



*March 2010*



*“Education,  
Collaboration,  
Fellowship,  
Networking.”*

Visit  
[www.iacmeonline.org](http://www.iacmeonline.org)  
for all the latest IACME  
information

Spring has finally arrived and it's time for the  
IACME Annual Meeting  
**Friday, May 21, 2010**

**Double Tree Airport Hotel in Rosemont, IL**

Brochures have been e-mailed and registration is open!!  
Plan to be an active participant and don't miss this great event.  
Be certain to sign up by May 14<sup>th</sup>.

Visit [www.iacmeonline.org](http://www.iacmeonline.org) for more information or to register.

### **Last Call for IACME 2010 Board Nominations**

The Illinois Alliance for Continuing Medical Education announces its annual Call for Nominations to the Board of Directors. This year the board is seeking four (4) candidates to fill board vacancies. The IACME encourages all of its members to consider running for the open position. Deadline to submit a nomination is March 28. Nomination material may be found on the IACME website [www.iacmeonline.org](http://www.iacmeonline.org) under the Members Services section or email [ilalliance@aol.com](mailto:ilalliance@aol.com) for more information.

### **2010 Pearson Award Nominations Now Being Accepted**

Submit your nominee for this year's Thomas G. Pearson, EdD, Distinguished Service Award. We are now accepting nominations for members who have shown exemplary contribution and outstanding service to the CME community. Deadline to submit a nomination is April 18 and the award will be presented at the IACME Annual Meeting on May 21, 2010. Nomination material may be found on the IACME website [www.iacmeonline.org](http://www.iacmeonline.org) under the Members Services section or email [ilalliance@aol.com](mailto:ilalliance@aol.com) for more information.

### **IACME has a NEW E-mail Address**

IACME would like all members to note that the new official e-mail address for the IACME is now [ilalliance@aol.com](mailto:ilalliance@aol.com). Please direct all future communications to our new e-mail and we will be sure respond to all inquiries. Should you need to reach IACME directly you can always call 630-674-5292. Thank you!

### **The Illinois Perspective on the Updated Criteria: an IACME forum to provide ideas and practice examples to meet the new criteria**

As the January IACME newsletter introduced, we will kick off a series of articles this month highlighting the work of recently accredited IACME member providers. These articles will focus on the first 15 criteria, as a similar series addressing 16-22 is being

published in the Alliance for CME Almanac. Following each article, a case study in that criteria cluster will appear in the next month's issue. Please join the discussion on LinkedIn if you have any feedback you want to provide to your colleagues! (See box on the IACME LinkedIn Discussion Group elsewhere in this issue.)

We present three examples from the IACME membership below

1. The Chicago Medical Society
2. Silver Cross Hospital
3. DIME ( an independent, accredited medical education provider)

NOTE: The following examples represent the opinions of the individual providers and are not in any way endorsed or approved by the IACME, the ACCME, ACME or any other body.

#### A Medical Society's Perspective: Responding to ACCME Criteria 2 & 3

##### **What process did you undergo to define C 2 & 3?**

Staff reviewed examples, descriptions and various scenarios related to the criteria. Staff also discussed the meaning, interpretation, and significance of implementing C2 & 3 with their CME planning committees and organizational leadership as well as the implications on workflow.

##### **What action did you undertake to implement C 2 & 3?**

- Obtained the definitions and provided specific examples of a PPG, competence and performance.
- Revised the CME application process to require all CME activities to be based on an identified professional practice gap (PPG) which requires providing evidence that supports the gap as the **primary** step in planning CME.
- As a part of the application (and initial planning) process, CME planners are asked to distinguish whether the activity is designed to **learn how to do something** (competence-based) or **modify/improve something** (performance-based).
- As a part of the application process, CME planners are asked to develop educational strategies or interventions, derived from the PPG, designed to empower the CME learner to make competence-based or performance-based changes. Consequently, CME planners formulate expected learning outcomes, as an essential part of the CME planning and design process, and communicate the expected outcomes to the CME learner via the meeting notice.

##### **What aspects of leadership were required for you to do this?**

Staff engaged with various stakeholders in the planning process including: CME Committee, Subcommittee on Joint Sponsorship, Executive Committee, Board of Trustees, and executive staff.

Staff also communicated with and instructed its joint sponsors from its educational network to obtain further feedback. In addition, staff reached out to other accredited providers to gather a knowledge base of different views and perspectives regarding their approaches and interpretations.

**What were your key challenges/barriers and how were they addressed?**

- Use of the updated criteria's language and terminology, and an interpretation of the meaning of "professional practice gap," "competence," and "performance," Staff researched examples, contacted the ACCME, and continued dialogue with various CME stakeholders to gain a more comprehensive understanding.
- Resistance to change within the entire organization about the new way of planning CME which included some members of the planning committee, leadership, and some joint sponsors. Staff held various counseling sessions, online meetings, and conference calls to work through some of the challenging areas with these parties.
- Implementing C2 & 3 using a practical and efficient method. Planning staff and committee members agreed that a step-by-step application template, along with supplementary descriptions and examples, and follow up guidance and counseling have been effective approaches to breaking through some of these barriers.

**What recommendation do you have for best practice regarding C2 & 3?**

Track the implementation and progress of C2 & 3 with CME planners to identify barriers. Subsequently develop strategies to remove these planning barriers. A key goal for implementing C2 & 3 is to strive for quality improvement with CME by successfully matching the learners' PPG and enhancing their level of competence, performance and/or patient outcomes.

**A Hospital's Perspective: Responding to ACCME Criteria 2 & 3**

**What process did you undergo to define C 2 & 3?**

- Developed a CME Policy and Procedure that better reflected the Updated Criteria for Accreditation. Included a part on development and implementation of CME activities.
  - According to the policy, the professional practice gaps and the needs that underlie them are determined at the multidisciplinary CME Committee meeting or through CME activity proposal review. Key to both processes is identifying expected activity results, and means to measure activity outcomes.

- Significant portion of committee's discussion is now devoted to identifying the gaps and specifying the learning needs. Similarly, the committee discusses expected activity results (change in competence, performance or patient outcomes) and the planned methodology to measure the outcomes.
- Members of the Medical Staff may submit activity proposals for the CME Committee's review and approval. They are required to identify and address professional practice gaps and specific learning needs, as well as expected activity results (change in competence, performance or patient outcomes). The planners are required to identify the means they will used to measure activity outcomes.

**What action did you undertake to implement C 2 & 3?**

- Follow policy and procedure on development and implementation of CME activities.
  - The CME Committee includes representatives from major medical departments and hospital administration, as well as Departments of Quality Resource Management, Library Science, Nursing, and IT. The members bring forth information on professional practice gaps in a form of formal and informal reports at a regular CME Committee meeting. Professional practice gaps are identified based on the information provided. Specific learning needs that underlie the gaps, expected results (change in competence, performance or patient outcomes) and means to measure the outcomes are usually determined by the Ad Hoc CME Committee.
  - There are CME activity tools in place, which assure compliance with Criteria 2 & 3: Activity Planning Worksheet and Activity Planning Form. Both documents contain series of questions that pertain to activity planning and evaluation. The tools ask activity planners to identify professional practice gaps and specific learning needs pertinent to the planned activities. It asks to list the sources that are used to determine the learning needs. Similarly, the tools request that the planners identify expected activity results (change in competence, performance or patient outcomes) and means to measure the outcomes The CME Committee does not approve incomplete or vague

activity proposals.

**What aspects of leadership were required for you to do this?**

- CME Coordinator
  - CME Policy and Procedure development
- CME Committee
  - CME Policy and Procedure approval; following and enforcing CME Policy and Procedures
- Organizational Leadership
  - CME Policy and Procedure approval by Medical Executive Committee and Board of Directors
- Physician Champions
  - Taking initiative to develop and submit activity proposals/author CME activities

**What were your key challenges/barriers and how were they addressed?**

- Resistance to change from the Medical Staff
  - A lack of desire to shift from the old model of CME to the new one.

BARRIER ADDRESSED THROUGH: The CME Committee and Medical Staff education, e.g. a lecture for the CME Committee on the “changing face of CME” by an expert CME professional, preferably, an MD, followed by an interactive discussion between the presenter and the participants.

- Limited resources
  - Lack of time that QRM personnel could devote explicitly to CME, e.g. professional practice gap analysis/measuring the outcomes.

BARRIER ADDRESSED THROUGH: Collaboration with QRM staff, specifically, identifying quality indicators that are already followed and the data that is continuously collected, so that it can be used for common purpose.

**What recommendation do you have for best practice regarding C2 &3?**

- Educate Medical and Hospital Staff on the new model of CME/Updated Accreditation Criteria/Activity Design in light of the new criteria. Communicate to physicians why the CME directed at changing competence, performance or patient outcomes matters and how it is beneficial to them.
- Develop CME Policy and Procedure according to the updated accreditation criteria. Receive physician/organizational leadership back up, preferably official, e.g. approval of Policy and Procedure by CME Committee, Medical Executive Committee, Board of Directors; commit to following and enforcing the policy and procedure.

- Develop tools that would help activity planners follow accreditation requirements and ensure compliance with accreditation criteria, e.g. Activity Planning Worksheet; Activity Planning Form.
- Hold only those activities that are formally reviewed and approved by the CME Committee to receive *AMA PRA Category 1 Credit(s)™*.

An independent accredited medical education provider's (Medical Education Company) Perspective: Responding to ACCME Criteria 2 & 3

**What process did you undergo to define C 2 & 3?**

- Certification services team attended ACCME workshops and thoroughly reviewed the Updated Criteria on their release.
- Discussed pre updated criteria process for needs assessment.
- Analyzed how/where/when we were already obtaining professional practice gaps and including using them to determine the needs of learners.
- Assessed our target audience(s) and the types of professional practice gaps we should be looking to narrow based on our (newly revised) mission.
- Developed policy around the determination of professional practice gaps at the beginning of the activity planning process.

**What action did you undertake to implement C 2 & 3?**

- Certification services team developed training program for staff on all of the criteria.
- Worked with Medical Director, Scientific Directors on a refined format for what was formerly a needs assessment process.
- Dovetailed this into the Activity Planning Document (includes suggested resources to assess gaps at a national level).
- Trained educational strategy team on the search for and development of grant requests focused on narrowing professional practice gaps.
- Held several trainings for all staff on the new criteria, including and emphasizing C2 and C3.
- Participate in further training at the ACME meeting, AMA Task Force meeting, ACCME workshops, other CME continuing professional development activities.
- Provided training and discussion with DIME Advisory Board to assess quality of PPG's as they appear in the activity planning documents reviewed by the board.
- Discussed with board how the professional practice gaps obtained in a therapeutic area will help focus the goals of the DIME CME Program each year.

**What aspects of leadership were required for you to do this?**

- Executive support of adoption of new criteria: Managing Director.
- Staff leadership of adoption of new criteria: Director, Education and Compliance.

- Scientific understanding and mentoring around professional practice gap definition: Medical Director, Scientific Directors, Director, Education and Compliance.
- Funder/supporter understanding of requirements for compliance: VP, Educational Strategy and Development, Director, Education and Compliance, Scientific Directors.

**What were your key challenges/barriers and how were they addressed?**

- Organizational transformation to new paradigm of designing activities around the narrowing of documented professional practice gaps and away from perceived educational needs of learners.

**How Addressed:**

- Training, development of new activity planning document, more training, resources to support search and documentation, more training.

- Finding true documentation of practice gaps.

**How Addressed:**

- Increase in partnerships with healthcare organizations in order to get closer to data.
- Collecting and indexing documentation of gaps by therapeutic area.
- Discussions with thought leaders as to how patient outcomes gaps (more readily available) can be translated to professional practice gaps.

**What recommendation do you have for best practice regarding C2 &3?**

- Embrace the professional practice gap concept on an organizational level.
- Begin to collect national and regional gaps for your target audience and content area.
- Maintain an understanding of the translation of the larger national gaps to your specific audience.
- Look for other causes than knowledge and competence for the gap and if possible, address these in your activity.
- Carefully document for each activity the gaps that you address and their sources.

**Don't wait for the next meeting to network. Join the IACME LinkedIn Discussion Group! Go to:**

**[http://www.linkedin.com/groups?gid=1903150&trk=myg\\_ugrp\\_ovr](http://www.linkedin.com/groups?gid=1903150&trk=myg_ugrp_ovr)**

**You must be a member of the IACME to join.**