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The CME Forum

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News, Notes, Perspectives, and Thoughts from a CME Frame of Mind

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SPECIAL REPORT:

Highlights from the 18th Annual Conference of the National Task Force on CME Provider/Industry Collaboration

18th Annual AMA Task Force Meeting Overview

The 18th Annual Task Force Meeting took place October 17-19 in Arlington, Virginia with a focus on "CME Collaboration to Improve Patient Care: A Call to Action". The conference, with a record number of attendees in the meetings history, at approximately 700 attendees, offered interactive plenary and breakout sessions specifically geared toward collaboration among stakeholders such as medical education communications companies, (MECCs), industry, medical societies and associations, the FDA and accredited providers; and included speeches from a number of renowned industry professionals. This year's meeting was clearly one that both industry and providers were looking forward to, understanding that change needs to happen from within, rather than being thrust on us by external factors. Topics of debate and discussion ranged from self-regulation and oversight of our industry to what we as providers must do to ensure quality, independent medical education.

Message from the Editorial Team

Welcome to the inaugural issue of The CME Forum, a newsletter that presents news, analysis, insights and opinions on current trends and developments in our dynamic and transformative industry.

As an organization that includes the word 'collaboration' in its tagline, we are excited about the discussion of and significance of this term for CME. Therefore, what better opportunity than a "Special Report" on the 18th Annual Conference of the National Task Force on CME Provider/Industry Collaboration, for the launch of our newsletter. Our goal is to provide you with the most up-to-date developments, challenges and perspectives on the direction our industry is headed. As Robert Fox, EdD, keynote presenter at the AMA Task Force meeting implied, the end goal is to ensure appropriate patient care and outcomes, or as Dr. Kopelow put it in his address, to ensure CME continues as a value-added asset to the practice and study of medicine.

~The CME Forum Editorial Team

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Disclosure

As the theme of the AMA Task Force meeting was collaboration and its inherent value to providing effective CME to healthcare learners, we must disclose that G&A's business model is based on collaboration between key stakeholders and the development of educational activities.

SPECIAL REPORT: Day 1 Highlights

Aligning for the Next Level of Continuing Professional Development (CPD) for Physicians and Surgeons

Collaboration in CME is not a word that we should be distancing ourselves from and should be seen as something that brings much needed value to the learner. This was the essence of the opening statement by Robert Fox, EdD, Professor of Adult and Higher Education, The University of Oklahoma, which set the tone for the 18th Annual AMA Task Force Meeting. Fox challenged CME providers to increase their level of formal education and begin to utilize the vast amounts of literature and studies available for improving the effectiveness of medical education as a requirement for the job of CME professional.

Fox noted that the "heart of collaboration is shared knowledge" and reinforced that successful collaboration is possible with high levels of competence and transparency. He also highlighted that common goals, values and beliefs are essential to collaboration.

By way of historical background, Fox discussed learning and change theory and its implications on CME. He stated that the direction of CME has evolved in response to numerous studies that have been completed over the past 10 to 15 years on learning and change. In the 1980s, CME programs were simplistic; providing content that was of value, but without any consideration to what effect education had on clinical behavior, skills and knowledge. Now, medical education, based on learning and change theory, is focusing on teaching and education as a means of facilitating change in behavior. We must continue to utilize evidence based information while developing and providing CME.

In closing, Fox focused on what we should do now. He provided a list of possible criteria to consider while establishing new standards for quality education in Continuing Professional Development. (See box at right.) The recommendations and themes from Dr. Fox's presentation appeared in various forms throughout the conference providing evidence that these strategic philosophies concerning collaboration are key industry trends.

Fox Recommendations

- Use new standards as targets for developing practices and personnel
- Insist on trained, certified site surveys/random inspections of CME activities
- Ask industry to pay for inspections based on violations
- Demand transparency
- Report/reward excellence
- Require certified training for CME providers

SPECIAL REPORT: Day 2 Highlights

The Independence of Continuing Medical Education

Murray Kopelow, MD, MSC, FRCPC, and Chief Executive of the ACCME, in his highly anticipated presentation discussed the purpose and mission of the ACCME, rationalized the changes necessary to maintain relevancy in an ever-changing landscape, and laid out his vision for maintaining this relevancy through a focus on "independence" and a more dynamic set of accreditation guidelines.

Review of ACCME Mission and Purpose

Dr. Kopelow began his presentation by reviewing the makeup of the ACCME board by various groups in an attempt to give the audience a better historical perspective on the purpose and mission of the ACCME. The mission of the ACCME is "to promote, develop, and encourage the development of principles, policies, and standards for continuing medical education," he reminded the audience.

Utilizing his Task Force presentation from 2004, his review included a comparison of CME now and then. Without the independence that the 2004 standards introduced, "state boards likely would not have continued to require CME," potentially abandoning the ACCME and leaving it with significantly less value. Instead, the Federation of State Medical Boards said, "The new standards represent a shift in CME in that providers will move through levels of accreditation that require them to take on greater responsibility for changing and improving CME opportunities and to become a strategic asset to quality of life and safety issues."

Dr. Kopelow went on to support the "Certified CME" buttons and in the midst of his presentation, asked for one from an audience member stating that it is different and distinct from other medical education: "CME is professional education created for the medical profession by the medical profession or its agents." Addressing Conflict of Interest (COI) resolution is imperative to maintaining independence, he said.

Senate Finance Committee (SFC) Report

The SFC, Kopelow pointed out, did not impugn the standards of the ACCME, rather the enforcement of its own guidelines. (See right for SFC Findings Summary) "…And (the ACCME) did not have the data to refute these claims." The situation is dire, he reported. Essentially the SFC Report implied that industry control (or lack of independence can create bias which can result in the use of a product used more than it is necessary.

It can be inferred from this that a lack of independence makes the CME enterprise vulnerable to Office of the Inspector General (OIG) investigation of off-label promotion and further, that the independence of the CME enterprise is necessary to continue as a relevant and self-regulated profession.

SFC Findings Summary

1. Mechanisms exist through which commercial supporters can influence content.
2. Self report may not be good enough to police CME.
3. There exists no process for looking for bias.
4. Accreditation consequences are weak and do not force change in a timely manner.

SPECIAL REPORT: Day 2 Highlights

The Independence of Continuing Medical Education (cont'd)

Kopelow admitted that there was a "perceived lack of response" by the ACCME, but he provided detail on the response that most were unaware of and described it as appropriate and necessary given the situation. He said that the ACCME immediately communicated to the SFC that the organization is **sensitive** to the issues**, receptive** to the observations (of the report) and committed to ensuring the **validity** of the CME enterprise.

"The ACCME is committed to ensuring the validity of the CME Enterprise"

Importance of Independence

Additionally, the ACCME board met in July to discuss the situation and affirmed that the ACCME's role is to protect the independence of CME. In keeping with this, he identified five areas for attention.

ACCME Five Areas of Attention

1. Enhancement to the collection analysis and synthesis of data and information
2. The processes the ACME uses to administer its standards
3. A review of the management of commercial support
4. ACCME's education and outreach programs
5. Collaboration, cooperation and communication

The Prime Directive

Kopelow then set out the vision for progress toward protecting independence. Collaboration, communication and cooperation with the ACCME by providers, learners, and commercial supporters needs to increase through face-to-face, written comments, web forums, advocacy organizations, member organizations, and other media. What we will see next, he says, is a set of guidelines that will describe specifically how to be compliant. These will be offered up for discussion, and then formed into policy. The overarching theme of his presentation was that government first used the word independence in 2004. "When CME is independent, then it will not be regulated." Maintaining this independence is the "prime directive" of the ACCME, he concluded.

"Maintaining Independence is the prime directive of the ACCME"

SPECIAL REPORT: Day 2 Highlights

Kopelow Audience Q&A

Q Is the ACCME trying to eliminate MECCs with the redefinition of commercial interest?

A Kopelow said that the ACCME is not trying to get rid of MECCs. He believes MECCs can restructure and still be a part of the ACCME as accredited providers or in other roles. He recognizes the value of MECCs.

Q If a commercial supporter distributes an RFP are they suggesting a topic exerting influence over the content and is answering that RFP non-compliant?

A Kopelow said no and feels this process is "OK". Commercial supporters may describe through an RFP what it is they want to fund and that is "OK".

Q The revised definition creates a set of requirements for one group of providers and not the other. In a recent survey in JAMA, 25% of department heads from 125 medical schools were either board directors, founders of drug companies, or had some other COI and suggested that the term "financial interest" should be used as a guide and applied to all providers in order to create a level playing field.

A Kopelow responded that he would include the suggestion in the discussion and did not dismiss it. He said that the questioner's set of beliefs was not the same, but promised to discuss it with the board.

Q Would the inclusion of speakers' names in grant proposal also be a violation of ACCME guidelines?

A Kopelow said simply that he could not answer. He could not make up policy in that forum. He said he wanted to be more specific but could not.

Q In light of the goal to uphold higher standards, and given that commercial supporters have extensive expertise in education and clinical areas. However, there is a lack of dialogue and commercial supporters have resources to improve quality through more dialogue.

A Kopelow responded that he needed more dialogue and individual meetings with commercial supporters and agreed to meet for discussion.

"If a commercial supporter distributes an RFP, is that a suggested topic exerting influence over the content and is answering that RFP non-compliant?"

SPECIAL REPORT: Day 2 Highlights

Friday Breakout Session: Current Perspectives on Outcomes

Presenters: Derek Dietz, MA; Mazi Adbolrasunia, PhD; and Doug Pousam, MBA

Moderater: Eric Peterson, EdM

Peterson began the session by explaining that outcomes are the measured result of a learning activity. Many might think of outcomes specifically as a change in behavior driven by the learning; however "outcomes", he reminds us, include many different results of learning.

The speakers discussed past and recent work for defining levels of outcomes reviewing early work by Kirkpatrick for recognizing outcomes levels and Moore's work in adapting these levels for CME. (See right hand column) While Moore's first three levels of outcomes are important to evaluate, the CME enterprise is working toward achieving outcomes directed at performance, patient health, and population health.

The presentations also included an overview of current outcomes models incorporated into CME activities including the Clinical Assertion, Case Vignette, and Confidence-Based Assessment models. Experienced educational planners integrate these and other level three and four outcomes into their proposals, and recognize the models discussed as effective and cost-efficient. Rather than just a novel trend, level three and four outcomes are here to stay and should be a minimum expectation for all well-designed educational initiatives.

Kirkpatrick Outcomes Levels:

1. Reaction
2. Learning
3. Behavior
4. Results

Moore's Outcomes Levels

1. Participation
2. Satisfaction
3. Learning
4. Performance
5. Patient Health
6. Population Health

Breakout Session: What is a CME Professional?

Meeting Panel: Nancy Davis, PhD, National Institute for Quality Improvement and Education; Jacqueline Mayhew, Pfizer, Inc.; and Sterling North, University of Maryland School of Medicine

Moderater: Greg Thomas, MPH, American Academy of Physician Assistants.

Greg Thomas began the meeting by conveying how many of us joined the CME enterprise through the "Great Back Door" to the bemusement of those in attendance. He continued with a brief demographic survey. Through a quick asssement, it was found that most of the attendees had been in CME for an average of 7+ years. The audience consisted of mixed disciplines, and when asked what they did prior to CME, answered that most came from positions in healthcare, meeting planning, and publishing.

Sterling North presented first and reviewed the competency areas identified by the Alliance for CME. He reviewed the competencies, the process for identifying them, and the rationale for including them, concluding that "as CME shifts in response to changes, the elements required (competencies) will shift as well". He added that the required competencies work for organizations as well as individuals.

As CME shifts in response to changes, the elements required (competencies) will shift as well.

Nancy Davis then described what she termed the competencies of the "new" CME professional given modern demands such as regulation, science, stakeholders, priorities, technology, etc. She envisions CME moving from knowledge to performance and learning to practice. "Participation to performance, knowledge to competency," she said. Every CME activity should have a quality improvement (QI) tool. In general, we need to marry CME and QI and discuss methods for CME interventions to improve quality with goals.

Next, Jackie Mayhew asked, "Do commercial supporters need to demonstrate competencies?" The answer was yes. Pfizer's mission is one of alignment of interests to benefit patients, or the convergence of business focus with patients needs.

An attendee asked the panel for an "elevator pitch" for CME professionals, a description that CME professionals could use while discussing their careers over cocktails. As the session concluded, the attendees left without an adequate answer to that question. It seems that the discussion of competency, skill and certification is one that we need to continue to advance.

The CME FORUM: PERSPECTIVES

'Charlatans Abound' in the Realm of Collaboration?

By Seanne Murray, Esq

During the opening speech at the 18th Annual AMA Task Force, Robert Fox, EdD, said "charlatans abound" amongst providers of CME. I believe that Fox is correct and I wonder how our industry can allow this to be so. Intellectual and professional fraud can be perpetuated by those choosing profit over education. Commercial supporters say they are seeking innovation and new ideas, yet, often, they continue to support only the people and organizations they are familiar with even in cases where the outcomes of the supported education have been weak.

We must ask ourselves how we can promulgate high levels of competence and excellence in our industry. The answer, in truth, is collaboration, but not collaboration between commercial supporters and providers, as implied in the latest industry conferences and now perhaps a moot point according to ACCME guidelines. We need collaboration amongst institutions, associations and thought leaders with expertise in specific therapeutic areas. A convergence of these groups working together strategically to identify unmet needs and gaps in education and develop educational strategies based on proven healthcare models will serve to focus on the needs of the profession, as opposed to special interests and financial opportunities while weeding out the charlatans. MECC's with expertise in providing vehicles that address the learning needs of the audience that work appropriately with the design of the educational initiative can play an important role in achieving success based on analysis of outcomes data.

Panel discussions at conferences and meetings indicate that the quality of the proposals submitted is often poor at best. I look forward to a panel of commercial supporters and providers that will give recognition to quality CME initiatives founded on evidence based medicine and therapeutic expertise and initiated by the real industry leaders — healthcare providers, society organizations and medical institutions.

"We must ask ourselves, how we can promulgate high levels of competence and excellence in our industry."

We welcome your opinions. To respond to this commentary, suggest topics, or contribute your perspective, please send your emails to info@gullapalliandassoc.com

UPCOMING EVENTS

Conference: 9th Annual Guidelines for Disseminating Off-Label Information, Washington, DC, Oct 25-26, 2007

Webinar: Pharma/Med Device Industry Support of Continuing Medical Education Programs, Oct 30, 2007

Conference: 4th Annual Defining Appropriate and Effective Interactions with Thought Leaders and Key Opinion Leaders (KOLs) Vienna, VA, Nov 15-16, 2007

Webinar: Off-Label Communications: how to develop internal policies and procedures to help maintain compliance, Nov 29, 2007

Conference: 5th Annual Pharmaceutical Executive MedEd Forum, Philadelphia, PA, Nov 28-30, 2007,

Conference: Forum on Evidence-Based Medicine, Philadelphia, PA, Dec 5-6, 2007

Conference ACME 33rd Annual Conference, Orlando FL, Jan 19-22, 2008

Conference: 4th Annual Pharmaceutical Meeting Planners Forum Baltimore, MD, Mar 18-19, 2008

Conference: CBI's Second Annual West Coast Bio/Pharmaceutical and Medical Device Grants, Location TBD, May 15 - 16, 2008

Conference CME Congress 2008, Vancouver, BC, May 28-31, 2008

Conference: 8th Annual Continuing Medical Education Summit, Philadelphia, PA, Jun 12-13, 2008

Conference: CBI's 3rd Annual European Congress on Pharmaceutical Meeting Planning and Continuing Medical Education, Location TBD, Jun 24-25, 2008

Conference CBI's 3rd Annual Bio/Pharmaceutical Educational Grants Conference, Philadelphia, PA, Sep 18-19, 2008

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