of heroin, with the controls on prescribed opioids tightening, and the price of heroin dropping, and the availability and quality rising. Quality that can easily lead to death from mistakes. Quality that makes death from overdose surpass those from car accidents and gunshots.

And Ms. T isn't the first parent to tell me of a teen on heroin. The story is that it can be purchased easily in middle and high school, and that story appears to be true from personal reports of my patients.

Second déjà vu. I had recently read of nasal naloxone, the do-it-yourself form of our wonder drug that for tens of dollars can reverse death for any trained bystander with it and the knowledge of where



MMWR, November 21,2014/63(46);1095.

the nose is. No high from it, only a rapid and profound withdrawal, for perhaps twenty minutes. No need to find a vein or to give an injection. Easy to teach, easy to use, easy to buy.

Easy to buy? Not so quick folks, our heroine is still dead from her heroin overdose.

Public health laws have permitted prescription to those at risk of overdose forever and, in New York State, to those at risk of witnessing an overdose since April 2006. In fact, legislation passed in 2014 has made it a bit easier. Furthermore the law protects responders from civil liability and criminal prosecution for administering naloxone. Many organizations, including drug treatment programs and syringe exchange programs have been getting free naloxone kits from New York State or NYC Health Departments. They train potential overdose witnesses and equip them with a kit containing 2 doses of naloxone, instructions and a mask for rescue breathing. First responders including EMTs and police

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are rapidly being trained in its use across the state. Primary care providers are also eligible for this program.

How can I prescribe it? First, I need to know about it and about my patient's issue. Just a few months ago, I knew about neither.

Second, the pharmacy must have it. This is beginning to happen in a few states and it is expected that NYS will soon be among them.

Third, reimbursement systems must pay for it: this varies across plans including Medicaid managed care providers.

First, yes, we must know of this lifesaver and make our patients comfortable asking for it, no strings. We need posters in our waiting rooms and toilets. And we must agree that saving our heroine is worth giving the prescription to someone who wants it 'for a friend'.

The second and third items on the list will require us to approach local pharmacies to carry it, and ask insurance companies to pay for it. This should be available like any other prescribed medication. In the meantime, we can join the state distribution program. More on that below.

Harm reduction is about saving lives. And look, the teenager is waking up and has a chance…a chance to turn her life around.

We in family medicine take care of a lot of stuff and people that make us hold our noses at times. Maybe this should be one of those times. If it were our kid, would we keep naloxone on hand? If our grandparents were taking large opioid doses for pain, should we have it readily available?

Which leads us to the poor undertaker, whose job is safe because it can't be outsourced overseas. People are still dying, death panels or not. But we can reduce the number of our kids dying by recognizing and dealing with a real problem. Let's take the undertaker out for a beer and apologize.

Oh yes, the twitching hand. It got better.

The Basics

Opioid overdoses can be prevented from progressing to death when naloxone is administered in a timely manner. As a narcotic antagonist, naloxone displaces opiates from receptor sites in the brain and reverses respiratory depression that usually is the cause of overdose deaths.[1] During the period of time when an overdose can become fatal, respiratory depression can be reversed by giving the individual naloxone.[2]

On the other hand, naloxone is not effective in treating overdoses of benzodiazepines, alcohol or stimulants. However, if opioids are taken in combination with other sedatives or stimulants, naloxone is likely to be helpful. Naloxone injection has been approved by FDA and used for more than 40 years by emergency medical services (EMS) personnel to reverse opioid overdose and resuscitate persons who otherwise might have died in the absence of treatment.[3]

Naloxone has no psychoactive effects and does not present any potential for abuse.[4,2] Naloxone comes in various formulations. Injectable naloxone is relatively inexpensive. It typically is supplied as a kit with two vials of naloxone, and 2 syringes/ needles, at a cost of about $20-25 per dose and $40-50 per dose.[5] Another formulation of naloxone is used intra-nasally albeit off label. These kits typically include 2 vials to be screwed into a syringe; an atomizer is used instead of a needle. These cost about $100 per kit. These kits are generally dispensed with a brief training on how to administer naloxone using a syringe. The FDA has also approved a naloxone automated injector, called Evzio® which does not require special training to use because it has verbal instructions which are activated when the cover is removed from the device. The per dose cost of naloxone via the auto-injector is not yet determined but expected to come in at over $500 per kit of 2.

Many Walgreens are now stocking the formulation used intranasally with the atomizers. A prescription is necessary and thus far insurance may not cover it.

Questions & Answers with Dr. Bob Morrow and Dr. Sharon Stancliff:

Bob: Ok, I feel it is my moral duty as a physician to help people survive an opioid overdose. My e-prescribing module doesn't have the nasal kits and my pharmacist threw a hissy when I discussed it with him.

Sharon: Individual prescribers may register with the State program, as may some medical practices since 2006, and receive free kits from the State. You could always prescribe naloxone to someone at risk of overdose and pharmacists could carry it. As you note there are needs- doctors to know, pharmacists to carry AND naloxone on enough formularies for pharmacies to see it reasonable to stock. That last one has been in process - all those Medicaid managed care providers - a challenge. And if they will pay for someone at risk of overdose will they also pay for someone like your patient with a family member at risk? I don't know yet. So I encourage you to fill out the registration and get a supply of kits. A new law which took effect in 2014 allows pharmacists to dispense naloxone in a collaborative practice model with a physician; similar to vaccines, except dispense instead of administer. And regardless of which way pharmacies get it out, we still need to be approaching pharmacies! Here is the link for the NYS program: http://www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/

Bob: But the gap for me to prescribe is small but still a gap. Local pharmacies are a challenge, health plans are a challenge, and people don't know to ask for it unless they are in a treatment program.

Sharon: All true. We can prescribe, but these challenges remain. You can simply sign up, and if you are anxious to get the kits to some patients soon, that would be the best first step as the pharmacy issues

may not be solved easily. A number of agencies and organizations have been very supportive of the program including MSSNY, NYSDOH & OASAS. The state has worked to publicize the role and availability of naloxone but so far it has not gained a lot of traction in primary care circles.

Bob: The application form seems complex, and I don't get what I'm supposed to enter in several fields, since I'm in independent practice.

Sharon: Yes, the application is geared towards organizations rather than individual practitioners. See the list below for some tips to ease the process.

Bob: I'll bet our NYSAFP can help with this. Wouldn't that be a way to save lives and give some of our patients and their families a chance to use those lives more safely! Sounds like our Congress of Delegates should give our legislators thanks for making this possible.

Application Tips:

- The registration form is a brief sketch of all the regulations.
- Clinical Director: must be a prescriber – MD, DO, NP or PA
- Program Director: may be an administrative person who can oversee the program or can be the clinical director.
- Targeted Population: might be just your patients who may encounter an overdose, or perhaps you will also offer training to your community or an organization seeing at-risk people.
- Outreach: not applicable if just your patients. Cooperation with local community groups might be a choice as well.
- Affiliated Prescribers: others in your practice that you wish to work with.

Helpful Links:

New York State Department of Health – Registration form, template for policies and procedures, training guidelines and other resources
http://www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/

Harm Reduction Coalition – Training resources including handouts and links to videos
http://harmreduction.org/issues/overdose-prevention/

Prescribe to Prevent – Resources specific to prescribing naloxone
http://prescribetoprevent.org/prescribers/

Substance Abuse and Mental Health Service Administration: Overdose Prevention Toolkits
http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2014/SMA14-4742

Public Health Law Atlas – Find out how many other states allow similar programs
http://lawatlas.org/query?dataset=laws-regulating-administration-of-naloxone

Endnotes

1 Enteen L, Bauer J, McLean R, Wheeler E, Huriaux E, Kral AH, Bamberger JD. Overdose prevention and naloxone prescription for opioid users in San Francisco. J Urban Health. 2010 Dec; 87(6):931–941.

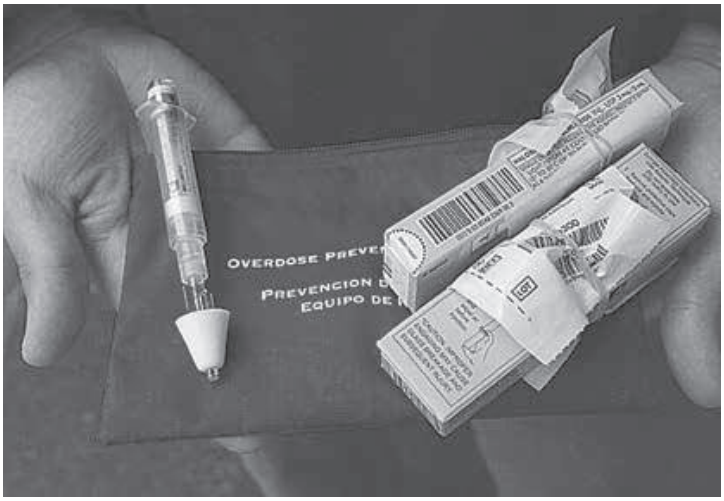
2 BMJ Evidence Centre. Treatment of opioid overdose with naloxone. British Medical Journal. Updated October 23, 2012. [Accessed March 24, 2013, at http://www.bmj.com]

3 Seal KH, Thawley R, Gee L et al. Naloxone distribution and cardiopulmonary resuscitation training for injection drug users to prevent heroin overdose death: A pilot intervention study. J Urban Health. 2005; 82(2):303–311.

4 Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. CDC WONDER Online Database, 2012.

5 Enteen L, Bauer J, McLean R, Wheeler E, Huriaux E, Kral AH, Bamberger JD. Overdose prevention and naloxone prescription for opioid users in San Francisco. J Urban Health. 2010 Dec; 87(6):931–941.

Robert [Bob] Morrow, MD, *received his MD from Mt. Sinai School of Medicine in NYC and did his residency training at the Residency in Family Practice and Social Medicine. He has been in the independent practice of family medicine since 1980. He also works as an Associate Director for Interventional CME in the Center for CME at the Albert Einstein College of Medicine. He is active in the Academy on state and regional levels.* **Sharon Stancliff, MD**, *is an internationally known expert on opioid overdose prevention and buprenorphine use. Dr. Stancliff has been working with people who use drugs since 1990 including provision of primary care, drug treatment, HIV care and syringe access. Dr. Stancliff currently provides services on drug related problems in Zanzibar, the Ukraine and in New York State for the AIDS Institute, New York State Department of Health. Dr. Stancliff graduated from the School of Medicine at University of California at Davis, did her Family Practice residency at the University of Arizona and completed the AIDS Institute-sponsored Nicolas Rango HIV Clinical Scholars Program at Beth Israel Medical Center in New York City.*



A Quick Take on the Decision to Purchase an LMS

By Dena Silva, Program Manager

Office of Professional and Continuing Education (PACE), UNT Health Science Center

CPD providers are required to continually assess and improve individual activities and the overall program. The rapid evolution of technology provides an opportunity to assess the way activities are provided and how participant data is collected, analyzed and interpreted. As more providers abandon databases and cobbled-together solutions in favor of bonafide learning management systems (LMSs), it is beneficial to reflect on the lessons learned from early adopters. An overarching lesson is that no one can stand on a podium or behind a vendor table and tell you the secret to finding the perfect LMS for your program; this is a personal road to travel to determine which system fits best within your organization, and the path that you want to travel over the next few years.

Program structure, user base, and initial and recurring costs are all important factors to consider when looking to implement a new LMS for your program. Conducting an inventory is one important step. This can be structured in the form of an RFP for vendors but its purpose should be to dig deep into the roots and map out the "must-haves" for the new system. Many early adopters have missed key accreditation requirements or overlooked simple processes in their program evaluation. A deep dive on the front end will ease the data mapping and input process for you and your vendor later on. Once the "must-haves" are in place you get to start dreaming about the "what-ifs", which is the exciting part. Where do you want to take your program? How can the LMS assist you in collecting data for outcomes, speaker or user engagement, or for populating enduring material? A new LMS can greatly enhance your CPD program, but only if it is well thought out to make your operation more efficient and not more complex.

Editor's Note: Ms. Silva and the PACE team procured and implemented an LMS system in 2014.

UPCOMING EVENTS

SACME Spring Meeting
April 29 – May 2, 2015
Tampa, Florida

SHM-AAIM Quality and Safety Educators Academy
May 7-9, 2015
Phoenix, Arizona

Alliance Industry Summit
May 11-13, 2015
Philadelphia, Pennsylvania

AHME Institute
May 13-15, 2015
San Diego, California

GAME Regional Conference
May 22, 2015
Montreal, Canada

AMEE/GAME Conference
September 5-9, 2015
Glasgow, United Kingdom

Alliance Quality Symposium
September 28-30, 2015
Chicago, Illinois

SACME Fall Meeting
November 12-13, 2015
Baltimore, Maryland

Alliance Annual Conference
January 13-16, 2015
National Harbor, Maryland

See www.sacme.org for updated events.

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