

FALL MEETING ANNOUNCEMENT

By Julie A. Brown, CCMEP, Program Committee Chair

This year's SACME Fall Meeting-to take place in conjunction with the AAMC's 2010 annual meeting- is being held November 5-7, 2010 in the bustling center of U.S. healthcare funding and policy, Washington, D.C. Aligned with the Washington, D.C. location, the event theme will be **"CME's Role in Improving Health Care Quality,"** and will take place at the Marriot Wardman Park Hotel.

Registration is now open, and the full schedule is available at SACME's website.

The activity curriculum will be staged sequentially to address: the health system of today and the future; U.S. and Canadian best practice case studies outlining the challenges and opportunities for CME to be an integral part of this quality, evidenced-based system; examples of U.S. and Canadian government funded solutions towards incorporating CME elements into this system; and the ongoing importance of preparing physicians to be lifelong learners prepared for the challenges they will face in the future as health delivery and clinical knowledge evolve.

The opening keynote (9:00am November 6) *Re-envisioning CME within the Health Systems of Today, and Tomorrow* will be delivered by the new president and CEO of the Institute for Healthcare Improvement (IHI)



Maureen Bisognano, who took the place of outgoing president Donald Berwick, MD, the recently appointed Administrator of the Centers for Medicare & Medicaid Services (CMS).

The agenda also features **Molly Cooke, MD**, author of the recently published Carnegie Foundation report *Educating Physicians: A Call for Reform of Medical School and Residency*. In addition to being a co-director of the Foundation's Study of Medical Education Dr. Cooke is also the William G. Irwin Endowed Chair, and Director of the Academy of Medical Educators, Professor of Medicine, UCSF. **Donald Moore, PhD**, Director of Continuing Medical Education, Vanderbilt University School of Medicine; **Ian Graham, MA, PhD**, Vice-
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President of Knowledge Translation, Canadian Institutes of Health Research (CIHR), **Jean Slutsky, PA, MSPH**, Director, Center for Outcomes and Evidence (COE), Agency for Healthcare Research and Quality (AHRQ), **Jann Balmer, PhD**, Director, Office of CME, University of Virginia School of Medicine, **Mike Evans, MD**, Associate Professor, Departments of Family Medicine and Public Health, University of Toronto, **Rika Maeshiro MD, MPH**, Assistant Vice President for Public Health and Prevention, Association of American Medical Colleges, **Steve Willis, MD**, Associate Dean for Continuing Medical Education, Brody School of Medicine at East Carolina University and **Craig Campbell, MD**, Director of Professional Development The Royal College of Physicians & Surgeons of Canada.

For the first time, the event will also feature a joint session with AAMC entitled, *Using MedEdPORTAL — a resource for faculty development, teaching and CME: the example of QI*.

The Research Workshop, a popular staple of the fall meeting, will take place November 5 from 1:00-5:00pm. The goal of this year's Workshop is to “**Increase capacity for research and scholarship in continuing medical education (CME).**” The Workshop curriculum is designed to assist participants in the process of carefully and systematically examining research to help them judge its value and relevance to their unique situation or circumstance. Specific objectives of the Workshop are to review the use of publication guidelines such as CONSORT and SQUIRE for:

- a) planning, implementing, and evaluating research designs, and
- b) writing research reports.

Distinguished faculty for the Workshop include: **Curtis Olson, PhD**, Head, Research and Development, University of Wisconsin-Madison, and incoming editor of the *Journal of Continuing Education in the Health Professions (JCEHP)*; **Paul Mazmanian, PhD**, Associate Dean, Evaluation Studies, School of Medicine, Virginia Commonwealth University, and outgoing editor of *JCEHP*; **Morris J. Blachman, PhD**, Assistant Dean,

CPD and Strategic Affairs, University of South Carolina School of Medicine; and **Betsy White Williams, PhD, MPH**, Director, CME Outcomes Measures and Research, Rush University Medical Center. Complete Workshop details can also be found at www.sacme.org.

In addition to the SACME events, the co-located [AAMC program](#) features varied sessions on CME as well as Keynotes by enlightening and important luminaries such as journalist and author **Malcolm Gladwell** and **Kathleen Sebelius**, Secretary of Health and Human Services. This opportunity for networking and learning among the leaders who are setting the agenda for academic medical centers in the United States and Canada should not be missed.

Whether you attend religiously or haven't attended a Fall SACME meeting recently, 2010 is the year for you!

Check the [SACME website](#) today for full program details and to register.

SACME MEMBERSHIP

SURVEY

By Gordon West, PhD, CCMEP

The SACME Board continues to be interested in the interests of the SACME membership as it addresses the Society's direction, both now and in the future. As such, representatives from the Membership (Gordon West), Communications (Leanne Andreasen), and Research (Betsy Williams) Committees were delegated the task of creating a member survey. Through the survey, members will be able to express their opinions about various issues facing SACME.

The survey, containing questions of interest to the named committees and the Program Committee will be created and distributed to members in October. We ask that you take the few minutes needed to complete the survey (no more than 10 questions) and return the answers online within a week. The intent is to use the results to direct a focused discussion session with interested members at the Fall meeting in Washington, D.C.

We look forward to hearing from you!

HEALTH CARE REFORM 2: THE POPULATION

HEALTH AGENDA

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

Rika Maeshiro, MD, MPH, Dir., Public Health & Prevention Programs
Association of American Medical Colleges



Note: In the July issue of Intercom, I initiated a discussion about the opportunities and challenges posed by Health Care Reform (HCR) in the United States. In this issue, my colleague Rika Maeshiro and I delve into the specifics of the 2010 Affordable Care Act, identify related CME needs, and consider potential sources of support and partnership — especially those related to public and population health.

Background:

North American medicine has long been known — justly so — for its innovations in therapies and diagnostic testing, aimed at curing disease states. CME, the communication vehicle for clinical care, has focused mainly on this aspect of medicine. Rightly or wrongly, some of this emphasis has been driven by the large commercial support which CME garners from pharmaceutical and device technology sectors. In contrast, the advent of health care reform in the U.S.* (The 2010 Affordable Care Act) allows us to shift our focus somewhat to topics related to the concepts of prevention and screening and the broad notions of public and population health. While these have always seen some interest in CME planning, this brief article touches on the act itself and its key provisions in this area. It also offers more operational suggestions for the regular inclusion of public health, prevention and screening into CME activities.

The Act:

The Act does a number of things to bolster the prevention imperative.

It provides individuals with improved access by requiring new private health plans and insurance policies to provide preventive services (such as those highly recommended by the US Preventive Services Task Force). Examples of such covered services include screening for breast, cervical and colorectal cancer, depression and HIV; for alcohol-misuse counseling; and immunizations. In addition, Medicare in 2011 will cover an annual wellness visit that includes a risk

assessment and prevention plan. The law also promotes wellness in the workplace, providing new health promotion opportunities for employers and employees and promotes the role of communities in promoting prevention, partnerships between local or state governments and community groups. CME providers among others can play strong, critical and even strategic roles in this area.

Further, a new Prevention and Public Health Fund will have an annual appropriation ranging from \$500 million (this year) to \$2 billion (in 2015), administered by the Department of Health and Human Services. Initial funds have already been invested in strengthening public health infrastructure, prevention research, surveillance, integration of primary care into community-based behavioral health programs, and HIV prevention. The Act strengthens a primary care workforce, and encourages the entire medical community to promote prevention. It covers tobacco-use counseling and tobacco-cessation interventions, as well as obesity screening and counseling for adults and children. For example, to promote healthy weight for populations, the Act appropriates funds for fiscal years 2010 through 2014 for demonstration projects to develop model programs for reducing childhood obesity (Koh and Sebelius).

Educational planning for public/population health topics:

How does this act translate to CME? The key areas of CME planning — selection of a target audience, needs assessment, educational design and evaluation — are familiar terrain for CE providers. The public health/prevention focus offers a slightly different take on each of these steps, and — though challenging — is worth considering and undertaking.

First — target audience. Although primary care physicians may be responsible for many clinical disease prevention

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and health promotion interventions (and the Act provides for an increase in the number of primary care providers), physicians from most, if not all specialties have opportunities to include aspects of prevention and population/public health in their practices and other professional endeavors. For example, the Society for Academic Emergency Medicine has had a Public Health Interest Group since 2003, and in 2009 sponsored a 1-day meeting called “Consensus Conference on Public Health in the Emergency Department: Surveillance, Screening, and Intervention.” Here, emergency physicians learned about injury prevention and Screening, Brief Intervention and Referral to Treatment (SBIRT) applied to substance abuse disorders. (<http://www.saem.org/saemdn/Home/Communities/InterestGroups/PublicHealth/tabid/136/Default.aspx>) Similarly, one of us recalls a neurosurgeon in Hamilton, Ontario as an early proponent of bicycle helmets in the province — a topic he spoke of frequently, including in his specialist-oriented CME presentations. Further, public health issues lend themselves to a new and expanding audience for CME providers — allied health professionals — in teams or individually, an important subject for another editorial.

Second — needs assessment. Especially needs of the subjective variety, pose a challenge inasmuch as most physicians, occupied with solving an immediate problem, may not appreciate the extent to which prevention and population/public health can be powerful tools. McGlynn, et. al., (2003), indicates that Americans receive only half of the preventive measure they might. Knowing which prevention efforts would be most effective for a particular patient or population can also be a challenge, physicians may still not recognize the differences between clinical guidelines that are based on expert opinion vs. those that are based on a review of the evidence (like those developed by the U.S. Preventive Services Task Force and the Canadian Task Force on Preventive Health Care). In fact, the application of many aspects of public health (e.g., biostatistics and epidemiology as foundations of evidence-based preventive practices; disease and health surveillance techniques; a better understanding of health policy) may be ripe areas for CME activities. Many other supporting references in clinical prevention topic areas are easily found. Each of these, if based on best evidence, form part of a needs- and gap-assessment process. Similarly,

the Hospital Compare Data Base lists many preventive process measures, which can be used as needs assessment tools (see below, under evaluation)

Third — educational design also presents a challenge in making physicians think about prevention and screening. Here, case discussion might pose questions to learners such as, “how could this problem have been prevented?” to help better recognize opportunities for health promotion guidance and the determinants of health at play in their communities. For example, “what screening tests exist to detect this problem at a stage earlier than that seen in the case?” may be a provocative and engaging way to begin a discussion. Further, post-course reminders (red stickers to place on the charts of smokers for example) are often helpful, useful ways to broaden the uptake of preventive and screening measures.

Fourth and finally — evaluation in this area might appear to be problematic for planners. While larger population health data (decreasing smoking rates in a community, for example) might be attributed to widespread, community-based public and CME interventions, it is more likely that quality measures (providing advice to smokers, using disease-preventing vaccines, checking blood pressures routinely in patients) will be increasingly traceable. Tracking outcomes — a key ingredient in our evolving accreditation criteria for CME — can be accomplished by post course surveys of attendees, use of hospital records regarding process measures and commitment-to-change models of evaluation. The federal government’s website ‘Hospital Compare’ lists many preventive measures (prevention of deep vein clotting, use of pneumonia vaccines, among many) that are useful in planning and evaluation

Funding and Implications:

Although dollars are not identified specifically for CME, the act clearly provides for more coverage for Americans, more primary care and more prevention — all of which will drive the CME agenda. Further, there are provisions in the Act (the community networks strengthening prevention, or decreasing childhood obesity, for example) in which CME can play a vital role — building on already-established networks of physicians, including those with expertise in preventive medicine (community medicine in Canada*), the medical specialty that focuses on prevention and population/public health. Lastly, many of the quality measures derived

from the fields of screening and prevention derive benefit to the physicians in the Medicare/Medicaid package of physician quality reporting initiative (PQRI) — these too will drive the agenda.

Next steps, outcomes, conclusion:

Despite its difficulties, this shift is a worthwhile and an important imperative. Driven in part by CME efforts in this area, North American medicine may be know in another decade for its role in prevention as much as for its innovations in therapies and diagnostic testing, aimed, naturally enough, at cure for disease states.

Want to learn more? Some references are provided below, and if you don't receive it already, go to www.aamc.org/cme and sign up for our bi-weekly newsletter.

References

The Patient Protection and Affordable Care Act, P.L. 111-148, 23 March 2010

McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. *N Engl J Med* 2003;348:2635-2645)

Howard K. Koh, M.D., M.P.H., and Kathleen G. Sebelius, M.P.A. This article (10.1056/NEJMp1008560) was published on August 25, 2010, at NEJM.org.

Hospital Compare Database <http://www.hospitalcompare.hhs.gov/hospital-compare>

* With apologies to our Canadian colleagues for whom health care 'reform' and the topics of prevention, screening, primary care and public health have been are 'old hat'.

PRESIDENT'S COLUMN: CME IS THE CURE

By Todd Dorman, MD

All countries struggle with how to best provide health care to its citizens. Many models exist and there is great heterogeneity of approaches. What is common, despite this diversity, is that health care undergoes iterative reform. "Curing" the identified maladies requires effective policy that augments and supports evidence-based care integrated with public health approaches. In other words, it requires effective strategies that utilize tools proven effective. Such strategies and tools then provide value to the system and the country. Thus, in my humble opinion, the two most important words in CME today are ... Effectiveness and Value.

Demonstrating these two concepts changes the game. Utilizing effective educational strategies to advance research, patient care, teaching and administrative management in health care is how health care reform can work. Making reform work is key to politicians as they will be held accountable for passing previous and future regulation. Even Health Innovation Zones (HIZ) will require a strong CME community in order to achieve at expected levels. What many do not realize is that policy makers spend a lot of time on policy and not on the process. Once initial policy is approved the work is not done—it has just begun. Additional policies are frequently needed, agencies have to create and implement procedures and practices, guidelines have to be crafted and promulgated. This is the exact niche

where certified CME can step in, pick up the banner and help make health care reform work, demonstrating to all stakeholders that CME is an effective strategy for improvement. Change will only happen in a positive sense if the health care team understands what the present performance state is, why it is important to change that state and then how to change performance in a manner that avoids unintended negative consequences. Thus little change happens unless appropriate educational strategies are deployed. Stated in a different manner, CME is a strategic lever for improvement and certified CME can be the cure.

The AHRQ monograph published a few years ago demonstrated that CME is indeed effective. Yes, that older body of literature demonstrated that it is more effective at knowledge transfer, but that is principally because CME was created originally to do just that, transfer knowledge to those already considered experts or masters in the field. The AHRQ monograph and the subsequent CHEST supplement did not show, as some have claimed, that CME was ineffective in changing behavior or patient outcomes. These published works showed that there was insufficient



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data to state a confident claim of effectiveness in these domains. Again, this should not be too surprising. If CME was principally intended to transfer knowledge then the studies would principally be designed to assess that ability. Thus the number and quality of studies designed to study effectiveness at the sharp end (e.g. patient outcomes) was simply lacking.

All of education is plagued by the claim that it is less effective than it could or should be. I would never argue that we are good enough and can't improve, but the real missing piece has been adequate tools to help assess effectiveness of education at any level including k-12 and higher education; the battle over this has raged for over a century. This lack of robust tools for assessment has led many to use lower level educational outcomes or other surrogates as evidence of quality education (e.g. rankings, endowment, etc). Holding CME accountable for effectiveness studies that simply don't exist across much of the educational continuum is inherently unfair and unjustified. Given the stakes involved in health care though, it is reasonable to ask if CME could shift to focus more at outcomes. Indeed, as you are well aware this has already started. CME is uniquely situated so that it can and is assessing these higher level outcomes. Better tools are needed, but real looks at quality and performance are already underway.

Along the way we need to be careful not to focus solely on direct patient outcomes, but to remember that improving research, teaching and administrative outcomes are also important and contribute indirectly to patient outcomes, even if impossible to measure conveniently. In addition, society has benefited from physicians serving in leadership roles in the community and this requires a broad-based knowledge that should not be wholly abandoned. We also should not forget that knowledge outside one's field of expertise supports innovation as well.

The early results from CME that is effective at improving health, presented mostly in abstract form at meetings, has supported the notion that modern, certified CME is effective at behavioral and outcome improvement. The final outcomes of these PI-CME activities will be vitally important. Given that modern CME is focused significantly on performance improvement (PI) and is utilizing proven

PI methodologies, it is highly likely that the next few years will see a plethora of manuscripts published on effective PI-CME. In the meantime, it would be useful if the CME community began sharing success stories. The digital world offers a great landscape in which to publicize these early results. Such stories of effectiveness would also help the image problems that cast a shadow over CME at times. These stories may also contain information that shows how a confluence of interests can exist and that such confluence can be associated with the exact outcomes patients want and deserve.

Now, to turn our attention to the broader issue of the value of CME. I have spoken on the value of CME before and so I will not belabor that aspect here. Suffice it to say that healthcare receives great value from certified CME. There is, however, a gap between what we all know about the value of CME and the external perception of CME. Digital stories might again be one strategy to help shift the tide.

Academic CME has started to make progress with showing the value of CME to our community and to our senior executives. Feedback has been quite positive to date. We need to take that momentum and move onward, showing the value to our teaching community, to our attendees and to patients. I wonder if there are health care providers who have documented improvements in practice that might be encouraged to come forward and tell their CME stories. Imagine the impact of a physician, a nurse, a pharmacist, or a care team communicating — utilizing hard examples — of how attendance at certified activities changed their practice and helped a specific patient or saved a specific life! Imagine a group of patients discussing how their care was improved by their care team because of the certified CME their care team attended through a medical school, at a hospital or while attending a national meeting of a professional society!

Are you surprised that I would focus at effectiveness or value during my tenure as SACME president? I hope not, given my past contributions to the field. I also hope you can more easily see why these two domains are so important and why they are a bit of a mantra for me. In conclusion, SACME will help advance health in this nation by being able to support the demonstration of CME's effectiveness and value and by disseminating the result of that body of work.

In so doing, CME will be the cure!

THE INAUGURAL SACME SUMMER LEADERSHIP INSTITUTE (SLI)

(AND HOW WE SURVIVED THE GREAT FLOOD OF JULY 26, 2010)

By Ivan Silver, MD, MEd, FRCPC



For the better part of a week at Johns Hopkins, SACME put its best foot forward by hosting its first Leadership Institute. Twenty participants working in CME leadership positions from the U.S., Canada and Chile gathered in the heat of the summer to return to school for an intense week of study, exchange of ideas, the telling of stories, development of leadership projects, mentorship, mutual support and lots of laughter. Participants were treated to a cornucopia of new concepts, schemata, lenses, frames, and metaphors.

The dialogue with participants started well before the Institute; information was gathered about participant's current roles and responsibilities and what they were expecting from the Institute. Prior to the course, participants completed a leadership inventory questionnaire (The Insights Discovery Personal Profile). Later, at the Institute, participants were provided detailed feedback on their leadership characteristics and profile. Participants and faculty were introduced to the concept of the "Moodle" — an online forum hosted by Johns Hopkins where all of the presentations were posted and discussion encouraged.

The curriculum was broad and deep and delivered in multi-modal formats. Topics included leadership and change management, strategic management, conflict resolution, interpersonal effectiveness, PI methodologies, research in CME, complexity theory, media planning, case-based economics, team building and diversity, succession planning, lessons from managing CME disasters and the future of CME. Learners were treated to some of Johns Hopkins' top teachers and leaders from the University of Toronto, SACME, ACCME, and AAMC. Participants were engaged with small group problem solving and project work, role playing, gaming and story telling. For example, in the media training session, how could you not be engaged by interacting with Baltimore's leading

investigative reporter, Jayne Miller giving tips on how to best interact with the media during a crisis?

Participants were also witness to a CME natural disaster. Imagine planning a CME event for "out of towners," placing them at the same hotel and then being told after the first day of the course that a major pipe inside the hotel had burst causing a complete evacuation of the hotel; and to top it off, to be told that there were "no other rooms in the inn" because of another large convention in town. Thanks to Course Director and SACME president, Todd Dorman, and his outstanding administrators, Mary Jeter and Carlita Kearney, we were all billeted at other hotels and were able to collect our luggage the next day. No one in attendance had ever had a similar CME calamity. In the end, we witnessed effective leadership in action — a play within a play. Problem solving at its best.

Preliminary feedback about the SLI from attendees has been enthusiastically positive:

"This was an incredible opportunity to network and learn from colleagues. I appreciated the presentation of topics and the impact on my practice."

"Very informative and pertinent focus for me in my role now and going forward. Thank you!"

"Thank you for organizing this and for all your efforts with the hotel."

"Excellent conference. Best SACME conference ever! Enjoyed the diversity and applicability of topics and speakers. Enjoyed the interactivity of the presentations."

Participants highlighted the relevancy of the topics, the networking, the contextually linked activities, exposure

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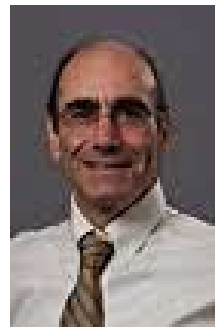
to new ideas, the incorporation of learner discussions/brainstorming in each session, the stories, individual mentoring and especially the overall interactivity. Topics that were felt to be particularly well presented included the media training, the PI methodologies, crisis management, succession planning, and the economics and strategic management sessions. There were also several suggestions made on how to improve the Institute in the future including more time for reflection and application to practice, even more interactivity and less didactics, shorter teaching days, and at least one social evening for informal networking. Todd Dorman and his planning committee hope to survey participants at regular intervals over the next 2 years to further assess the impact of this Institute on administrative practices.

SACME has taken a big step forward in organizing the SLI. This program is “one of a kind” in the world — leadership training specifically geared to CME leaders. We all need to thank Todd for his leadership, Mary Jeter and Carlita Kearney for their outstanding administrative work and the planning committee, Lois Colburn, Gabrielle Kane, Dave Davis and Melinda Steele for all of their hard work and efforts to make this happen. Many thanks to our outstanding faculty: Kevin Grigsby, Catherine Morrison, Edward Miller, Richard Davis, Joann Rodgers, Gary Stephenson, Jeff Nelligan, and Douglas Hough (all from Johns Hopkins), Dave Davis from the AAMC, Murray Kopelow from the ACCME, Susan Lieff from the University of Toronto, Dr. Edward Miller, Dean and CEO of Johns Hopkins and our SACME leadership, Todd, Gabrielle and Lois.

More than ever, CME needs to professionalize its leadership. We are on our way!

CURT OLSON, NEW EDITOR OF THE *JOURNAL OF CONTINUING EDUCATION IN THE HEALTH PROFESSIONS*

By Paul E. Mazmanian, PhD



Curtis A. Olson, PhD, accepts responsibility for editing the *Journal of Continuing Education in the Health Professions (JCEHP)*, effective January 1, 2011. Curt brings an impressive depth of scholarship in continuing education and research methods, along with sensitivity not only to teaching and learning across the continuum of medical education, but also to quality and organizational culture in clinical and translational science.

The credibility and standing of continuing education rests in part upon the quality of the literature it publishes and upon the best practices it enables. For that reason, the *Journal of Continuing Education in the Health Professions* must continue to develop better research and scholarship that emphasizes the value of lifelong learning and the effectiveness of continuing education in systems of care.

Curt Olson is the right person at the right time. Uncertainty is menacing, and from its hardened, longstanding,

position overlooking organized continuing education, it can simultaneously energize and stigmatize continuing education in the health professions. As the interests of those most vested in the field grow more or less threatened, understandably, their voices grow shrill or soft. With each new report or newspaper article, the alarms can sound more or less foreboding. A careful listening ear is required to interpret the environment and to select the best practices and most important research questions, while developing the best science and demonstrating to stakeholders that continuing education can be effective in helping to improve clinical practice and patient outcomes. Curt delivers an exceptionally accommodating blend of patience, expertise, and productivity. The continuing education community will continue to be well served by his initiative and his successes, as he assumes the role of Editor, *Journal of Continuing Education in the Health Professions*.

NEWS FROM THE AMERICAN MEDICAL

ASSOCIATION

By Alejandro Aparicio, MD, FACP



The 2010 Annual Meeting of the AMA House of Delegates (HOD) took place in Chicago in June. A number of Board of Trustees and Council Reports were approved during the meeting, as well as Resolutions proposed by the HOD. There is not enough space in this column to list all the Policies and Directives to Take Action that were contained in each report or resolution, but they can all be found at www.ama-assn.org/go/hod. The CME community may be particularly interested in the following reports and resolutions: Council on Medical Education Report 3 — Specialty Board Certification and Recertification and Maintenance of Licensure; Council on Medical Education Report 6 — Telemedicine and Medical Licensure; Council on Medical Education Report 7 — Continuing Medical Education in Disaster Medicine and Public Health Preparedness; Council on Medical Education Report 12 — Regulation of Continuing Medical Education Content; CME Report 13 — Expectations for Lifelong Learning; Council on Medical Education Report 14 — Opposition to Increased CME Provider Fees; Resolution 301 — Ensuring Physician Competence in the Care of Older Adults; and Resolution 310 — Suggested Revision in ACCME Evaluations.

In the summer edition of the CPPD report you can read highlights of the actions taken as well as a more detailed summary of Council on Medical Education Report 14 — Opposition to Increased CME Provider Fees. This article includes some of the data gathered from a nationwide survey that were used to prepare the Council 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.

One of the actions taken by the AMA Council on Medical Education at the June meeting was to approve the 2010 version of the Physician's Recognition Award and credit system, Information for accredited providers and physicians booklet. This year the booklet is being published exclusively in electronic format and can be found at www.ama-assn.org/go/prabooklet.

The 2010 revision is the culmination of over a year of work. Part of the preparation that went into this revision included 22 meetings from April through August of 2009 with over 160 representatives from more than 58 organizations. One of those very productive meetings was with the SACME leadership. All the comments were summarized, considered and discussed by the CME Subcommittee of the Council on Medical Education. The draft document was shared with American Academy of Family Physicians, the American Osteopathic Association, and the ACCME and its member organizations, before the final version was approved by the Council. There are no new formats included in this version, but there are changes that, in the opinion of the Council, further increase the robustness of some of the educational formats that can be certified for credit. There is also a change in the wording of the designation statement that allows for physicians and other consumers of credit to know the *AMA PRA Category 1 Credit™* educational format that is being referenced.

There were also some revisions in the language throughout the document which, although not policy changes, will help clarify some AMA PRA policies. The on-going process of improvement that AMA utilizes to continue to enhance the educational value of certified CME incorporates the feedback received from CME providers, physicians and others, information obtained from research or pilot studies, and adult learning principles with the goal of continuing to assist physicians in providing better care. We hope to continue to receive your feedback and ideas in the future.

The Division of CPPD will provide education about the 2010 revisions in a variety of venues, including webinars (dates, times and registration information can be found at www.ama-assn.org/go/webinars), presentations at the Alliance for CME meeting in January 2011, an article in the Winter 2010 issue of the CPPD Report, and FAQs on our website — just to name a few.

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MEET YOUR CANADIAN REPRESENTATIVE

Dr. Tanya Horsley is a Research Associate within the Centre for Learning in Practice (CLIP), at the Royal College of Physicians and Surgeons of Canada. She currently holds an academic appointment within the Department of Epidemiology and Community Medicine at the University of Ottawa and an Investigator position with Children's Hospital of Eastern Ontario Research Institute (CHEO RI).

Tanya obtained her PhD in 2002 from the University of Western Ontario with a thesis entitled "The use of autogenous hamstring tendons for anterior cruciate ligament reconstruction". She completed a Post Doctoral Fellowship specifically dedicated to systematic reviews at the National Centers for Chronic Disease Prevention and Health Promotion, in the Division of Diabetes Translation with the Centers for Disease Control (CDC) in Atlanta (2005–2007). She also gained valuable methodological expertise in systematic reviews of both randomized and non-randomized designs, having worked previously with both the Ottawa and McMaster Agency for Healthcare Research and Quality Evidence-based Practice Centers (AHRQ EPC).



Dr. Horsley has been involved with the production, teaching, and peer review of systematic reviews for 9 years. Her engagement with systematic reviews of continuing medical education have led to research collaborations, mentorship opportunities, and teaching workshops for SACME members, and more recently the development of the systematic review peer-review tool currently used for the Journal of Continuing Education in Health Professions (JCEHP). She has published widely in peer-reviewed journals and continues to pursue her own academic interests particularly for improving the conduct and reporting of systematic reviews, and more specifically, increasing the quantity and quality of physician reflection through question asking within the broader context of lifelong learning strategies.

Statement to Regional Members:

I'm delighted to become the new Canadian Regional Representative for SACME. It goes without saying that Mary Bell did a wonderful job representing the Northern contingency of SACME and I hope to carry the momentum forward. In the upcoming months I will look forward to being in touch with many (if not all) of you to learn more about what you think is going well in terms of your membership with SACME and whether there are areas for improvement that can be suggested to the Board.

To kick start my position I've been working with Jim Ranieri to launch a new SACME "sub-listserv" for all members from Canada. This is intended to keep Canadian members apprised of CME happenings specifically relevant to Canadians (in addition to the regular SACME updates) like local/regional/national grant competitions etc. With hopes of improving the utility of the listserv synergies with CACHE (Anne-Taylor Vaisey) are currently being explored.

If you have announcements you feel are appropriate for this group please send them along (thorsley@rcpsc.edu or thorsley@royalcollege.ca — as your representative

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NEWS FROM THE AMA *continued from page 9 ...*

Finally, the National Task Force on CME Provider/ Industry Collaboration continues its Fact Sheet campaign that was initiated in 2009. The "Get the Facts!" campaign is a national effort to disseminate information on certified CME and related issues important to the CME community. By the time you read this column, the most recent Fact Sheet on FDA Regulation of Product Promotional Activity should be available. You can find all the Fact Sheets at <http://www.ama-assn.org/ama/pub/education-careers/continuing-medical-education/events/national-task-force-cme-provider-industry/get-the-facts-campaign.shtml>.

The Fact Sheets will also be available at the Annual Conference of National Task Force, taking place October 13-15, in Baltimore. Darrell G. Kirch, MD, president and CEO of the Association of American Medical Colleges, will deliver the keynote address: "Principled Partnerships: Practical or Pipe Dream?" More information about the Conference can be found at: www.ama-assn.org/go/cmetaskforce.

AAMC GEA NEWS

By Jack Kues, PhD, CCMEP, CME
Section Chair

The CME Section of the GEA has been expanding the visibility of CME at the annual AAMC meeting by developing joint sessions with other important groups in academic medicine. This November's meeting includes sessions with the Council of Academic Societies (CAS), a moderated discussion with representatives from the Office of Inspector General (OIG), and a joint session with the Chief Medical Officers Group (CMOG). In addition, Dave Davis will be giving the Nina Matheson Lecture on Monday afternoon: "Scaling the Knowledge Pyramid: the Shared Role of the Clinician, the Educator, and the Librarian." There will be a joint session with RIME (Research in Medical Education) again this year where we will discuss issues for the future of academic CME at the annual CME Section Business Meeting on Tuesday afternoon.

The AAMC meeting provides us a great opportunity to educate other areas of academic medicine about what we are doing in CME. Likewise, we have the opportunity to learn about the educational issues for our deans, chief medical officers, and the other parts of the medical education continuum. All of last year's sessions were well attended by representatives from all other areas of academic medicine as well as our own CME colleagues. Topics like performance improvement, relationships with industry, and faculty development are being discussed throughout academic medical centers and Dave Davis and the CME Section of the GEA have been working to make sure that CME is represented.

Lastly, my tenure ends in November. Barbara Barnes will be the new chair of the CME Section of the GEA.

MEET YOUR CANADIAN REPRESENTATIVE *continued from page 10 ...*

the SACME Board — for consideration. I'll look forward to working with you in the coming months, particularly with regards to attracting new members to strengthen the depth and breadth of SACME. Feel free to be in touch at any time — even if it's just to talk shop!

INTERCOM

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UPCOMING EVENTS

**21st Annual Conference of the National
Task Force on CME Provider/Industry
Collaboration: "Moving Forward in an Age of
Uncertainty: Creating Innovative, Practical
Educational Solutions"**

October 13-15, 2010
Baltimore Marriott Waterfront
Baltimore, Maryland
www.ama-assn.org

SACME Fall Meeting

November 5-8, 2010
Washington, DC
www.sacme.org

2010 AAMC Annual Meeting

November 5-10, 2010
Marriott Wardman Park and Omni Shoreham
Washington, DC
www.aamc.org/meetings/annual/2010

2010 CMSS Annual Meeting

November 12-13, 2010
Rosemont, Illinois
www.cmss.org

36th (2011) ACME Annual Conference

January 26-29, 2011
San Francisco Marriott
San Francisco, California
www.acme-assn.org

SACME Spring Meeting

April 6-10, 2011
New York, NY
www.sacme.org

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