

## AMBULATORY PERFORMANCE IMPROVEMENT IN CONTINUING MEDICAL EDUCATION: ONE PROVIDER'S PERSPECTIVE

By Stephen E. Willis, MD

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Executive Director, Eastern Area Health Education Center (AHEC)

At the Brody School of Medicine at East Carolina University and Eastern AHEC, we have chosen to focus our quality improvement initiatives on the ambulatory setting because of our perception that there are fewer available resources to support small practices than there are in larger practices and hospitals.

Our PI (Performance Improvement)-CME initiative began in July 2005. Funding for our initiative is provided by philanthropic and other grants such as the Improving Performance in Practice Initiative (IPIP) and by internally appropriated funds. There is no commercial support. Our budget for this endeavor is \$110,000 to \$120,000 per QI Consultant (QIC) per year. This includes travel, supplies, administrative support and other miscellaneous costs but not indirect costs or the contribution of others in the Office of CME. Our Quality Improvement Consultant was hired in November 2006. It was at this point we began to visit practices regularly.

All our efforts are now focused on the primary care of diabetes and/or asthma within a given practice. We currently work with ten practices including about 55 physicians and/or mid-level practitioners. It appears that the capacity for a QIC, at least early on, is 10-12 practices. We do not know the level of ongoing involvement with practices that will be required to sustain activities but clearly that will determine the rate at which new practices can be brought into the initiative.

The IPIP initiative is funded by the Robert Wood Johnson Foundation in a grant to the American Board of Medical Specialties and, in North Carolina, funds provided by The North Carolina Division of Public Health. It is a collaboration of many state and regional organizations including the North Carolina AHEC program, the Community Care of North Carolina (CCNC), the NC Medicare QIO, specialty societies for Family Medicine, Internal Medicine and Pediatrics, the North

Carolina Medical Society, and the North Carolina Department of Public Health. The IPIP initiative started in February 2006.

The data we utilize for performance improvement activities is generated from Medicaid utilization and chart audit data furnished by the Com-

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munity Care of North Carolina and monthly chart audits and/or electronic health record queries sampling a subset of all patients in a given practice. These data are supplemented by other relevant information from a variety of sources.

A goal is that all practices wishing to do so will have the tools and ability to qualify for National Committee for Quality Assurance (NCQA) certification. Much of our early efforts have focused on collecting baseline data. No practice has more than 3 months of data thus far. In order to collect these data as efficiently as possible we are at various stages with practices in helping utilize Electronic Health Records (EHRs) as tools for PI/QI for those that have them. Additionally, the formation of effective PI/QI teams involves some effort as practices do not tend to have such a team in place at the outset. PI/QI activities aimed at redesigning systems and processes focused on improved patient care commenced in January of 2007. Process changes aimed at improving health care outcomes are, in fact, occurring; however, it is too soon to see this reflected in overall health care outcomes. Additionally, while with the initial practices we have not undertaken to measure it, our sense is that important changes in practice culture are occurring as well.

Based on our experiences, we have learned a number of useful lessons:

- PI/QI is a “team sport”: If change is to occur within the practice, the process must involve an interdisciplinary team—for instance, physician(s), nurse(s) and office support staff. External collaborators, as exemplified by the IPIP initiative, are invaluable and greatly enhance the process. Working in conjunction with CCNC case managers has also been invaluable. As the case managers work with patients, the QIC works with the practice to bring about appropriate change identified by the practice’s QI team.
- “Check egos and turf issues at the door”: Perhaps most importantly, everyone involved must be willing to get “out of the box” and try new endeavors knowing that some of these efforts may not succeed.
- Use a well-accepted, nationally-validated set of performance measures: This enables you to avoid getting “bogged down” in defining the measures and goals for performance and enables all those participating in the PI initiative to adopt agreed upon performance goals.

- Have early successes: Work only with those who are serious about it. At least initially, you do not need everyone in the practice to buy in. Make incremental changes following a well-accepted change strategy.
- Focus on the practice’s most pressing issue first, even if it is somewhat peripheral to the intent of the broader initiative. This will establish your credibility and that of the process.
- Let data drive the process: You do not need statistically significant data but it must be collected utilizing a consistent process. Data provide the critical information necessary to motivate and sustain improvement.
- Be patient: There is typically substantial effort required for a practice to establish a mechanism and process so that aggregate data can be collected, processes changed, and the outcomes of that change measured. This process needs to occur prior to, or concurrent with, initiating process changes aimed at measurably improving patient care. While process improvement can occur fairly quickly it will take longer to see that improvement reflected in patient care outcomes.
- Establish a “collaborative” among practices participating in the PI/QI initiative. This has been a useful means of communicating and sharing information and expertise. Thus far, the issue of transparency of practice-wide data to other practices in the collaborative has not been an issue.
- Focus on system change and practice redesign. In our experience, most practice gaps are not due to knowledge gaps.
- Electronic health records, can either be an obstacle or an asset and are not required for QI/ PI to occur.
- Professional development for select CME staff is critical as facilitating PI/QI initiatives is nothing like traditional CME. In our case, in early 2006, the Associate Dean and two staff completed the QI Institute offered by the NC Hospital Association and the NC AHEC program.
- Tailoring traditional CE/CME offerings to regional needs becomes much easier. It is hard to imagine a more valid source of needs assessment data than actual clinical performance and, when available, patient outcomes.
- Traditional interdisciplinary CE offerings become much more attractive.
- At least for the “early adopters”, the availability of Category I CME Credit does not seem to be a primary motivator. Thus far, while many physicians have

qualified for Category I CME credit, only one has applied for it.

- Broad-based community interventions are desirable in addition to focusing on health care practices and providers.

As we expected, it is clear that we still have much to learn. Perhaps the most important long-range challenge and les-

son will be: will, and how can practices afford to sustain the QI/PI process as the QIC becomes less available? Further lessons learned will present themselves over time and we hope to be able to sustain both the commitment and flexibility necessary to deal with ongoing challenges as we implement this new format of continuing medical education.

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## FROM THE PRESIDENT

By Jocelyn Lockyer, PhD  
President, SACME

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I attended my first SACME meeting in 1984. That year, the meeting was in San Francisco. It was a meeting that combined SACME with a two-day “Research in CME” program.

Don’t laugh—remember your younger self. I had only read about San Francisco in novels (well probably in romance novels). I was anxious about the presentation that John Parboosingh and I were going to make about research we had done. I was sure someone would ask a tough statistical question that would undermine our whole research. I was sure my academic credentials (MHA) would be insufficient in a group of MDs and PhDs.

The meeting clearly surpassed my wildest dreams. I have made great friends through SACME. I have attended most of the Fall and Spring meetings, Summer Research Institutes, and “Congresses on CME” since that time. I got involved pretty quickly—in my 1985 University annual report, I report being a member of the research committee. Eventually, I took a sabbatical and was awarded a PhD in 2002!

This year, with Michael Fordis’s help, we reflected on SACME’s 30 years of progress. It was a chance to realize just how far SACME has come in 30 years. As an academic society, SACME and its membership have contributed in substantive ways to

- the growth and development of individual members
- networking across schools and organizations
- how CME providers design their educational activities
- building research capacity and direction

- research about physician learning and change, physician assessment, and effective educational design
- theory building in CME
- accreditation standards and other regulatory approaches



We have a tremendous infrastructure in SACME to help us. We have

- skilled people actively involved in SACME
- ways of communicating through our regular meetings, committees, listserv, JCEHP, and Intercom
- a research and development resource base to facilitate literature searches (see page 12 of this newsletter)
- a new look and feel web site filled with informative resources (see page 10 of this newsletter)
- archival material and resources documenting our history
- an Endowment Council which provides small grants for research projects
- lots of opportunity to contribute to SACME through its open committees: membership, publications, research, and program in addition to other committees that also seek members.

If you are new to SACME and not sure how you can get involved, please jump right in and offer to help. You can begin by attending one of the open meetings this fall. Or you can contact your regional representative for ideas. Or contact one of the committee chairs and offer assistance. Let me promise you--you will be rewarded and enriched in ways you cannot even imagine!

# MISSED OPPORTUNITIES: ARE WE MEETING THE NEEDS OF ALL OUR PHYSICIANS?

By Jocelyn Lockyer, PhD  
President, SACME

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For many years, the United States and Canada have benefited from physicians trained in other countries. Indeed, 25 and 23.1 percent of the workforce in our countries, respectively, are International Medical Graduates (IMGs). For the US, the largest IMG groups attended medical school in India, the Philippines, Mexico, and Pakistan. For Canada, the largest IMG groups were trained in the United Kingdom, South Africa, India, Ireland and Saudi Arabia.<sup>1</sup> Both countries expect this trend of recruiting physicians to meet population needs to continue at the same or higher levels.

IMG physicians entered the US and Canada from very different systems of care and may have worked with patients whose health care needs and expectations were different from those present in the US and Canada.

The academic literature and media about IMG physicians describes the 'brain drain' and the ethics of recruiting physicians from less developed countries. It also describes the plight of physicians who immigrate and cannot find employment as physicians. There is a body of measurement literature related to performance on standardized entry-type examinations (e.g., USMLE examinations). There is some literature documenting how the care provided by IMGs differs from that of US or Canadian-trained physicians. Last there are the articles which describe the work being done by US and Canadian trained physicians abroad.

Despite the literature in the lay press and in academic and scholarly journals, there has been little attention paid in either CME or medical education meetings and journals to the role(s) that CME units can play to support this group of newcomers. We know little about their needs as learners. We appear to have few educational programs or activities to facilitate their transition.

For me this begs a central question, along with several sub questions.

- Is this a missed opportunity?
- How many IMGs are among the populations of physicians we target for our programs?
- How many of these IMGs are "new" to our systems (ie, <5 years)?
- Do we know what their needs are as they "transition" into practice?
- Are these physicians well served by our regular clinical education programs?
- Should we be creating programs to address needs that might be specific to them? For example, if their previous clinical work was primarily urgent/emergent care, how will they learn the nuances of chronic disease management or North American concepts of patient centered care or patient-physician communication? How are they trained for patient advocacy? Where do they learn how to refer patients efficiently or draw upon the skills of other health care professionals?
- What are our responsibilities with regard to this group of physicians who were recruited or chose to come to practice in our countries?

While an article such as this can only raise the issues that may be of concern to SACME membership, I hope that you will share work that you are doing related to IMGs through the SACME listserv, in JCEHP, and at our fall meeting so that we can ensure newcomers integrate successfully and we can be part of the solution.

1. Mullan F, The metrics of the physician brain drain, NEJM 2005; 353:1810-8

**Save the Date!!**  
**2007 SACME Fall Meeting**  
**November 2-4, 2007**  
**Washington, DC**  
Details are forthcoming on the web site:  
[www.sacme.org](http://www.sacme.org)



2006 - 2007 Leadership Team: Melinda Steele, Michael Fordis, Jocelyn Lockyer and Lois Colburn



Thanks to Amie Devine, Bris Villaneuva and Genevieve Napier (left to right) from Northwestern University for a great job managing the Spring Meeting.



Cold but fun Copper Mountain sleigh ride to dinner

## SPRING PROGRAM TOOK ACADEMIC CME TO NEW HEIGHTS

By Nancy Davis, PhD, Program Chair

The 2007 Spring Program was held in Copper Mountain, Colorado. At 9,500 feet above sea level the venue proved, at times, to be a challenge for participants. We all learned first-hand about the effects of thin air. The view was beautiful though, with the conference center looking out over the slopes and a gentle snow falling most of the time we were there.

The program opened with an overview of ACCME's new Criteria for Accreditation presented by Kate Reginier, MA, MBA, ACCME Deputy Chief Executive. She then introduced three SACME members who are implementing the criteria, focusing on use of quality data in planning and delivering CME. Kathleen Brooks, MD, MBA, MPA, Assistant Dean for CME at the University of Minnesota; Richard (Van) Harrison, PhD, Director of CME, University of Michigan; and Steven Willis, MD, Associate Dean, CME Brody School of Medicine, East Carolina University, all gave compelling presentations of their work integrating quality improvement and CME.

The message was similar when Daniel Klass, MD, Associate Registrar and Director of the Division of Quality Management at the College of Physicians of Ontario, presented the Revalidation System in Canada. Focused on requirements for re-licensure, this performance-based model was another example of a new focus for continuing professional development.

Barbara Barnes, MD, MS, Assistant Vice Chancellor for Continuing Education in the Health Sciences at the University of Pittsburgh, and Van Harrison led a discussion on practical strategies for evaluating changes that result from CME. A panel presented practical examples from their institutions. Jack Kues, PhD, Senior Vice President for Continuous Professional Development and Assistant Dean for CME at the University of Cincinnati led a discussion of a business approach for the academic CME

office. These very practical sessions spoke to the unique needs of academic CME professionals.

Research in CME (RICME) and Best Practices sessions were better than ever with seven original research projects presented and four best practices. The audience was engaged and offered great feedback for presenters. The Program and Research Committees have decided to reinstate a RICME session at the Fall meeting so there will be two opportunities a year to present original research and best practices in CME.



Research in CME was a theme carried through the session on Outcomes as well. Jocelyn Lockyer's overview featuring Don Moore's levels of evaluation was followed by two examples from the field presented by Betsy White Williams, PhD, MPH, Rush University and Paul Mazmanian, PhD, Virginia Commonwealth University. Both shared examples of high level outcomes evaluation in the academic CME environment.

The featured presentation was titled, "CME, QI and Transfer of Practice" by David Price, MD, Director of Medical Education, Colorado Permanente Medical Group, Denver, Colorado. Dr. Price presented a convincing argument that CME can assist in a multifaceted approach toward physician performance improvement. He encouraged the group to explicitly talk with CME planners about how they see CME helping them achieve their goals asking, "What do you intend to change with this activity?" He wove the thread of CME through several models including the Plan, Do, Study, Act (PDSA) quality improvement cycle, Rogers' model of adopting new innovations, complexity theory, and PRECED/PROCEED. The interactive session allowed participants to give examples from their own practices and ask Dr. Price to advise them. The session was based on Dr. Price's article, "Continuing Medical Education, Quality Improvement, and Organizational Change: Implications of Recent Theories for Twenty-First-Century CME", published in *Medical Teacher*, Vol. 27, No. 3, 2005, pp. 259-268. The article and slides from the presentation are available on the SACME web site.

SACME celebrates its 30th Anniversary this year and fitting for that occasion was a session led by SACME

Past Presidents of SACME attending the Spring Meeting: left to right; Dennis Wentz ('87); Marty Hotvedt ('05); Craig Campbell ('04); Barbara Barnes, ('01); Phil Manning ('76 & 77); Nancy Davis ('03); Van Harrison ('93); Michael Fordis ('06) and Jack Kues ('02)

president, Michael Fordis which featured SACME leaders across three eras of SACME history. Phil Manning, MD, one of the founders of the organization described the early years, followed by Dennis Wentz, MD; Barbara Barnes, MD, MS; and Craig Campbell, MD. It was enlightening to hear the history of SACME and how far we have come in 30 years!

The Copper Mountain Resort offered up a wonderful reception along with a torch parade and fireworks. The sleigh ride dinner was cold but a wonderful experience. There was time to hit the slopes or enjoy some of the many outdoor winter activities offered by the resort. Once again, the SACME meeting seemed the right mix of learning, networking, collegiality and fun.

The Program Committee met during the meeting and selected the Annenberg Health Sciences Center, Rancho Mirage, California as host for the Spring 2009 meeting and the University of Miami as the 2010 host. The 2008 meeting will be held in conjunction with the CME Congress, May 2008, Vancouver, British Columbia.

NOTE: Slides from all presentations where speakers gave permission are posted to the SACME web site: [www.sacme.org](http://www.sacme.org)

Watch the web site for details of the Fall meeting, November 2-4, Washington DC.

# SACME AWARDS PRESENTED AT THE SPRING MEETING AT COPPER MOUNTAIN

by Craig Campbell, MD

## 2007 Fox Award

It gives me great pleasure to announce that **Dr. Todd Dorman** of Johns Hopkins University is the winner of the 2007 Fox Award for his research presentation “**Effectiveness of Continuing Medical Education (CME): A Systematic Review.**” This work was done in collaboration with Dr. Spyridon Marinopoulos, and developed a systematic review of the effectiveness of CME and the impact of differing instructional designs in the domains of physician knowledge, attitudes, skills, practice behaviours, and clinical practice outcomes. Seventy-nine percent of 19 eligible studies demonstrated long-term (>30 days) improvement in knowledge; 75% of 20 eligible studies demonstrated long-term improvement in attitudes; 86% of 7 eligible studies demonstrated long-term improvement in skills; 68% of 74 eligible studies demonstrated long-term improvement in practice behaviors; 47% of 34 eligible studies demonstrated long-term improvement in clinical practice outcomes. The overall quality of the evidence was low to very low.

The 2007 Fox Award is awarded to the author of the best presentation of a completed research project at the Research in Continuing Medical Education session of the 2007 spring meeting in Copper Mountain Colorado. A panel of four judges assesses the merits of the completed empirical research projects and bases its decision on the projects’ originality, link to theory, methodological rigor, and importance to contribution to the literature. Todd’s presentation received the highest rating in fulfilling these criteria.

## 2007 Distinguished Service in Continuing Medical Education

The Distinguished Service in Continuing Medical Education Award is given to an individual who has either made outstanding contributions to continuing medical education and has contributed to the development of important advances or innovations in continuing medical education over an extended period of time.

Based on the above criteria the Society for Academic CME is pleased to announce that this award has been given to **Dr. Dale Dauphinee** for his outstanding contributions to CME as an educator, researcher, and leader. Congratulations Dr. Dauphinee!



Rynda Clark receiving award

## President’s Award: 2007

The President’s Award recognizes individuals who have either served the Society with distinction and/or made significant contributions to the practice of continuing medical education.

For 2007 the President’s Award is given to **Ms. Rynda Clark, MPA**, in recognition of her many years of

service to the Society including her work as Western Region Representative on the SACME Board.

## THE MANNING AWARD

by Gabrielle Kane, MD

The winner of the 2006-2007 Manning Award is **Heather Armson MD** for her project “Practice reflections by family physicians participating in three different practice based learning programs: are there differences in commitment-to-change statements?” Dr. Armson is the director of the Practice-Based Small Group Learning Program at the Foundation for Medical Practice Education. Her co-investigators from the Foundation are

Sarah Kinzie, MD, Stefanie Roder, PhD, Tom Elmslie, MD and Jacqueline Wakefield, MD. Together this very experienced team developed a polished proposal for a sophisticated research project that builds on previous work on “Commitment to Change” theory.

The Foundation for Medical Practice Education is a Canadian non-profit organization dedicated to the development, production and evaluation of educational programs for community-based family medicine and general practitioners. Although it is based at McMaster

University in Hamilton, Ontario, it is a national program in which several Canadian medical schools participate. The Practice-Based Small Group (PBSG) Learning Program was the first program that the Foundation developed, and now supports over 3000 registrants in over 400 small groups across Canada, with several international groups as well. With support from academic centers, these groups define their own needs and curricula, and their learning involves reflection on their practice experience. PBSG has been the subject of several research projects, including work on commitment to change (CTC). The investigators have an impressive track record in this area; Dr Wakefield was the recipient of the 2003 Decker award for research excellence.

The principle investigator, Dr. Armson, is a family physician in Calgary, Alberta, Canada. She practiced in the community for a number of years and joined the academic teaching faculty at the University of Calgary, Department of Family Medicine in 2001. She was the faculty development officer for the Department of Family Medicine from 2000 – 2005. She currently participates on a number of projects and committees related to physician learning and residency teaching. She was awarded the Alberta College of Family Physicians Continuing Professional Achievement Recognition of Excellence award in 2005. She completed a Masters in Continuing Education at the University of Calgary in 2005 with a masters' project entitled "Implementation of communities of practice to enhance continuing professional development in family physicians". Dr. Armson has been involved as a facilitator in the Practice-Based Small-Group Learn-

ing program since 1995, and currently is the Director of Training and Development. Her research interests include knowledge translation, physician learning and change, and the role of community in implementation of knowledge into practice.

The proposed study will explore the nature and diversity of planned practice changes as taken from CTC statements made by family physicians participating in practice-based small group learning. The study will be divided into two parts each with a specific purpose in mind. The first part of the proposed study, conducted over the first year, will determine to what extent a personal practice reflection tool can capture the breadth and depth of personal reflection and planned practice changes as captured in CTC statements.

In the second year, this tool will be used to explore the impact of the learning environment on practice reflection and the type of CTC statements generated. Three different CME environments will be used for this study, all of them distinct activities run by the foundation: (1) a one-time small group workshop designed for physicians who cannot, or prefer not to, commit to an ongoing small group; (2) stable groups of 5-10 family physicians who meet, over time, with a trained peer facilitator and use evidence-based educational materials to discuss problem cases, explore new information and encourage practice change including the consideration of implementation issues; and (3) a practice-based individual learning program for physicians who cannot or prefer not to meet in a group setting. All programs will use the same evidence-based educational materials developed around an iden-

tified practice "gap". Participants of the three programs will use a practice reflection tool and identify plans for practice change in the form of CTC statements. The hypothesis is that physicians who learn in interactive peer groups will have a greater diversity of statements of learning and commitment to changes because of the exposure to the perspectives and experiences of more physician colleagues.

The Endowment Council considered the topic of great relevance to the discipline of CME as it will not only validate a practice reflection tool, but also provide important insight into the learning process in different formats. The investigating team has impressive experience and research infrastructure. We look forward to following their progress with great interest.

The **Manning Award** is offered every two years, and has a maximum value of \$50,000 (up to \$25,000 annually for two years). The Endowment Council also funds the **Large SACME grant**, which is worth up to \$20,000 per project, awarded once every two years, alternating with the Manning Award. **Several small grants** of up to \$5,000 are available annually.

A call for proposals for both the small and large grants will be made shortly through the SACME listserv and posted on the SACME web site. Letters of Intent will not be necessary for these awards. The deadline will be in September 2007 and decisions will be announced at the Fall meeting in Washington.

# SACME FALL PROGRAM DEFINITELY NOT LOST IN TRANSLATION

By Nancy Davis, PhD, Program Chair

*Translational Research and the Role of CME* is the theme of the SACME Fall meeting which will be held in conjunction with the AAMC meeting, November 2-4 in Washington, DC. Final details are not confirmed so watch the SACME web site for updates.

Two spectacular speakers have been invited to kick off the program. Carolyn Clancy, MD, Director of the Agency for Healthcare Research and Quality (AHRQ) has been invited to give an update on AHRQ activities and opportunities for translational research in CME.

Following Dr. Clancy, Steven Woolf, MD, MPH will focus on putting research into action and the role of CME. Dr. Woolf is Professor and Director of Research, Department of Family Medicine, Epidemiology and Community Health, Virginia Commonwealth University and part of the Ambulatory Care Outcomes Research Network (ACORN) in Virginia. His work focuses on health services research and evidence-based medicine. These are guaranteed to be thought-provoking presentations that will provide a foundation for the discussion that will follow.

The results of the AHRQ-funded evidence report on the effectiveness of CME will be presented by Todd Dorman, MD, Associate Dean & Director of CME, Johns Hopkins University School of Medicine. Dr. Dorman won the 2007 Fox Award for his presentation of the study abstract at the SACME spring meeting in March.

The morning will end with an introduction of AAMC's new initiative for Continuing Health Care Education and Improvement for which Dave Davis, MD has been appointed Vice President. Dr. Davis will give an overview of the goals and priorities of this new initiative and invite feedback from fellow SACME members.

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## INTERCOM

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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.

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## SACME WEB SITE SPORTS BRAND NEW LOOK AND FEEL

By Joyce M. Fried and Anne Taylor-Vaisey

It is with enormous pleasure that the Society for Academic Continuing Medical Education presents its upgraded web site. With an entirely new look, it is easy to locate at the same URL: <http://www.sacme.org>.

Association web sites ideally perform several functions: projecting a professional image; conducting the association's business; providing members with access to subject specific resources and publications; enabling interaction among members; and serving as an electronic archive of publications and historical documents. We hope that the upgraded SACME web site accomplishes all of these and more.

The web site was originally created by Bob Bollinger in 1999, and for many years its rich content placed it at the forefront of academic web sites. Since 2001 it has been administered by Jim Ranieri, Executive Secretariat, and edited by Anne-Taylor Vaisey, an honorary member of SACME since 2001.

Last year the SACME Board of Directors and the Communications Committee discussed the web site and what they considered its '90s look and feel. Many web site creators are now moving away from the cumbersome process of building individual html pages to more manageable content management systems. The Society leadership felt that a design and function upgrade was warranted. A Request for Proposal was written by the Communications Committee and sent to various web companies. Through a careful selection process, Electramedia of Toronto was chosen, and since December 2006 we have been building the new web site on yourwebdepartment™, Electramedia's content management system. Electramedia will also host the new site.

While a pleasing design was being created, Anne Taylor-Vaisey tackled the job of taking the huge amount of content on the old site and reorganizing it to make it more easily navigable. It took more than 300 volunteer hours

to transfer content, create new pages, and add links to resources that will be useful to SACME members. Jim Ranieri was involved in the administrative aspect of the site, ensuring that SACME's business will continue to be conducted smoothly and without interruption.

As you familiarize yourself with the site, you will find that we have placed direct links to some of the highly accessed sections right on the home page—member lookup, survey data, become a member, and news. In particular, the Newsworthy section will be updated frequently to keep SACME members informed about happenings both within SACME and in the fields of continuing medical education and adult learning. The CME Best Practices section is like a virtual reference shelf right at your fingertips—accreditation information, survey data, a directory of associations, links to the major publications in medical education, glossaries of terms, resources in evidence-based medicine, and much more.

The Member Area contains an improved and searchable SACME member directory, notices of job opportunities, minutes and presentations from SACME meetings, and a link to the full text online version of the Journal of Continuing Education in the Health Professions. An online subscription to this journal is a significant member benefit, along with a print subscription.

It has taken a huge effort to get where we are today and we are really delighted with the end product. The site has a crisp and modern look and feel and it provides SACME members with a treasure trove of resources and content. Anne has graciously agreed to continue as web editor while Jim Ranieri of Prime Management Services will continue to administer the site. We welcome your comments on and ideas for the new site. Together we can make the SACME web site a valuable resource that will keep pace with our every-changing field and benefit not only SACME members, but also anyone interested in continuing medical education and adult learning.

# MORE SPACE AND NEW FEATURES FOR THE JOURNAL OF CONTINUING EDUCATION IN THE HEALTH PROFESSIONS

BY PAUL MAZMANIAN, PH.D.

EDITOR OF THE *JOURNAL OF CONTINUING EDUCATION IN THE HEALTH PROFESSIONS*

The *Journal of Continuing Education in the Health Professions* (JCEHP) started because of a need to study an active field of practice, and as JCEHP approached its 27th year of publication, it faced growing demands for space. Joyce Fried, from the University of California, Los Angeles, responded, finding a budget neutral print format that allows 75% more editorial content, cover to cover. She provided a new look, opportunities for two new features, and an expanded book review section.

One of the new features is “Innovations in Programs and Assessment.” It reports especially imaginative projects that might never be presented as research but could trigger new ideas for studies or for practice. “Innovations” is managed by Jocelyn Lockyer, University of Calgary. “Insights” also is new. It features stories, poems, cartoons, or photographs sent by clinicians, patients, teachers, and students. “Insights” offers glimpses into teaching, learning, and health care. Gabrielle Kane, from the University of Washington, manages “Insights.”

With the refreshed format, the book review feature gained additional space. Almost any content or topic related to learning and health care is likely to be interpreted and summarized for readers. Curtis Olson, University of Wisconsin, manages “Book Reviews.”

JCEHP is owned by the Alliance for Continuing Medical Education (ACME); the Society for Academic Continuing Medical Education (SACME); and the Council on CME, Association for Hospital Education (AHME). In April 2007, more than 60 members of these organizations agreed to serve as peer reviewers of JCEHP manuscripts. During the same month, advertising efforts were stepped up, with SACME and AHME members receiving examples of ads that might be appropriate for universities and others to use in promoting their good work, while supporting the journal. Four organizations responded within 24 hours.

The future of the Journal of Continuing Education in the Health Professions looks promising. Vanderbilt University is leading development of a supplemental issue on how to integrate CME with other interventions to improve the performance of physicians who care for minority patients with depression. Later in 2007, a complete issue of JCEHP will address self-assessment of health care professionals, and the 2008 CME Congress, Vancouver, is planning to publish a JCEHP supplement that enables a lasting record of international perspectives on research in continuing medical education. All this activity and the history of JCEHP should be archived soon, as Laure Perrier, from the University of Toronto, prepares JCEHP.com, for full text search capability that extends back through 1981, with the first issue of JCEHP. The journal was known then as Möbius, A Journal for Continuing Education Professionals in the Health Sciences. It was published by the University of California, San Francisco.

\* Persons interested in advertising should contact Warran Dawson at Warran.Dawson@vcu.edu, or go to JCEHP.com and click on “advertise.” Quarter page ads start at \$350.

Persons interested in reviewing should contact Natasha C. Williams, Editorial Assistant, at williamsnc@vcu.edu, fax 804-828-7438.

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**BY LAURE PERRIER, MEd, MLIS  
RDRB MANAGER**

Through the RDRB (Research and Development Resource Base) anyone can access over 15,000 citations to research medical and health-related questions in continuing education, knowledge translation, guideline implementation and related areas. Search the RDRB online at: [www.cme.utoronto.ca/search](http://www.cme.utoronto.ca/search).

The re-developed RDRB offers a user-friendly tool for educators, researchers, policy-makers and others planning effective, innovative continuing education strategies. Of interest to the Continuing Education community is the expansion of the RDRB to include literature on Interprofessional Education & Collaboration. Faculty Development literature will be added shortly, and options are offered to search each of these collections.

A key feature of the newly redesigned RDRB is the opportunity to keep citations of interest in a 'holding area'. This allows users to do several searches, move citations into one area, then return to this unique collection of citations they have built and saved.

The RDRB also now offers the opportunity to save results to reference management software. Options include saving to RefWorks, EndNote, or Reference Manager. Users will appreciate this time-saving feature, especially when working on large projects.

Visit this powerful database of literature anytime online at [www.cme.utoronto.ca/search](http://www.cme.utoronto.ca/search). Questions are answered and help is available by sending an email to: [rdrb.cme@utoronto.ca](mailto:rdrb.cme@utoronto.ca).

*We gratefully acknowledge re-development funding and ongoing assistance for the RDRB from our supporters:*

*The Alliance for Continuing Medical Education; the Society for Academic Continuing Medical Education; The Royal College of Physicians and Surgeons of Canada; Canadian Association for Continuing Health Education, The Knowledge Translation Program at the Li Ka Shing Knowledge Institute, St Michael's Hospital; Continuing Education and Professional Development, University of Toronto.*

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## **NEWS FROM THE AMERICAN MEDICAL ASSOCIATION**

**By Alejandro Aparicio, MD, FACP**

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In January of this year, AHRQ published its Evidence Report/Technology Assessment No. 149<sup>1</sup>. Prepared by the Johns Hopkins Evidence-based Practice Center and titled Effectiveness of Continuing Medical Education, it analyzed the results presented in 139 articles and nine systematic reviews, published since 1981 and that met the criteria developed by the authors, addressing the effectiveness of CME. In the conclusion the authors write that: "Despite the low quality of the evidence, CME appears to be effective at the acquisition and retention of knowledge, attitudes, skills, behaviors and clinical outcomes". The report also points out the need for research in the area of CME. We need to know how to better match each CME modality with the particular physician's need

and SACME should play an integral role in the development of a research agenda that would help develop that body of knowledge.

At around the same time, the Winter issue of the AMA's CPPD report<sup>2</sup> was published with a lead article by Dave Davis, MD. Many of us have heard Dr. Davis misquoted as having said that CME doesn't work. In his article, "That's not exactly what I said", he corrects the notion that "lectures don't work at all", which in turn had been translated to "CME doesn't work at all"

Robertson et al, in their article "Impact studies in continuing education for health professions: update"<sup>3</sup>, in 2003

wrote "...CE, which is ongoing, interactive, contextually relevant, and based on needs assessment, can improve knowledge, skills, attitudes, behavior, and health care outcomes."

All of these articles remind us of the importance of the work that we do. Whatever our involvement in CME is, activity planner, CME activity faculty, accreditation surveyor, CME committee staff, member or chair, researcher, or any of the other multiple roles that we find in the CME community, the result of our work has an impact on physicians. And that impact helps them help their patients.

One of the new ways in which CME can help physicians help their patients is through the use of Performance Improvement (PI) CME activities. Although approved only recently (2004), PI CME has been gaining acceptance as a tool that brings continuing medical education, evidence-based performance measures and the increased emphasis in quality improvement and patient safety yet closer together to improve the care of all patients. This is supported by an article, "CME Changes Course" by Tamar Hosansky, in the January/February 2007 issue of Medical Meetings (pages 16-21). In it, the author reports on the results of a physician survey showing that despite 53% of respondents not answering the question, 19% of respondents were planning to use performance improvement activities in the subsequent 12 months. We continue to try to provide tools to the CME community by publishing examples in the CPPD report of how different types of providers, hospitals, specialty societies and medical schools have been implementing PI CME. If you are not currently receiving the CPPD report, you can receive it by visiting <http://www.ama-assn.org/ama/pub/category/5700.html>

Some CPPD staff news: I am happy to report that Kevin Heffernan, who many of you have met already, has been promoted to the position of Director, CME Accreditation and CPPD Educational Activities. In his new position he will continue to supervise the annual Collaboration Task Force Conference.

One last item, the 18th annual Conference of the National Task Force on CME Provider/Industry Collaboration will be held at the Hyatt Regency Crystal City, 2799 Jefferson Davis Highway, Arlington, Virginia, from Oct. 17

to the 19. The theme for this year's conference is: CME Collaboration to Improve Patient Care: A Call to Action. In addition to providing an opportunity to network and participate in sessions with leading experts, this conference will offer interactive plenary and breakout sessions specifically geared toward collaboration among CME providers, the regulated industry, the Food and Drug Administration, and accrediting agencies. Again this year, SACME members have participated in the planning and will be part of the faculty. For more information visit [www.ama-assn.org/go/cmetaskforce](http://www.ama-assn.org/go/cmetaskforce) or contact Kevin Heffernan at [kevin.heffernan@ama-assn.org](mailto:kevin.heffernan@ama-assn.org).

- (1) Marinopoulos, SS, Dorman T, Ratanawongsa N, Wilson LM, Ashar BH, Magaziner JL, Miller RG, Thomas PA, Prokopowicz GP, Qayyum R, Bass EB. Effectiveness of Continuing Medical Education. Evidence Report/Technology Assessment No. 149 (Prepared by the Johns Hopkins Evidence-based Practice Center, under Contract No. 290-02-0018.) AHRQ Publication No. 07-E006. Rockville, MD: Agency for Healthcare Research and Quality. January 2007
- (2) <http://www.ama-assn.org/ama1/pub/upload/mm/455/cppd21.pdf> accessed April 27, 2007
- (3) Robertson et al., Impact studies in continuing education for health professions: update J. of Continuing Educ. in the Health Prof 2003; 23(3):146-156

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## SACME FALL PROGRAM

*continued from page 9...*

RICME is back on the fall agenda this year and will feature works in progress allowing researchers to receive feedback from SACME members in order to enhance their projects. Research Committee Chair, Craig Campbell, MD will facilitate this interactive session.

Finally, the SACME working group led by Barbara Barnes, MD, will discuss academic health centers' responses to the ACCME Criteria for Accreditation. Medical school CME offices will have unique opportunities and challenges with the new criteria. Look for best practices and discussions from some early adopters.

The usual tight schedule of committee meetings will be held on Saturday and SACME will continue its 30th anniversary celebration during the reception that evening.

We look forward to seeing you all at the fall meeting. Watch the web site for updates.

Newsletter of the Society for Academic  
Continuing Medical Education  
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## UPCOMING EVENTS

**Guidelines International Network's Fourth Conference**

**August 22-25, 2007**

**University of Toronto Conference Centre, Toronto, Canada**

**18th Annual Conference of the National Task Force on CME**

**Provider / Industry Collaboration**

**October 17-19, 2007**

**Arlington, VA**

**[www.ama-assn.org](http://www.ama-assn.org)**

**Canadian Association of Continuing Health Education**

**October 13-15, 2007**

**Quebec City, Quebec, Canada**

**[www.cachecanada.org](http://www.cachecanada.org)**

**SACME Fall Meeting in conjunction with the 2007 AAMC Annual Meeting**

**November 2-7, 2007**

**Washington, DC**

**[www.aamc.org](http://www.aamc.org)**

**2008 Alliance for CME Annual Conference**

**January 19-22, 2008**

**Orlando, FL**

**[www.acme-assn.org/](http://www.acme-assn.org/)**

**CME Congress 2008 and Spring SACME Meeting**  
**May 29-31, 2008**

**Sheraton Wall Centre**

**Vancouver, British Columbia, Canada**

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