

June 30, 2010



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Collaboration,
Fellowship,
Networking.”***

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A WORD FROM THE NEW IACME PRESIDENT Rebecca DeVivo, MPH, MSW

Greetings! For those who don't know me, I head up the education department for the American Society for Gastrointestinal Endoscopy, and for the next year I am very proud to be the President of the IACME. I don't know about your organizations, but the past couple of years have been tough on our society – budget cuts, decreasing commercial support, and increasing demands on an already-stretched staff.

I believe it is times like this when organizations like the IACME can be most valuable. I know the inclination is to cut the cost of membership, and not take time out of the office for additional meetings...But I honestly can't think of a time when I need the ideas, support and feedback of my colleagues more. Plus, although I believe the national meetings also have great value, the fees for IACME membership and education are currently a much easier sell to my boss.

Big things are coming up for the Board of the IACME. We have just signed a contract to completely overhaul our web-site to increase functioning and user-friendliness. Our communications committee is working hard to provide practical tips and a discussion forum through this newsletter as well as newer avenues such as LinkedIn. We will also be having a strategic planning meeting this summer to focus on what we provide our members and how we can help you get the most of your membership.

I would like to personally invite you to be a part of these conversations. Volunteer opportunities are available if you're interested in getting involved with our committees – just email ilalliance@aol.com. Do you have a great idea but don't have time to spend on a committee? Share it with us! Email IACME, post it on LinkedIn, or feel free to email me directly at rdevivo@asge.org.

I look forward to working with you all in the next year, and I hope you have a wonderful holiday weekend!

IACME ANNUAL SUMMER EDUCATIONAL MEETING A SUCCESS!

The summer conference took place on Friday, May 21, 2010, at the Double Tree Hotel in Rosemont, Illinois. In attendance were over 100 participants. Featured speakers included George C. Mejjicano, MD, MS, of the University of Wisconsin, Sonja Boone, MD, of the American Medical Association, and Kathy Marian, MEd, of the American Academy of Family Physicians. These dynamic speakers along with several breakout presenters addressed everything from the nitty gritty of accreditation criteria, to how we fund CME and where the future is taking us. Program details and handouts are available at www.iacmeonline.org

IACME ANNUAL BUSINESS MEETING AND AWARDS CEREMONY

2010 Election Results

The Nominating Committee reported the number of distributed ballots and total votes cast in the 2010 election. Congratulations goes out to the new board members who were introduced at the meeting:

Linda Dupont, Aurora Health Care – 4 year term

Dion Richetti, DIME – 4 year term

Janine Scotti, PeerPoint Medical Education Institute – 4 year term

NEW 2010-2011 Board Officers

The following is a list of the new IACME officers:

Rebecca DeVivo - President

Michelle Adams - President-elect

Mellie Pouwels – Immediate Past President

Rita LePard - Secretary

Kevin Heffernan - Treasurer

Mellie Pouwels Receives IACME Gavel

In her outgoing address, Mellie Villahermosa Pouwels, MA, IACME's 2009-2010 President, described organizational accomplishments during the last year, thanked the board for its support and received the IACME gavel. Michelle Adams' moving speech and presentation of the gavel was one of the many highlights of the meeting!

GOING GREEN

In Response to our request for members to submit their ideas, please read our first suggestion:

The easiest way to begin thinking about going green in CME is to think: Reduce, Reuse, Recycle. How can you reduce the consumption of supplies (two-sided printing, more email and electronic formats, less paper, turning off lights, etc.), what can be reused, and do you recycle all paper, aluminum and plastic? When you serve food do you use compostable cups, plates, and utensils? Is there a compost service that Food Service offers? Then it is a matter of measuring what percentage you are reducing, reusing, and recycling, and continually increasing that percentage.

Do you have ideas on how to “Go Green CME!” Please e-mail ilalliance@aol.com or join the discussion on LinkedIn. Go to: http://www.linkedin.com/groups?gid=1903150&trk=myg_ugrp_ovr

MARK YOUR CALENDAR!!!

IACME and ISMS Collaborative Conference

Friday, October 1, 2010

Spearheading this effort on behalf of IACME and working on the event are Rita LePard, ISMS Education Staff Specialist and IACME Director, and Chris Presta, IACME Program Committee Chair.

Implementing Criteria 11 and 12: a case study

This case study was submitted by an accredited provider who received accreditation with commendation under the 2006 criteria for accreditation in 2009. The provider describes their approach to implementing the new criteria for the first time. The case study is written as 5 steps toward meeting criteria 11 and 12.

11. The provider analyzes changes in learners (competence, performance, or patient outcomes) achieved as a result of the overall program's activities/educational interventions.

12. The provider gathers data or information and conducts a program-based analysis on the degree to which the CME mission of the provider has been met through the conduct of CME activities/educational interventions.

Step 1: Decide on a framework for overall program evaluation

The provider has a 6-member multidisciplinary educational advisory board that includes educators and clinicians. A major role of the advisory board is to review the provider's activities throughout the year and meet semi-annually to assess the program's success and to provide guidance for improvement, as a continuous feedback loop. The board provides an important level of accountability to the organization and their longevity (several have been with the board for more than 10 years).

Step 2: Start with your mission's expected results

Beginning in September 2006 as the provider began its transition to the ACCME's Updated Criteria for Accreditation, the organization met with its advisory board to determine a revised CME Mission Statement and within that decide on where to set the bar for their "expected results".

At its November 2006 meeting, the Advisory Board determined that based on its position as an independent CME-focused educational provider, the provider was best positioned to measure changes in physician competence, or the application of knowledge gained through CME to a clinical situation. The organization recognized that it may support change in performance and patient outcomes, but measuring these changes without consistent access to physician practice data would not be feasible. As a result, the organization decided to set the measurement of competence as the baseline for its expected results.

Step 3: realign your activity planning to ensure that all (or at least the majority) of activities will be designed to measure changes in your expected results

Beginning in January 2007, the provider trained its staff on new outcomes standards and implemented direction that all new activities must be designed to measure change in physician competence.

As many of the activities that took place in 2007 were planned in 2006, the 2007 CME program contained a mixture of activities that measured primarily physician satisfaction (Moore's level 2) with a small number measuring competence or patient outcomes (Moore's Level 3, 5 using the 2003 scale). The data in Figure 1 below was presented to the Advisory Board at its meeting in May 2008

Activity Outcome Levels

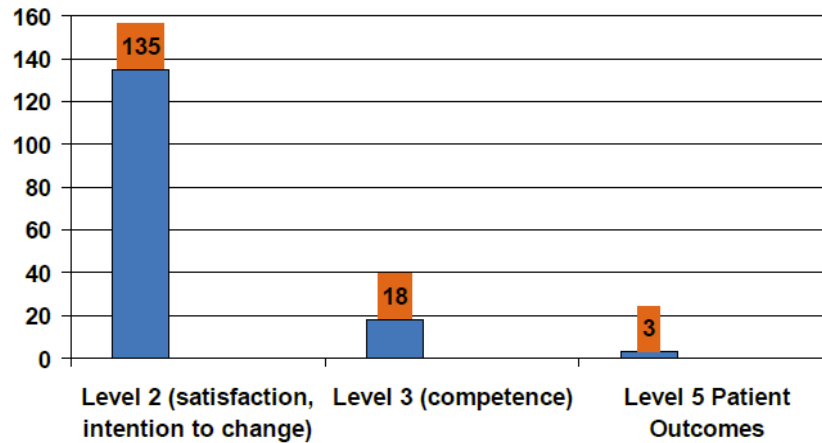


Figure 1

The number of activities across the organization's CME program evaluated in 2007 at higher outcomes levels was a significant increase from 2006. The 18 activities designed to measure competence was an increase of over 100% from 2006 when only 8 were measured at a level of competence or greater.

Step 4: Analyze your conclusions on a program level through a method of aggregation of activity level results

The provider reviewed the 18 activities and their results in competence, and came to conclusions, which were presented to the Advisory Board in May 2008. An example of some of these conclusions is listed below:

Expected Results: Competence Change by Activity

Activity Title	Changed Competence?	Method	Therapeutic Area/ Disease State	Notes
INSPIRE: Multidisciplinary Perspectives on Controversial Management Approaches for Patients With Cerebrovascular and Cardiovascular Risks (10 Centers of Excellence Meetings)	Unknown	Case Vignette ARS questions pre and post each Meeting	Cardiology/ Stroke	Data was lost by vendor
Statins and the Vasculature: Benefits Beyond the Lipid Profile (Satellite Symposium at AHA)	Yes	Pre and Post Activity Survey: case vignette	Cardiology/ Dyslipidemia	Very low response rate to post test
Biological Therapies in RA and SLE: Applying Lessons from Clinical Trials to the Clinic (Satellite Symposium at ACR)	Yes	Pre and Post Activity Survey: case vignette	Rheumatology: RA and SLE	The % of respondents correctly answering the CV questions increased for all three questions.

Figure 2

As 2008 unfolded, the provider was able to examine a more robust data set measuring change at the competence level, as all new activities they sponsored were designed to be evaluated for a change in competence, performance or patient outcomes. At its September 2008 Advisory Board meeting, the provider's staff presented a more comprehensive level 3 program analysis. This analysis uses the areas of professional practice that provider had chosen to concentrate on and outlines in its CME Mission Statement. The table below indicates the scope of

evaluation at the competence level, based on the data available at the time of the last program analysis of 2008.

Area of Professional Practice	Area of Focus	Change in Competence Measured?	Change in Performance Measured?	Change in Patient Outcomes Measured?	Results Available as of 09/20/08
Autoimmune Disease	MS	Yes	No	No	Yes
Autoimmune Disease	RA	Yes	No	No	Yes
Infectious Disease	HIV	No	No	No	No
Infectious Disease	HCV	No	No	No	No
Cardio vascular Disease	Acute Coronary Syndrome	Yes	No	No	Yes
Cancer	Multiple Myeloma	Yes	No	No	Yes
Pain	Opioid Management	No	No	No	No
Metabolic Disease	Diabetes	Yes	Yes	Yes	No
Women's Health	Reproductive Endocrinology	No	No	No	No
Other	Pulmonology	Yes	Yes	Yes	No

Step 5: use the data you acquire to assess whether you met your mission, and what you, as a CME provider, need to do to move closer to achieving the mission.

Following review of the data by the provider's staff and the presentation of the data to the organization's advisory board in September 2008, the following conclusions were drawn:

- The provider made significant progress in implementing methodologies to measure change in competence across its CME program in 2007-2008.
- The expected results for the overall CME program are a change in competence of physician learners across each content area of focus.
- Data to this point were not broad enough or complete enough to demonstrate significant change in each area of focus in which activities were developed.
- There are no previous competence level data with which to compare.
- A significant number of activities developed by the provider in 2008 did not yet have data available at the time of the report to the Advisory Board.

How is your organization addressing Criteria 11 and 12?

What you are doing may help your colleagues, or spark questions that will help you! **Add to the conversation on the IACME LinkedIn Discussion Group! Go to:**

http://www.linkedin.com/groups?gid=1903150&trk=myg_ugrp_ovr

You must be a member of the IACME to join.

