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THE SOCIETY FOR ACADEMIC CONTINUING MEDICAL EDUCATION

SACME Takes a Bite Out of the Big Apple for Annual Spring Meeting

By Julie A. Brown, CCMEP; Spring Meeting Program Chair

Spring Conference to address "Patient-centered CME: from a Local to a Global Perspective" featuring a special address from the UN

Following on the heels of record attendance numbers for the SACME Fall meeting, the 2011 SACME Annual Spring meeting is set for April 7-9 to take place on the campus of the Langone Medical Center of our host New York University (NYU) Post Graduate Medical School in the heart of mid-town east, New York City. This will be the first time that the meeting has been held in New York City and more record setting attendance is expected.

The conference theme will be ***"Patient-centered CME: from a Local to a Global Perspective."*** A limited number of rooms are available at a great discounted rate at the boutique hotel Affinia Dumont, a short walking distance from the medical center.

To register and view the preliminary schedule, topics, and speakers please visit www.sacme.org.

The 3-day activity will explore changes in the dynamic of the delivery of healthcare in North America and the important role of CME as a tool in promoting better quality and efficiency within that system. As always, the conference will highlight important research in the CME field, and research sessions will be interspersed throughout the meeting.

Abstracts for research sessions are currently being accepted for consideration. Please visit www.sacme.org to review criteria and to submit an abstract. Abstracts are being accepted in:

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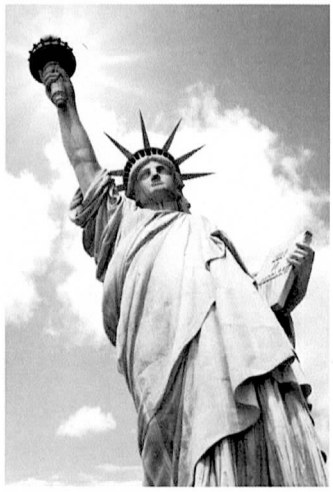
1. Research in Continuing Medical Education (RICME): 15-minute plenary presentation for completed studies and review papers, 20 minutes for works in very early stages and works in progress, 15-30 minutes for issues and challenges;
2. Best Practices in CME: 15-minute plenary presentation;
3. Poster Sessions.

To take advantage of New York City's role at the global epicenter of policy and commerce, the conference will feature a 2-part focus on Global CME and the role that we can play as SACME members. Specifically, the conference will kick off with an address by **Dr. Brian Davey, the Director of the Medical Services Division of the United Nations**. His address, ***"What Are You Doing to Save the World? What the U.N. Needs from CME,"*** will cover issues such as

- The special needs of the UN regarding CME,
- An outline of challenges and collaborations with the UN,
- Progress in specific areas of outcomes, including their work with NYU.
- Another featured Global presentation will focus on "***Emerging Needs in China and India***," including an exploration of areas for partnership, and the regulatory and practice environments.



After these special sessions, topics will cover areas such as:

- What Would You Do? Moral and Ethical Dilemmas of an Accredited Provider
- Accountable Care Organizations and (ACOs) and Health Information Zones (HIZ's): CME's Role
- The AAMC Aligning and Educating for Quality (AE4Q) Initiative; CME in Action for Accountable Care
- Data-Based CPD: Case Studies in Performance Improvement
- Meaningful Use in HIT—the CME and PI CME Contribution to Qualification

The conference, as always, will feature poster sessions and an expanded vendor exhibit area; as well as plenty of opportunities to network with peers!

For complete details and to register today please visit www.sacme.org. Early registration is on a record pace, and the discounted room rates are limited, so please make your plans today.

See you in the Spring in New York City! It's just around the corner!

HEALTH CARE REFORM 3: FROM LEARNING OBJECTIVES TO QUALITY MEASURES (AND BACK AGAIN)

By Dave Davis, MD, FCFP and Nancy Davis, PhD

This is the third in a series of articles for INTERCOM on the topic of health care reform and CME. The first, an overview article, discussed the general principles of the Affordable Care Act and their implications for CME; the second focused on public health, prevention and screening. This is the third, co-authored by Nancy Davis, focusing on the issue of "quality" and its application (or not) in the CME setting. To make the topic coherent and relevant to educators, we've approached the topic from the perspective of learning objectives.

Learning Objectives – the old way

We are all familiar with the establishment of learning objectives, a key step in planning for educational activities for physicians. Objectives can be roughly defined as the desired goals of an educational activity relative to the knowledge, skills, attitudes or performance changes intended by the planner. At their heart, they are a statement of what the physician expects to gain from the educational experience. In the "old" days, these were determined by input from the physician generally in a planning committee

setting – what knowledge did they wish to gain? What new skills might they want to acquire? In this model of planning, CME providers would keep learning objectives vague and global so as to meet the needs of as many diverse learners as possible and allow faculty latitude in their presentations

There are a few problems with this approach: physicians' ability to determine their own learning needs may be problematic, the information or knowledge to be conveyed may be less than accurate or evidence-based, and broad, vague learning objectives are not measureable and therefore not effective in measuring outcomes. We'll leave one more problem for the end

First, most of us are familiar with the literature that says physicians – in fact, most of us – don't assess their own performance and thus learning needs very well Not from negligence or poor motivation, we over or under estimate our efforts and so have a hard time judging our needs, in the absence of data about our performance In that context a typical planning committee may aim for "hot topics" or new products or devices, and avoid true gaps in care

Second, the facts that we convey in a CME setting may not be entirely accurate or evidence-based When asked by a CME participant at the University of Toronto's annual day in orthopedics in primary care years ago what his evidence for prescribing such-and-such was, an orthopedic surgeon (don't worry, you won't know him) said, "Evidence? I always order that medication!" The emphasis was on "always."

Third, a basic premise of learning objectives is that they be measureable Today we need to ensure they are also performance-based. Our friend, David Price, MD, Director of Education at Colorado Permanente Medical Group, likes to call them "performance expectations " In other words, what do we expect our learners to actually do in practice as a result of our activity?

Quality Metrics: better science, better outcomes

Enter the field of quality improvement and quality metrics The field of quality improvement has charged like a lion onto the health care scene, led by Berwick and colleagues over the last two decades. Quality Improvement is defined by the IOM as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." QI recognizes that for all the advances in acute care in this country, and for its excellence of care in many other areas, there is a gap between what we know and what we do Here's an example from our orthopedic friend above

The piano mover

A 39-year-old male helps move his neighbor's piano, straining his back, and goes to see his primary care provider the next day (lucky, huh?). The PCP orders a back X-ray and MRI, prescribes potent pain medication, and orders bed rest for three days. Our patient is actually not so lucky. the evidence is pretty clear that for relatively young people with acute back pain like this, no investigations are necessary and that prolonged bed rest – especially with strong pain relievers — just makes the back weaker This would be an example of over-use If the patient had other symptoms (say, weight loss, much longer history of pain, or no history of injury say) and the PCP suggested only "watchful waiting," this would be an example of underuse

How do we know what is appropriate use? For the most part, clinical practice guidelines are a great addition to the literature and the practice of medicine, especially when they are based on solid literature reviews, have an unbiased and well-described developmental process, and represent the views of all stakeholders From these evidence-based guidelines come performance measures The evidence-based guidelines on acute back pain, for example, provide clear evidence for treatment and provide quality measures to assess care and prevent inappropriate variances

So what? Applying quality metrics to the creation of learning objectives and effective CME intervention

When learning objectives are stated as performance measures, they become specific, relevant to practice, and measureable An example for our illustrative case might be Measure #151 from the Physicians Consortium for Performance Improvement:

Advice Against Bed Rest

Percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who received advice against bed rest lasting four days or longer at the initial visit to the clinician for the episode of back pain

Based on this measure, our performance expectation (or learning objective) in a CME activity with a topic on back

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pain might be: "Advise patients presenting with acute back pain against bed rest for four days or longer."

Tell me again: why should we do this?

In addition to the very important reason of healthcare quality improvement -- improving the care and outcomes of patients—there are other drivers today for physicians to improve their practices. They all fall roughly under the heading of changes supported by the Affordable Care Act. For example, "pay for performance" is an incentive led by the Center for Medicare and Medicaid Services (CMS) in its Physicians' Quality Reporting System (PQRS—formerly Physicians Quality Reporting Initiative—PQRI) and implemented by many private payers. Further, the ABMS Maintenance of Certification (MOC) criteria require performance measurement and improvement in practice.

How can we do this?

- Think globally. Understand quality improvement principles and their application to CME and use quality measures and national guidelines in planning and evaluation of educational activities. Use these measures to develop learning objectives and think of them as performance expectations.
- Act locally. Locate and reach out to those who develop and report on quality data in your institution. These individuals and their roles vary from institution to institution and include chief quality officers, quality specialists, chief medical officers, or VPs of medical quality. In addition to the usual planning processes, use quality data for needs assessment and outcomes measurement.

We mentioned a final problem, above. We couched the use of learning objectives, or performance expectations, in the language of planning for a CME event as though that were a one-time only, stand-alone event, like the annual day in orthopedics for primary care that we've used as an example. We'd like to end by making a plea that we think of CME in much broader terms than the lecture or the stand-alone CME event. Not that these are bad or wasted, but rather they are insufficient to make the change by themselves. They are necessary maybe, but not sufficient.

Why not think of "CME" as the middle component of improvement. First, use measures to measure (assess). Based on gaps, globally, locally or individually, develop performance- based educational activities that include systems-based process interventions to improve/eliminate gaps. Second, plan, develop and implement the educational intervention considering such innovations as pre-course, on-line questions and needs assessments; and post-course reminders, checklists, patient education materials. Then re-measure to check for improvement, refine the process and disseminate it widely.

Effective implementation of these challenging steps –

- using objective quality data in planning
- determining where clinical data points to gaps and needs for improvement in your institution
- planning and implementing effective educational activities, and
- re-measuring using quality metrics

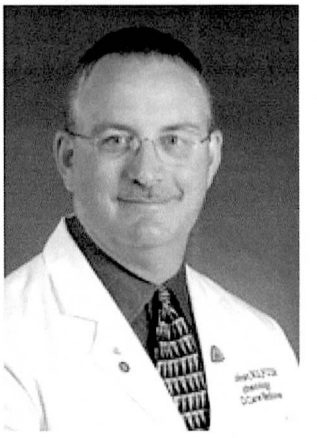
will help to achieve the overall goals of the Affordable Care Act. Most importantly, it helps the CME provider play an active role in ensuring better patient care.

Dave Davis, MD, FCFP, Senior Director, Continuing Education & Performance Improvement, DDavis@aamc.org

Nancy Davis, PhD, Founder and Executive Director, National Institute for Quality Improvement and Education

PRESIDENT'S COLUMN: WHAT'S SACME UP TO?

By Todd Dorman, MD



SACME has experienced significant growth over the last few years and along with that growth have been a number of significant accomplishments. I will try to run through a number of exciting things at play for SACME so that you, the membership, are fully aware of what the society has been doing.

SACME has reached out and started a series of interactions with Agency for Healthcare Research and Quality (AHRQ) across a variety of interesting domains. These will culminate not only in better dissemination

strategies but more effective dissemination of the work of the Evidence-based Practice Centers. In addition, new discoveries regarding lifelong learning and knowledge translation will be established Ongoing discussions regarding interactions and research in lifelong learning will likely produce additional opportunities in the future

We have helped grow our relationship with the Association of American Medical Colleges (AAMC) through what is known as the Joint Working Group (JWG). The JWG consists of SACME leadership, AAMC CME leadership and the leadership of the Group on Educational Affairs (GEA)-CME section within AAMC This relationship is leading to tighter integration of SACME at the AAMC Annual fall meeting and opens the door for collaboration with the AAMC through a variety of other specialty foci These include discussions with the Council of Deans and the Chief Medical Officers Group (CMOG) The JWG has also held discussions related to Liaison Committee on Medical Education (LCME) lifelong learning requirements and how we might better infuse CME/CPD into the system. The group continues to discuss and review the Harrison Survey and is looking to lessen the burden of the survey while maintaining the robust nature of the data. To do so we are evaluating several strategies that may even include integrating data submitted annually to the Program and Activity Reporting System (PARS) by the ACCME Finally, the JWG is discussing ways to leverage the regional sections of each organization

SACME has contributed significantly to the work of the Conjoint Committee which is addressing some of the issues raised by the Institute of Medicine report on conflict in education, research and practice A major issue at play is the Institute of Medicine (IOM) request that CME stakeholders discuss the need and potential format for a new funding model within two years of the publication of the report, a date that hits in spring of 2011 The Conjoint Committee, with significant help from SACME leadership, will convene a summit at its March meeting that is tackling this issue and thus will have met the timeline recommended in the IOM report

We are working with the American Medical Association (AMA) on its task force to review and consider the ability to utilize evidence grading mechanisms within certified CME SACME continues to have members serve as leaders in the AMA Industry Provider Task Force that is developing the Fact Sheets series These have proven quite useful in helping those with limited CME knowledge gain core knowledge and clarity regarding certified CME

The Tri-group (SACME, Association for Hospital Medical Education (AHME) & Alliance for Continuing Medical Education (CME)), produced in partnership with other stakeholders, the National Faculty Education Initiative (NFEI) program We are discussing additional strategies to solidify management of the group with an eye to future potential products These products could be additions to the NFEI series or even broaden the product line An example being evaluated is the potential development of a standard disclosure process and system for the CME community

The Journal of Continuing Education in the Health Professions (JCEHP) owners group has hired the new editor (Curt Olson) after Paul Mazmanian's expert stewardship The owners group is hiring a business manager to solidify management and provide consistent direction for the future growth of the journal The group is also evaluating electronic publication options to pair with the print version while also considering strategies to better utilize JCEHP com Finally, methods that can make the journal more available to the international market through a program for developing countries (e.g., Hinari) are being discussed.

SACME helped support the initiation of the Consensus Conferences and is now the sole director of this process The national research agenda has been established and funds are being sought to help accomplish the required research that will advance the field from theory to translation into practice The Consensus Conferences also included a focus on strategic management of CME that led to the inaugural Summer Leadership Institute, and we hope that funds can be raised to better develop scholarship capacity within the field of CME Partnerships with other organizations dedicated to improvement in health through research are being considered and utilization of the AAMC Medical Education Research Certificate (MERC) program as a means to enhance scholarship is being evaluated

SACME leadership has held several discussions with the leadership of the American Board of Medical Specialties (ABMS) and the Federation of State Medical Boards (FSMB) and will continue to hold discussions with these organizations regarding certified CME and CPD input into

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Maintenance of Certification (MOC) and Maintenance of Licensure (MOL) processes.

The SACME Spring meeting is being planned and should be an exciting meeting held in the shadows of the United Nations; and this year, as a pilot, will include an expanded exhibit hall. New York offers limitless options for entertainment outside of the meeting during down time.

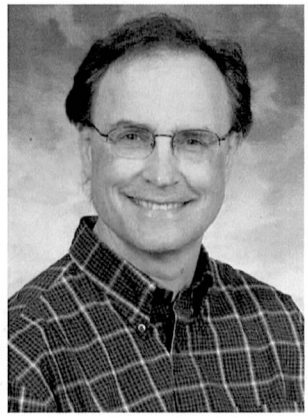
The 2012 Congress planning continues to focus at a few broad themes. This important international conference will help bring additional fields, such as simulation together with the CME/CPD community.

So, as you can see, SACME has been quite busy and will continue to be an extremely active and vital society as we strive to help advance the field of CME/CPD.

See you in New York!

TRANSFORMING BLACK MARKS ON PAPER INTO A VALUABLE RESOURCE

By: Curt A. Olson, PhD, Editor,
Journal for Continuing Education in the Health Professions



On January 1, 2011 it became official. My term as editor of The Journal of Continuing Education in the Health Professions began. It is truly an honor to follow Dr. Paul Mazmanian, the previous editor of JCEHP. Paul is to be congratulated for his superb work at the helm of the journal over the last ten years.

If I have learned anything at all in the past few months it is how dependent a journal is on the many people who contribute to its publication. But, for a journal to be anything more than a collection of pages covered with black marks, someone has to pick up an issue or find an article on the Web and *read* it. It is the act of reading that cashes in the potential that lies within the journal. The reader is the animator, giving life to authors' words. It is a power we all possess; some of us are authors, but we are all readers.

If asked about the role of a journal, most people will say something like "disseminating research". This is indeed an important function and it is one that authors and editors readily and routinely perform. But there are a number of other important contributions a journal can make. It can:

- serve as a network that connects us with others who share our challenges and interests;
- provide a common experience and language that binds us together as a community;
- keep us informed of what is going on in the field;
- expose us to new perspectives, concepts, and evidence that can unlock and solve problems;
- help us learn from the practical experiences of others;
- serve as a means for giving and getting recognition for work well done;
- magnify the impact of our work;
- serve as a source of tools and models that increase our likelihood of success;
- give us a new appreciation of someone we know through his or her writing;
- help us find literature on a topic of interest; and
- lift our eyes up from the demands of our daily work and give us a broader perspective on the range of possibilities and resources available to us.

What is important to note about this list is that *only JCEHP's readers can make these things happen.* Otherwise, black marks on paper.

It is the editor's job to be responsive not only to the interests of authors, the field and science, but also to the interests of readers. All this is a long-winded way of inviting you, the JCEHP reader, to let me know if you have feedback to offer about the journal. My goal is to ensure that JCEHP continues to be a valuable resource – your primary and most useful source of scientific and practical knowledge and information in the CPD field.

Report from the Executive Secretariat

By Jim Ranieri

New Members

The following members joined the Society between March 2010 and January 2011. We would like to welcome them to the organization:

- Heidi K. Moore, Ph.D. — Associate Scientist, University of Wisconsin School of Medicine & Public Health, Office of Continuing Professional Development
- Dennis P. McNeilly, Psy.D. — Assistant Dean for Continuing Education, UNMC
- Suzanne Escudier, M.D. — Assistant Professor, Department of Anesthesiology, Texas Tech University Health Sciences Center
- Abi Sriharan, M.Sc. — Director, International Continuing Health Education Collaborative, University of Toronto Mount Sinai Hospital
- Adele Webb, PhD, RN, AACRN, DPNAP, FAAN — Executive Director, Association of Nurses in AIDS Care
- Kate Ray, M.S. — Education Administrator, Mayo Clinic Mayo School of CPD
- Robert J. Birnbaum, M.D., Ph.D. — Executive Director, Postgraduate Medical Education, Massachusetts General Hospital
- Jane D. Kivlin, M.D. — Director, CME Medical College of Wisconsin
- Constance LeBlanc, M.D., CCFP, FCFP, MAEd — Associate Dean, Continuing Medical Education, Dalhousie University
- Michael Kneeland, M.D. — Interim Associate Dean for Continuing Medical Education, University of Massachusetts Medical School
- Saul J. Weiner M.D. — Senior Associate Dean for Educational Affairs, University of Illinois College of Medicine
- Bruce A. Nitsche, M.D. — Medical Director of CME, Virginia Mason Medical Center

Again the most common method of joining SACME was from a referral of a colleague. We are hopeful to reach last year's membership total again this year but need your help with referrals. We have brochures in both hard copy and available by email if you are interested. Please let me know. Directing colleagues to our web site is also a big help.

Abstract Submission

For the Spring 2011 meeting, SACME developed a new abstract submission system utilizing an integrated online submission, review, and notification features that we hope you found useful. It certainly made the process more efficient for the Research Committee and staff.

Frequently Asked Questions

Job Listings: Posting a job to the SACME web site, and announced on the SACME listserv, is free of charge. Announcements must be reviewed prior to posting, but all members are encouraged to take advantage of this opportunity.

Listserv Access: Only members are allowed on the SACME listserv. However, a member can elect to appoint another individual at their Institution to subscribe to the listserv in their place (essentially there is one email allowed per membership).

JCEHP Online Access: A link can be found to JCEHP issues in the Members' Only area, however, the access is provided by Wiley InterScience. If you need assistance with your access, you may contact me for assistance.

My contact information is Jim Ranieri, MPH, MBA, 3416 Primm Lane, Birmingham, AL 35216. Telephone: 205-978-7990. E-mail: info@sacme.org.

Find valuable CME/CPD resources at www.sacme.org

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- CME Resources
- Research Resources
- Publications

Meet Your Central Region Representative

Deborah Samuel is the Director, Division of CME at the American Academy of Pediatrics (AAP), located in Elk Grove Village, IL, a suburb of Chicago. The AAP Division of CME is responsible for the development, implementation, and evaluation of live CME activities and the accreditation of the AAP CME program. The division also provides joint and direct sponsorship (designation of *AMA PRA Category 1 Credit(s)*™) for CME activities developed in conjunction with AAP districts, chapters, and sections. Ms. Samuel provides primary staff support to the AAP Committee on CME, which oversees the AAP CME program. Having been with the AAP for nearly 13 years, Ms. Samuel has served the organization in other roles, including as the Manager, Education & Accreditation Services and a CME Manager.

Ms. Samuel has been a member of the Alliance for CME, Illinois Alliance for CME, and SACME for many years and has presented on various topics, including implementation of commitment to change contracts in live CME, joint sponsorship, test item writing activities, commercial support, and funding of CME. She recently completed a two-year term as Leader of the Alliance's Medical Specialty Societies (MSS) Member Section and has served on the planning committee and as a faculty member at the Alliance's MSS Member Section Meetings. Deborah has co-facilitated MSS "communities of practice" breakout sessions at past Annual Conferences of the National Task Force on CME Provider/Industry Collaboration. In April 2009, Ms. Samuel was elected to the SACME Board of Directors as the Central Region Representative and became the Membership Committee Chairperson in September 2010.

Ms. Samuel earned a Bachelor of Arts degree from DePaul University (Chicago) and a Master of Business Administration from Northern Illinois University. Prior to joining the AAP, Ms. Samuel worked in commercial real estate.

To Central Region Members

I am honored to serve as your Central Region Representative and represent you on the SACME Board of Directors. Please share with me any ideas, questions, or concerns about your SACME membership or ways we may be able to better serve you. I am happy to carry your feedback forward to the SACME board. Also, please keep in mind that there is a Central Region listserv that you can use to communicate with members in our region (central@esacme.org) or to highlight regional news. Of course, the SACME member listserv is always available for reaching the full membership.

To All Members

Having become the Membership Committee Chairperson in fall 2010, your regional representatives and I are interested in hearing your thoughts on how we might be able to enhance your membership experience. The Membership Committee is exploring many different activities, and you can catch-up on these from reading the minutes posted under the "Committee Minutes" section of the Member Area on the SACME web site. If you're attending the spring meeting in NYC, please join us at the Membership Committee meeting. One of the most effective ways to increase membership is through personal invitation, and I would encourage everyone to consider inviting a colleague (or two) to join SACME. The spring meeting will include the session, "SACME 101 – An Orientation For New and Prospective Members," where individuals can interact with the regional representatives and SACME leadership to learn more about the organization in an informal setting.

Contact Information

Please don't hesitate to contact me (dsamuel@aap.org) about any Central Region or Membership Committee activities or ideas. I look forward to hearing from you.

The SACME Board of Directors gratefully acknowledges an unrestricted educational grant received from **CME*info*.com** in support of this issue of *INTERCOM*.

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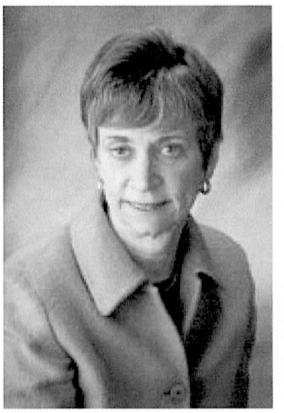
Update: CME Section of the AAMC Group on Educational Affairs (GEA)

By Barbara Barnes, MD, MS



I had the pleasure of becoming chair of the GEA CME Section at the AAMC annual meeting in November 2010, following two years of great leadership by Jack Kues. Dave Davis, Carol Goddard, and the Section Steering Committee (chair, past chair and regional representatives) have been actively engaged in establishing and implementing strategic priorities and further defining the role of our group, including its relationship to the overall GEA as well as other organizations. The Joint Working Group, which includes our Steering Committee and SACME leadership, is seeking out additional collaborations.

We were very pleased with the synergies that were established around programming at the 2010 AAMC annual meeting and were very appreciative of the large number of individuals who stayed until late Tuesday afternoon for our business meeting and session on strategic management led by Moss Blachman. This was a very special year for all of us, as we joined together to congratulate Karen Mann on receiving the prestigious Merrill Flair award for her significant contributions to medical education. We welcome suggestions for sessions at the 2011 annual meeting which will be held in Denver on November 4th through 9th. It is hard to believe but this year we will be celebrating the 50th anniversary of the RIME (Research in Medical Education) sessions. The call for abstracts is posted at http://www.aamc.org/gea, with a submission deadline of February 25, 2011. We are always anxious to have CME well represented at RIME and would very much encourage SACME members to submit. We also hope that SACME members will consider attending GEA regional meetings this spring.

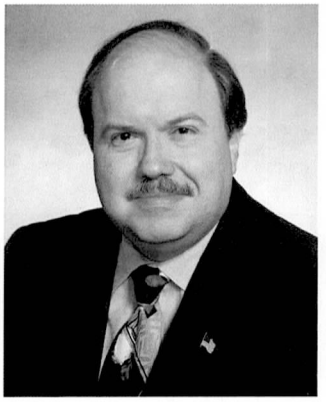
The CME Section of the GEA has exciting and aggressive strategic priorities for this year that include:

- Assisting new medical schools and branch campuses with engaging community-based preceptors to create high quality learning experiences. In addition to supporting traditional faculty development activities, we want to explore opportunities for recognizing the CPD that results from teaching medical students and residents. We have begun discussions with the ACCME and AMA to understand how this might be accomplished within current requirements as well as identifying potential changes in the standards to make it easier for CME providers to award credit for these activities.
- An initiative that we call "moving beyond accreditation." We recognize that many SACME members find accreditation requirements to be burdensome and challenging, limiting resources that might be devoted to innovative projects and linkages with improvement activities. To address these issues, we are developing two types of resources. Through the use of volunteer advisors ("Go Teams") and educational activities, we will help academic medical centers address accreditation requirements in an efficient and effective manner. Secondly, we have engaged Nancy Davis to provide assistance in integrating CME with quality improvement. Both of these strategies are in the early stages of development and more details will be forthcoming.
- Forming collaborations with GME to assist physicians in making the transition from residency to clinical practice. Physicians early in their careers, particularly those who practice in community settings not associated with an academic medical center, often find the need to acquire skills and competencies that were not addressed in their residency programs. We will be exploring pilot projects to better understand how we can support these gaps.
- And last but certainly not least, we will be identifying a new name for our section to better represent our commitment to improving practice and performance. Those of us who lived through the SMCDCME to SACME process recognize the challenges associated with this undertaking and very much welcome all thoughts and suggestions.

I feel blessed to be involved in the CME Section of the GEA at this time when there are so many opportunities to solidify our role in the continuum of education and practice. I very much look forward to working with the SACME leadership and membership as we address these exciting issues.

News from the American Medical Association

By Alejandro Aparicio, MD, FACP



In my previous column I mentioned that one of the actions taken by the AMA Council on Medical Education at the June 2010 meeting was to approve a new version of the "The Physician's Recognition Award and Credit System: Information for Accredited Providers and Physicians" booklet. The booklet was published in electronic format and can be found at www.ama-assn.org/go/prabooklet. The new requirements will be effective July 1, 2011, although CME providers may choose to implement these changes immediately. Because of the other items of information that I felt were important to include on that previous column, I did not provide details about the changes so I will do so this time

Periodically, the AMA through its Council on Medical Education and Division of Continuing Physician Professional Development conducts a comprehensive review of the AMA Physician's Recognition Award (PRA) and the AMA PRA credit system. The reviews help to ensure that the credit system continues to: enhance the core mission of the AMA (to promote the art and science of medicine and the betterment of public health), be physician-centered, help physicians improve patient care, be based on valid adult-learning principles, and demonstrate that the credit earned is credible to physicians, the public, credentialing agencies, medical boards and other stakeholders.

This current version of the booklet is the culmination of a series of 22 meetings with a total of 160 representatives from 58 stakeholder organizations, among them SACME leadership and the two other continuing medical education credit systems: the American Academy of Family Physicians (AAFP) and the American Osteopathic Organization (AOA). The information gathered at these meetings was summarized and the results and recommendations were presented to the AMA Council on Medical Education.

The council discussed proposed changes and adopted several revisions to the AMA PRA credit. Accredited CME providers must meet all 10 AMA core requirements (see page 4 of the AMA PRA informational booklet), and one of the seven learning format-specific requirements (see pages 4–7) in order to certify any activity for *AMA PRA Category 1 Credit*™ and to award this credit to physicians.

Some of the changes to the requirements that apply to the learning formats include the following:

For enduring materials and Journal-based CME activities, both must include an assessment of the learner that measures achievement of the educational purpose and/or objective(s) of the activity with an established minimum performance level that is communicated to the physician prior to participating in the activity. The intent of this requirement is that *AMA PRA Category 1 Credit*™ is only awarded to a physician who demonstrates meeting the objectives of the activity.

The AMA has not specified the type of assessment, questions or performance level that an accredited CME provider must use. The CME provider may use different assessment types based on the content and objectives (e.g., multiple-choice questions, case-based questions, short-answer, essays), as well as different levels of performance for each activity. Whatever assessment tool is used, however, it must be graded to determine that the physician achieved at least the minimum level that was established by the CME provider.

For manuscript review activities, the new description clarifies that a physician may only be awarded *AMA PRA Category 1 Credit*™ if the editor of the journal considers the review to be acceptable. This requirement is to ensure that a physician only receives credit for demonstrating successful completion of the CME activity.

For performance improvement CME (PI CME) activities there is now clarification that a physician must begin a PI CME activity with Stage A in order to assess their practice based on the chosen performance measures and establish a baseline prior to implementing changes in practice.

There is also a change in the AMA credit designation statement. It is now required that the first sentence of the credit designation statement indicate that the activity was developed to meet the specific requirements of one of the seven AMA approved learning formats. This change

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lets a potential learner know what type of activity they will be participating in and indicates to credentialing organizations, once the documentation of completion is submitted and received, the type of activity the learner has successfully completed. The new credit designation required for all activities certified for *AMA PRA Category 1 Credit*™ is:

> The [name of accredited CME provider] designates this [learning format] for a maximum of [number of credits] *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

One of seven AMA approved learning formats must be included in the AMA credit designation statement. They are: Live activity, Enduring material, Journal-based CME activity, Test item writing activity, Manuscript review activity, PI CME activity, and Internet point-of-care activity. It is not acceptable to use any other language to refer to the learning formats in the credit designation statement since only these seven formats have been approved for *AMA PRA Category 1 Credit*™ by the AMA.

There are other changes and information that may be of interest to you including a definition of Certified CME. At a time when terminology in the CME community seems to be confusing, this inclusive term, as defined, provides everyone in the CME community with a way to refer to educational activities certified for credit by the AAFP, the AOA and the AMA. Certified CME is defined as:

1. Nonpromotional learning activities certified for credit prior to the activity by an organization authorized by the credit system owner, or
2. Nonpromotional learning activities for which the credit system owner directly awards credit

Additional information related to the changes can be found in the most recent CPPD Report. If you are not currently subscribed to the CPPD report you can view previous issues – and sign up to receive future ones – at www.ama-assn.org/go/cppdreport.

See you at the Spring Meeting

INTERCOM

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UPCOMING EVENTS

PI CME & MOC Part IV Workshop
March 28, 2011
American Academy of Orthopedic Surgeons
Chicago, IL
www.niqie.org

2011 SACME Spring Meeting
April 6-10, 2011
NYU Post Graduate Medical School
New York, NY
www.sacme.org

MedBiquitous 2011 Annual Conference
May 9-11, 2011
Johns Hopkins University School of Medicine
Baltimore, MD
www.medbiq.org

1st International Conference on Faculty Development in the Health Professions
May 10-13, 2011
Li Ka Shing Knowledge Institute and Pantages Hotel Toronto Centre
Toronto, ON, Canada
http://www.facultydevelopment2011.com/

NIQIE 2011
September 14-16, 2011
Hotel Monaco
Alexandria, VA
www.niqie.org

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