

## Special Issue: The 2010 Alliance Annual Conference

*This special issue of the Almanac is devoted to the 2010 Alliance Annual Conference that was held in January in New Orleans. More than 1500 participants and 77 exhibiting organizations attended the conference, where they heard and participated in discussions about the hottest topics in CME.*

*Among the highlights of this issue are:*

- *The Frances Maitland annual lecture on mentoring given by Dennis Wentz*
- *Descriptions of five award-winning projects that will spark innovation in CME*
- *Photographs from the meeting.*

*Enjoy the issue and, if you didn't attend the 2010 Annual Conference, consider coming to the 2011 Annual Conference in San Francisco.*

## 2010 Frances Maitland Memorial Lecture

**Dennis K. Wentz, MD**  
**Principal, WentzMiller & Associates, LLC**

**From Dr. Wentz's Presentation at the 2010 Alliance Annual Conference**



Frances Maitland Memorial Lecturer:  
Dennis Wentz.

It is an honor to have been chosen to present the 2009 Frances Maitland Memorial Lecture. I follow in the footsteps of many distinguished colleagues from this Alliance who have been honored previously. These are Sue Ann Capizzi, the first lecturer, Kevin Bunnell, Marcella Hollinger, then Bob Raskowski, David Lichtenauer, George Oetting, Barbara Schneidman, Patricia Spencer, Bob Orsetti and Suzanne Ziemnik.

Thank you members of the Awards Committee, thank you Merck, for underwriting the lecture, and thank you members of the Alliance.

Earlier, I gave a talk on being a leader—what does it mean, where does it take us? To end the day honoring a leader like Frances Maitland is very special. And, even more special, to honor one who persevered early on in our

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### Educational Opportunities

#### **CME: The Basics Institute**

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field—the field that is now, in my view, the *discipline* of CME, *complete with professional certification*—is especially gratifying. Too often our history and our CME/continuing professional development (CPD) leaders are unsung, and have not been recognized or honored.

That is why I am editing a new book about our field entitled *Continuing Medical Education: Looking Back to Plan Ahead*. The rich history of CME has never been written before, and it will be published by Dartmouth College Press in 2011.

So who is Frances Maitland, the leader we remember today? Richard Wilbur, MD, JD, wrote about Frances in one of the chapters in the book. He was the first secretary of the Accreditation Council for Continuing Medical Education (ACCME) as it evolved in 1981 from the ashes of the Liaison Committee on Continuing Medical Education (LCCME). He writes about the first days of the LCCME in 1977:

*It was a daunting task. There were few files (most were at the [American Medical Association] AMA which refused to release them at first) and few guidelines. The budget was minuscule. There was also no staff, other than myself. Fortunately, I had recently hired a secretary for the [Council of Medical Specialty Societies] CMSS who had been working for and was recommended by the CEO of the Academy of Orthopaedic Surgeons in Chicago. She was a Canadian-born nurse whom he said was competent and wished to work in the Lake Forest area, where CMSS was headquartered. Frances Peisch proved to be not only competent, but also a quick learner. I had soon taught her enough about CME that she could begin to organize the files, and then to manage much of the CME accreditation side of CMSS business. Subsequently, following a divorce, she resumed her maiden name of Maitland and, over the years, developed into a leading player in the accreditation of CME.*

*Frances was an invaluable aide in all of this with her rapid grasp of the principles involved. She also had very strong beliefs about adhering to high ethical values, probably from her Scotch-Canadian background. Quality was never compromised. She was able to imbue this spirit of uncompromising high quality into the rest of the ACCME participants in a field which had been rendered suspect by the intrusion of the commercial interests. We continued to work together at the ACCME until I left CMSS in January 1991. She then continued as Executive Secretary until the administration was turned over to the AMA.*

I will speak briefly about some memories of Frances, then define what mentoring is all about, hopefully as Frances would see it, and conclude with a few words to inspire us as we move into the mentor-mentee session that follows.

I knew Frances Maitland over a long period of time, and the stories are so many. When I was first appointed to the ACCME in 1989 as one of the three Association of American Medical Colleges representatives, it was Frances who welcomed me. She welcomed everyone new to the Council, and nursed us along until we knew how to walk. Our relationship developed quickly as there were a number of issues unique to medical schools (I was then at Vanderbilt School of Medicine and had just finished my presidential term at the Society of Medical College Directors of CME). We continued for all of those years to be true friends, even though we often disagreed about many issues, especially after I went to the AMA. But we could talk frankly and at length, and occasionally even swayed each other's views.

Because of her value system, ethics, and her strongly held convictions, Frances Maitland was remarkably successful and helped to shape our discipline of CME.

Former Prime Minister of England Margaret Thatcher's definition of success fit Frances like a glove: When asked *What is success?* she answered, "I think it is a mixture of having a flair for the thing that you are doing, knowing that it is not enough, that you have got to have hard work and a certain sense of purpose."

Yes, Frances Maitland had the flair, she knew it was never enough, and did she ever work hard and have a purpose.

But she could be tough. And, as I thought about it, one of my main memories of Frances will always be that *she told it as it was*.

We celebrate once again the theme that runs through Frances' life, a role of being a mentor to so many. Sue Ann Capizzi in the first lecture in 2000 reminded us how *Mentor* came into our parlance. Mentor was the close friend of Ulysses in the *Odyssey*. Ulysses asked Mentor to be the caretaker and teacher of his son, Telemachus, while he journeyed. But that's not the whole story. I recently learned that there was a woman involved! Actually, it was Pallas Athene, the goddess of wisdom, who took Mentor's form and actually did the job of mentoring the young man. I think Frances knew that.

Today perhaps half of you are mentors, and the other half *mentees*—wherever that word came from, it's not in my dictionaries. Mentoring was rejuvenated at the Alliance

the moment Frances Maitland became the Executive Director. It became a formal program in her honor in 2000, and it has never been more necessary. Thanks to the Alliance leadership for keeping and expanding the tradition.

Because most of you are already mentors to someone, even though you don't think about it that way, I will focus these remarks on being a mentor.

What do mentors do? Mentoring should not be confused with providing tutoring, peer support, teaching, coaching, supervising, advising, counseling, sponsoring, role-modeling, or precepting. Although some of these are included in mentoring, mentors do more!

Here are a few random thoughts about mentoring that came to mind in thinking about Frances Maitland's approach:

1. Mentors listen! *And Frances did.* Attentively and accurately—Frances certainly knew how. She really listened to the whole story, not trying to interject her opinion onto us, continually taking stock of the whole situation, and only when asked, or when all sides had been heard, did we hear her opinion of the matter. By the way, mentoring usually is a direct process, with face-to-face contact.
2. Mentors are honest. *And Frances was.* Mentors understand that mentees frequently don't tell their mentors everything because they feel they might disappoint. You need to make your mentees comfortable in being their own person, not in somehow trying to emulate you. Mentees have to be comfortable in telling their mentors what they really think. Mentors have to honestly relate what the situation is.  
Bob Orsetti said in his lecture that Frances' most important advice as his mentor was: "Do what you say you are going to do, don't take on too much, and when in doubt, ask."
3. Mentors are tolerant. *And Frances was.* Good mentors understand that mentees may not follow your advice—it's their life to live.
4. Mentors do not promote their own agendas. *And Frances never did.* Importantly, mentors must not be worried about who gets the credit. But mentors raise real questions—and sometimes all that's needed are a few critical ones.  
Frances was a stickler for preciseness in the use and meaning of words. One of the things she and I debated over was whether medical *training per se*, was truly

*education* and worthy of CME credit from the AMA. Because we at the AMA had just struggled with the issue of required training for laparoscopic surgery, it was a major question. Surgeons were claiming competence in the new procedures after attending a largely didactic course. My position was that we should urgently award credit for training as a matter of necessity—she wasn't at all certain that it was truly education in the true meaning of that word. One always prepared to debate with Frances. The word *training* in Webster's Dictionary means *to make proficient with specialized instruction and practice*. Was training worthy of educational credit? We never agreed.

5. Mentors take you to the next level. *And Frances did.* David Lichtenauer, our great friend who died last year, spoke of how, when he was a newcomer to CME and the Alliance, Frances tucked him under her wing, and introduced him to the key players in CME. Eventually he was elected to the Alliance Board. Frances constantly pushed to motivate people and help them attain their highest ideals.
6. Mentors are supportive, and follow through. *And how Frances supported her mentees.* But good mentors support without rescuing. Sometimes mentees need to fail. Mentors need a sense of balance between the desire to help solve a problem and the temptation to go too far. Not every experience is a winner. But a mentor can always help put things in perspective, and there probably will be at least one positive lesson to be learned.
7. Mentors are sensitive. *And Frances was.* Mentors know how mentees want and need to spend their time. And as a result mentors must be patient, and did Frances ever fit this criterion.
8. Mentors can help see the future. *And Frances did.* I'm reminded of Frances' unswerving support when we formed the National Task Force on CME Provider/Industry Collaboration in 1990. Not only was she involved, she insisted that one of the ACCME Council members be on the Task Force as well. This was a new development. The ACCME was at the table of a Task Force that had several industry members. Never had industry been sitting at the table with the ACCME.
9. Mentors, at times, are teachers. *And Frances was.* Mentors must know their area well, perhaps inside out. Frances had the art of good teaching. She could be so laid-back but *you* knew *she* knew. At times we think we

are teaching something, but remember, as the psychologist B.F. Skinner said: "Education is what survives when *what has been learned* has been forgotten."

10. Mentors aren't always friends. *And Frances instinctively knew if she should keep a distance.* There can be a problem in a mentoring relationship. The reason is that mentors have power. Use your instinctive judgment each time. Keep some professional distance if needed. This is not to say that the relationship cannot be warm and enjoyable. But the relationship needs to stay objective.

And perhaps the mentor-mentee relationship needs to be *evaluated* from time to time. If it isn't working, for either the mentor or the mentee, one or the other needs to speak up and terminate a mismatched relationship.

Frances would probably agree with all of these points, but she would quickly add number 11: Mentors are humble. No doubt, she'd enjoy this little verse of poetry written by Emily Dickinson:

I'm nobody! Who are you?  
Are you nobody, too?  
Then there's a pair of us—don't tell!  
They'd banish us, you know!

In its 11 years, I am the third physician to have the honor of presenting this lecture. In Medicine, we have a long tradition of mentoring and none of us *could* have become caring and competent physicians without our mentors. From the earliest physicians we know of—Hippocrates, Galen, Maimonides, Rhazes—all of them taught by mentoring. The most renowned mentor in relatively modern times was Sir William Osler when he was teaching at Johns Hopkins University School of Medicine (prior to that he taught at McGill University and the University of Pennsylvania, and after Johns Hopkins he taught at Oxford University). The American Osler Society meets annually to discuss his writings and thoughts about being a complete physician. Mentoring is crucial to the education of young doctors.

Frances Maitland retired from the Alliance in 1996 and died in 1998. When a very large number of us gathered for her memorial service at Chicago's Newberry Library in 1999, the words of appreciation from those of us who knew her as a mentor were thrilling.

I hope you've caught a glimpse of the Frances Maitland that many of us knew—much more is in the prior lectures available on the Alliance website. But what lives on, and

what we remember today, is her example as a mentor to us all.

If sometime this spring you are taking a walk in the evening, look up at the night sky for a few minutes, identify Sagittarius and reflect on Gauguin's (slightly revised) trilogy:

- *Who are you?*
- *Where have you come from?*
- *Where are you going?*

And when you think about *where are you going*, include a commitment to be a mentor to someone.

Former Surgeon General Dr. C. Everett Koop once said to a physician audience, "Each of us carries the whole profession on our shoulders." I believe this applies equally to all of us who think of ourselves as CME Professionals in what has clearly become the discipline of CME.

In closing, the essence of Frances Maitland may be captured with these words from Frank Outlaw, as related to me by one of my mentors, Dr. Roy Schwarz:

Watch your thoughts; they become words.  
Watch your words; they become actions.  
Watch your actions; they become habits.  
Watch your habits; they become character.  
Watch your character; it becomes your destiny.

#### Reference

1. Detsky AS, Baerlocher MO. Academic mentoring—how to give it and how to get it. *JAMA*. 2007;297:2134–2136.

#### Mentors:

1. **Listen**
2. **Are honest**
3. **Are tolerant**
4. **Do not promote their own agendas**
5. **Take you to the next level**
6. **Are supportive, and follow through**
7. **Are sensitive**
8. **Can help see the future**
9. **At times are teachers**
10. **Aren't always friends**
11. **Are humble.**

# 2010 Award for Innovation in Continuing Professional Development for the CME Professional and/or Enterprise

In Recognition of Outstanding Innovation in Continuing Professional Development for CME Professionals

**Bruce J. Bellande, PhD, FACME, CCMEP, President**

**Heather Flynn, BS, Manager, Medical Informatics and Continuous Quality Improvement**

**Sheila Robertson, MPH, CCMEP, Educational Design, Development and Delivery Director**

**Richard J. Thielen, PhD, Manager of Content and Curriculum**

**All from CME Enterprise, Inc.**

## Educating from the Inside Out: A Provider Model for Continuing Professional Development of CME Professionals

Ralph Sanchez, MD, to whom this award is dedicated, was a long-time and dear friend of mine. For those who did not know Ralph, he was a physician, educator, and lifelong CME professional. During my tenure as Executive Director of the Alliance, Ralph and I would speak monthly. As time passed, Ralph's physical health progressively deteriorated, but his mind remained clear and sharp. Because of Ralph, I view this award as more than an honor. It is a testament to his vision, his friendship, and his legacy in the many contributions he made to us as professionals and to our profession. He is dearly missed.

—Bruce Bellande

Like all ACCME-accredited providers, CME Enterprise, Inc. is being challenged to stay ahead of the curve by developing more innovative and cost-effective approaches to CME. We face increased scrutiny within the industry, the government, and the media, resulting in a *survival of the fittest* environment that raises the question: *What will it*



Award for Innovation in Continuing Professional Development (L to R): Bruce Bellande of CME Enterprise, and Mila Kostic, Leader of the Award Selection Panel. Not pictured, recipient Heather Flynn of CME Enterprise.

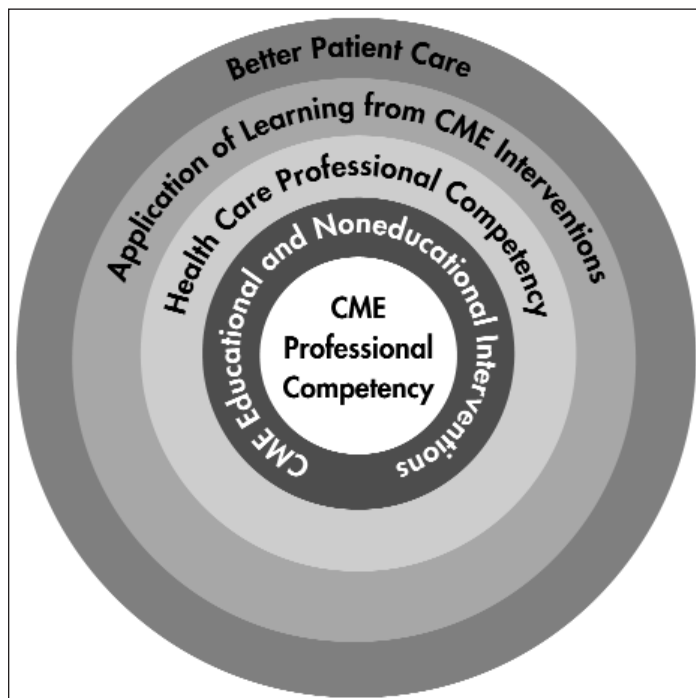
take to remain a viable player in the CME arena? The answer for our company began with a serious look inside our organization—at our people. We already have a good core of professional expertise; however, we believe that further investment in the competence of our team is critical not only to assuming greater leadership in the rapidly evolving world of learner-centered CME, but also to demonstrating our own

commitment to continuous professional development. We cannot ask health care professionals to commit themselves to performance improvement and lifelong learning if we as CME professionals don't *walk the talk*. It stands to reason that we incorporate adult learning principles into our own performance improvement, thus *educating from the inside out* (see Figure 1).

## Purpose and Foundation

In January 2009, the CME Enterprise president and leadership team collaborated to develop and implement a

**Figure 1: Educating from the Inside Out**



CPD program to support staff in maintaining their skills and developing new competencies while adding depth and structure to already-occurring CPD activities in various levels of formality. This effort directly supported Alliance Competencies 8.2 (*continually improve educational performance of the CME program through professional development*) and 8.3 (*promote professional development for self and staff*), as well as ACCME Criteria 13 and 14 regarding process improvement to meet the CME mission.

Fortunately, we had already clearly defined competencies for CME professionals based on the eight Alliance *Competency Areas for CME Professionals* and the five domains of the National Commission for Certification of CME Professionals exam to use as the program foundation.

### Needs Assessment and Gap Analysis

As with any educational initiative, we first identified existing gaps around which to plan the curriculum, and all staff completed a CPD self-assessment survey, closely replicating the Alliance CME Professional Competencies Self-Assessment. On a scale of one to five (where one=none and five=great), employees rated the relevance of each competency to their jobs and the extent to which they had attained that competency. We then analyzed the gaps, subtracting the proficiency rating from the relevance rating to calculate a priority level for those with relevance greater than two: Priority 1 was a difference of 1.0 or more; Priority 2 a difference of 0.50 to 0.99.

Data analysis at the aggregate organizational level found no Priority 1 gaps. Although a competency may have represented a large gap/need for a particular individual or department, due to the diverse roles and experience levels across the company, the aggregate data did not indicate any critical priorities. Overall staff competence was already high, validating the need for a flexible and customized CPD program addressing specific gap areas and setting the stage for targeted growth.

We then outlined four metrics by which to gauge the success of our pilot:

- 60 hours of CPD per employee
- Certification (whether certified CME professional [CCMEP], project management, or quality improvement) by 50% of our staff
- Summative evaluation to assess staff satisfaction and their perception of the program's success
- Repetition of the self-assessment survey to measure gap closure.

As CME professionals, we know that contact hour requirements, like *seat time*, are not surrogates for the more important higher level outcomes. Our purpose in setting a contact hour target was to motivate all staff to engage in the more formalized CPD program. Because we knew that some staff would be participating in project management or quality improvement training provided through our parent organization, positioning those staff to acquire a considerable number of hours in pursuit of certifications, we set the bar high to reflect that additional training.

### Curriculum Framework

After reviewing the needs assessment data, we inventoried our existing CPD interventions and brainstormed ways to address the identified gaps through a coordinated, companywide program. We envisioned multiple interventions anchored to a major initiative in which staff could choose to participate. Because the identified needs were so varied across the company, we decided to develop and conduct CCMEP certification exam study sessions as the cornerstone of our pilot. Our president, a former executive with the Alliance and himself a CCMEP, developed and presented the course, each session covering one competency or domain. All staff received binders containing a study guide complete with terminology, literature references, and examples.

Our ongoing journal club became another program staple. During these sessions, various staff members are assigned articles in publications such as the *Journal of Continuing Education in the Health Professions*, the *Journal of the American Medical Association*, and the *Harvard Business Review*. They then present key pearls that can be applied in our work to address scientific and content-related needs, as well as issues in communication and project management. These sessions are highly interactive, as all staff members are expected to contribute their perspectives and critique.

In addition, we conduct regular training on policies and procedures to ensure that we remain compliant with our own regulations and those of stakeholders. We also participate in relevant webinars, and staff who attend major meetings, such as the Alliance annual conference and the AMA task force on CME Provider/Industry Collaboration, debrief the group on key takeaways that can be applied creatively throughout our organization.

Another key element of the CPD program is our robust resource library, which *endures* the life and reinforces the learning of our live interventions by archiving handouts, study materials, and recordings of some interventions. In addition, our medical librarian routinely compiles

supplemental resources such as book chapters, slide sets, and peer-reviewed literature to further support staff seeking certification(s), advanced knowledge or enhanced competency.

### Administration and Tracking

For every companywide intervention, our office manager is the central scheduler. A standard sign-in sheet is used, and details such as the host/sponsor, title, date, time, potential and claimed contact hours, and handout status for the resource library are recorded in a tracking spreadsheet. For other interventions, such as national conference attendance, an abbreviated attestation form is used to verify contact hours. Most importantly, every intervention is tagged with both the Alliance competency area(s) and the CCMEP domain(s) to which it relates. This helps us produce a curriculum calendar of focused interventions that are linked to our gaps.

### Outcomes and Lessons Learned

We recently completed our program's summative evaluation of the pilot year, garnering valuable staff feedback. We have exceeded our goals for contact hours per employee and for certifications attained. Nearly 90% of staff thought the curriculum was relevant; however, many suggested tailoring the interventions to the individual's department and role (this will be implemented via individual learning plans in 2010). Staff indicated that, as a result of participating in CPD, their job proficiency improved either modestly (68% of staff) or significantly (16%).

One lesson learned was to be realistic about the staff time commitment in terms of both number of hours and work interruptions. In 2010, we intend to mitigate schedule conflicts by using the resource library more effectively. With advancements in tracking capabilities and program sophistication, staff will plan and track their own CPD through individual learning portfolios. By incorporating the

library into their personal development plans, staff can receive credit for study at times that suit their schedules and learning preferences.

Another lesson learned was to develop the curriculum at a pace we can realistically handle. It became clear we should first enhance the system at the company level and learn how it can best work for individual staff and our organization as a whole, later expanding our efforts at the departmental level to address needs unique to the responsibilities of individual department staff.

This CPD program can be applied without great cost or sophisticated technology. We utilize practical methods and tools as a way of putting into practice the Alliance competencies for a small to mid-sized provider, with substantial capabilities for long-term growth and large-scale application. Our CPD program capitalizes on many of the skills and practices our professionals already use in planning and implementing CME activities, thus representing an internal application of adult learning, activity planning, and measurement principles. The insights we gain from putting ourselves in our learners' shoes then cycle back to improve our day-to-day work so we can better assist health care professionals in providing optimal care for their patients.

### Points for Practice

- Use the principles of adult learning in CPD.
- Clearly define CPD competencies.
- Identify the CPD metrics of success.
- Be realistic about the staff time commitment to CPD.
- Develop the CPD curriculum at a realistic pace.

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# 2010 Award for Outstanding Live CME Activity

In Recognition of an Organization Responsible for Innovation and Excellence in the Design, Educational Format, and Instructional Delivery of a Live CME Activity

**Neil Love, MD, President**

**Brian Moss, BS, MBA, Executive Vice President**

**Douglas Paley, BA, Director, Communications**

**Kathryn Ault Ziel, PhD, Director, Medical Education**

**Aviva Asnis-Alibozek, PA-C, MPAS, Executive Scientific Director**

**All from Research To Practice**

**Exploring the Clinical Decisions of Community-Based Oncologists and Hematologists in the Management of Multiple Myeloma and Non-Hodgkin's Lymphoma**

## Background

Paramount to the successful development of educational activities that address the practical management concerns of physicians in practice is the effective identification and analysis of educational gaps of the target audience. Traditionally, educators have employed numerous different methods, mechanisms and strategies to accomplish this essential goal, but our organization, Research To Practice (RTP), has long favored the use of scientific, research-like approaches to obtain robust gap analysis data. This information is then used as the foundation for the distinct CME activities we have created.

One of the organization's most innovative and extensive efforts of this type took place during the recent development of a live symposium held in conjunction with the American Society of Clinical Oncology (ASCO) 2009 annual meeting. Prior to launching this initiative, we hypothesized that by gathering and aggregating actual treatment information obtained from real, de-identified patient cases managed by community-based oncologists and hematologists, a snapshot of clinical oncology practice could be developed, thereby uncovering potential educational gaps. We then postulated that this information could be used to shape the content for a live CME activity intended to increase clinician knowledge and competence.



Award for Outstanding Live CME Activity: Brian Moss, representing Research To Practice and recipient Neil Love.

## Methods

To capture the aforementioned treatment information, we created an electronic database of cases focused on the management of multiple myeloma and non-Hodgkin's lymphoma, specifically follicular lymphoma. These two topic areas were selected based on previous needs assessment findings documenting clinician educational interest in these diseases and the extensive amounts of new data that emerged over the past year and a half in these tumor types.

To begin this process, our clinical staff analyzed all recently published clinical trial findings, current staging guidelines, recommended therapeutic algorithms and other aspects of disease management to define the demographic and treatment variables required to effectively illustrate the current clinical practice profile for each tumor type. We also made the important decision to collect other information related to the patients' work situations, lifestyle, support structures and communication preferences. After development and submission of a comprehensive protocol describing the retrospective nature of the proposed data collection, we received institutional review board exemption and approval to proceed with the project.

We then designed and launched an online questionnaire and database to capture and aggregate the finalized case-specific variables. Forty-one community-based oncologists and hematologists were recruited and asked to provide de-identified information for up to five patients from their practices in each of three specific clinical situations—multiple myeloma at first diagnosis, follicular lymphoma at first diagnosis and relapsed follicular lymphoma, all treated on or after January 1, 2008. An honorarium was provided for contributing to the database. Over an approximately three-week period from April 10–27, 2009, the participating clinicians entered 435 individual cases into the database, consisting of 203 cases of multiple myeloma at first diagnosis, 130 cases of newly diagnosed follicular lymphoma and 102 cases of relapsed follicular lymphoma.

After the acquisition of this information, our clinical team worked to segment and analyze the clinical and

psychosocial data. During this assessment, RTP observed a number of educational gaps. For example, in more than half the cases entered into the myeloma database, the disease was either improperly staged or not staged based on the most up-to-date International Staging System (ISS) criteria.<sup>1</sup>

Similarly, for patients with newly diagnosed multiple myeloma, a fraction of clinicians failed to obtain interphase fluorescence in situ hybridization (FISH) and/or metaphase cytogenetic assessments as part of the routine diagnostic evaluation, even though these tests are guideline-recommended risk-stratification elements of the standard investigative workup.<sup>2</sup> Furthermore, 14% of clinicians did not report obtaining  $\beta$ 2-microglobulin values, a required component of the ISS calculation (see Figure 1).

These and other data points served as the primary gap analysis for the development of the learning objectives and agenda for a CME-certified symposium. We then assigned each of the six faculty members, including the co-chairs invited to participate in the event, a specific topic relevant to the database findings on which to prepare a didactic presentation. We also isolated six cases from the database that ideally illustrated the education gaps observed. The organization invited the contributing community-based medical oncologists to attend the meeting and provide their perspectives on the selected cases and the management decisions they used.

The 2.5-hour symposium was held on Sunday, May 31, 2009 in Orlando, Florida in conjunction with the 2009

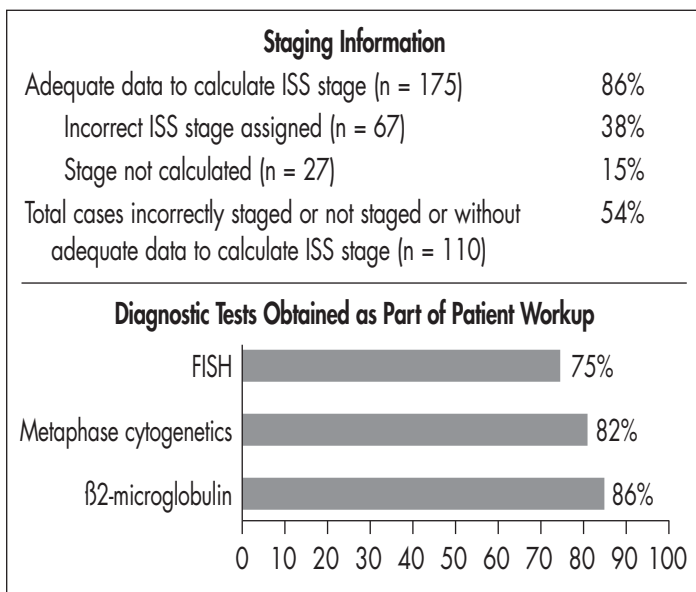
ASCO meeting. More than 250 oncology clinicians and health care professionals attended the event, which was divided into two parts with the first 1.25 hours focused on multiple myeloma and the second 1.25 hours dedicated to follicular lymphoma.

Three investigators with an expertise in myeloma and three community oncologists served as the panel for the first segment. To begin, the moderator, Dr Neil Love, explained the rationale for the development of the case database and then presented a number of data slides illustrating findings from specific clinical situations. He then called on one of the investigators to deliver a presentation reviewing published data to guide evidence-based decisions in the discussed treatment setting. After the presentation, a community-oncologist panelist presented a case from the database for discussion and commentary by the faculty.

This format was used for the rest of the myeloma section. Halfway through the event, the faculty and community-oncologist panelists were replaced with investigators with an expertise in the management of lymphoma and three new community-based clinicians. The format was resumed, focusing on results obtained from the lymphoma section of the database. Throughout the event, interactive keypad polling was employed to gauge the audience's perspectives and treatment recommendations. These responses were compared to relevant findings from the database to observe similarities and differences between these two groups of practicing clinicians.

To allow those not able to attend the opportunity to access the proceedings, this educational intervention was also transmitted live via webcast, and an archived version is available online on our website ([www.researchtopractice.com](http://www.researchtopractice.com)).

**Figure 1: Multiple Myeloma Case Database (N = 203)**



### Educational Outcomes Measurement

To analyze changes in learner competence and performance achieved as a result of the educational intervention, we developed a premeeting, case-based questionnaire intended to gauge baseline learner knowledge and practice patterns. The goal was to compare these data to a postactivity survey to assess changes in competence. We invited approximately 50 registrants to complete the survey in advance of the activity. Eighteen attendees elected to fill out the questionnaire. In the days after the event, we invited the 18 attendees who participated in the premeeting educational outcomes measurement (EOM) survey to complete a follow-up questionnaire. Twelve individuals provided their responses to the subsequent set of case-based questions. The results from this assessment illustrated a number of clear instances of change in learner competency.

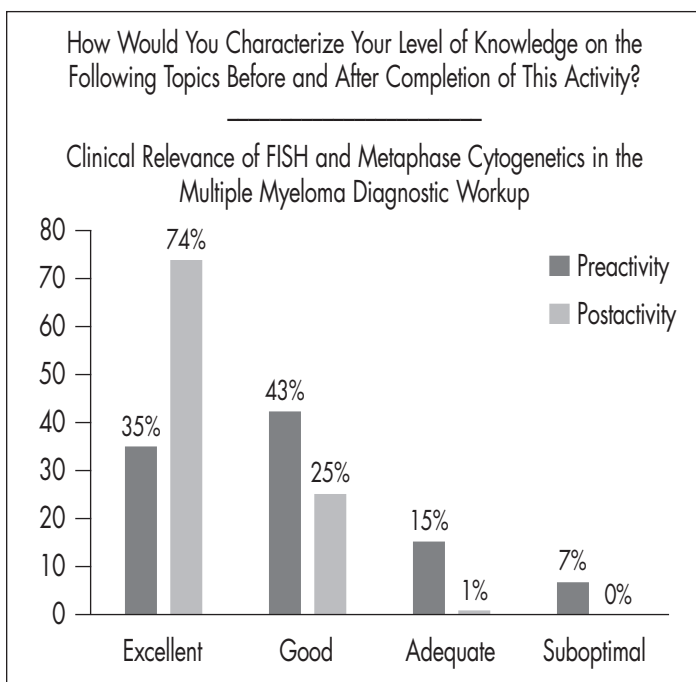
Similarly, we also utilized an immediate postmeeting CME evaluation, a part of which focused on subjective pre and postmeeting characterization of knowledge level. Results obtained from these queries further documented the effectiveness of the activity (see Figure 2).

Of equal importance, our scientific staff believed that the data obtained via the database were so novel and important that they merited further presentation and dissemination among oncology professionals. To that end, the organization submitted an abstract and was ultimately selected to present a poster during the scientific session at the recent American Society of Hematology annual meeting.<sup>3</sup> This enabled us to share findings from this project with a significant international audience.

### Conclusions

Based on the EOM and the scientifically relevant nature of the data obtained, we believe the creation and use of a case database as a primary needs assessment vehicle and content platform for a live educational event is both desirable and potentially beneficial to attendees and the oncology community as a whole. Although evaluations of additional initiatives of this kind are necessary to further substantiate these assertions, the success of this preliminary experience, and the information obtained, necessitates that

**Figure 2: Select Metrics from RTP's Immediate Postactivity CME Evaluation (N=84)**



other providers give consideration to this format. We hope to repeat and expand on this concept with a similar project in 2010.

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### Acknowledgement

This activity was supported by an educational grant from Millennium Pharmaceuticals, Inc.

### Points for Practice

- An electronic database of actual case information provided by practicing physicians is a feasible needs assessment strategy that can be implemented by other CME providers.
- Data gathered via a case database can be used to provide scientifically robust gap analyses meaningful not only to CME activity design but also to clinical patient care.
- A live CME activity to directly discuss and address specific data points obtained from a case database can help improve clinician knowledge and competence.



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# 2010 Award for Outstanding CME Enduring Material

In Recognition of Excellence in the Design and Implementation of a CME Enduring Material Activity

**Michael Reilly, MS, Vice President of Performance Improvement and Continuing Medical Education, QuestMedEd, LLC**

**Nancy Davis, PhD, President, National Institute for Quality Improvement and Education**

**Janet Cline, RPh, President, Creative Educational Concepts**

**Dana Frazier, BS, BBA, Director of Distance Education, Creative Educational Concepts**

**Simone Karp, RPh, Chief Business Officer, CECity**

The 2010 Alliance award for outstanding CME enduring material went to *Diagnosis and Staging of Multiple Myeloma and Front-Line Therapy for the Transplant-Ineligible Patient: Treatment Planning*, which is the first of eight modules in *Multiple Myeloma Translating Learning Into Care™: What's Best?*, released in May 2008. The activity is a true collaborative effort, certified for CME and other continuing education (CE) credit by Creative Educational Concepts. Other partners included QuestMedEd, CE City, and the National Institute for Quality Improvement and Education (NIQIE).

## Overview

This activity was designed to address educational gaps among the entire myeloma care team, with a specific focus on the needs of community-based practitioners, to assist them, where appropriate, in implementing practice change to enhance patient care. These changes were demonstrated through the use of Moore's CME Outcomes Evaluation Levels, specifically Level 4: Competency, using cases as surrogates for actual practice.<sup>1</sup>

Several factors made this enduring CME activity uniquely qualified to make a positive change in practice. First, multiple methods of needs assessment were utilized:

1. A literature review
2. A national formal, community-based, independent needs assessment



Award for Outstanding CME Enduring Material (L to R): Dana Frazier and Janet Cline of Creative Educational Concepts, Michael Reilly of QuestMedEd, LLC, Simone Karp of CECity and Nancy Davis of the National Institute for Quality Improvement and Education. Not pictured, recipients Lisa Tushla of Terranova Medica, LLC and Erica Johansson of Astute CE.

3. In-depth interviews of community-based members of the target audience
4. Formal participation of an interdisciplinary planning committee. This academic, community-based committee met live twice during the period to engage in an ongoing needs assessment/refinement of the activity and was also actively engaged throughout the life of the activity.

Additionally, the content was developed and designed under the guidance of a community-based, academic and interdisciplinary faculty able to address specific performance goals for fast-changing recommendations in management of an oncologic tumor type in the absence of nationally-defined performance criteria.

Finally, it employed a unique, eCME format specifically designed per adult learning principles to:

1. Maximize engagement
2. Reinforce learning and measure competency in surrogate cases
3. Build a community of practice
4. Address both treatment planning and supportive care issues that are relevant across audiences
5. Address nonclinical barriers to best care
6. Gather data to measure learning, retained knowledge, and competency.

## Needs Assessment

The development of the needs assessment was a multi-step process. After conducting a literature review and interviews with community-based oncologists, an initial set of

learning objectives was formulated. These learning objectives were revised, and relevant performance goals unique to myeloma were created after meeting with the interdisciplinary planning committee and faculty along with consulting the national performance criteria in oncology. Further, the planning committee recommended educational design enhancements to address participants' needs in multiple myeloma management. These included a rollover glossary with definition of key terms to ensure participant understanding and a multiple myeloma toolkit containing vetted resources to supplement the educational activities—many specifically designed to address nonclinical barriers to care.

### Educational Objectives and Demonstration of Competency

Educational goals for the module, *Diagnosis and Strategies for Transplant-Ineligible Patients*, included the following areas: initial diagnosis/evaluation, evaluation of regimens, follow-up strategies, and risk stratification. Participant performance for meeting these objectives was measured by their scores in the core component of the activity. Participants' *competency* was measured by their scores on the three associated web-based case scenarios as they addressed the following: improving communication

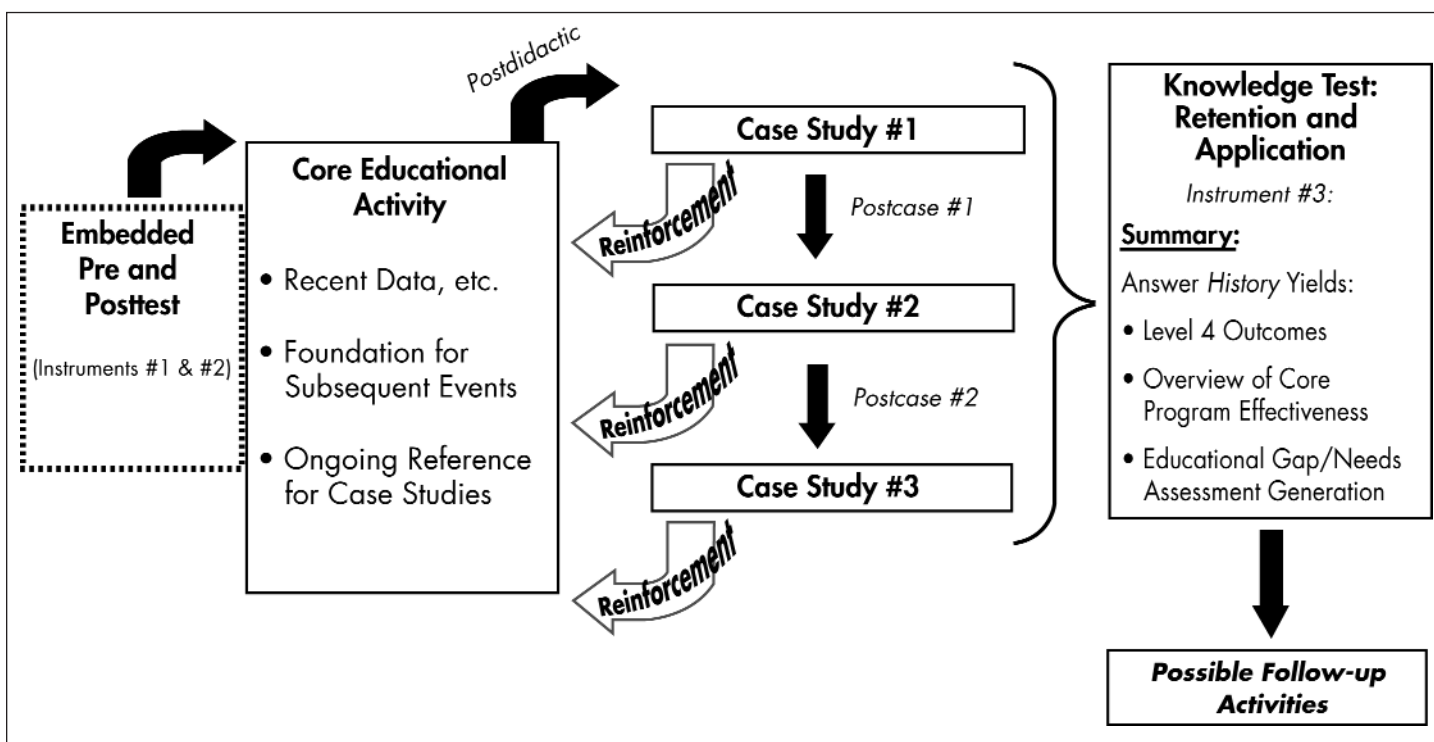
among care team members, instituting an evidence-based diagnostic work-up (checklist), choosing appropriate therapy based on patient characteristics, prescribing patient education, and appropriately enrolling patients in clinical trials.

### Overall Educational Design/Methodology

Employing the QuestMedEd *Translating Learning Into Care (TLC®)* process based on CECity's technology platform, this unique web-based educational activity consisted of four inter-related sequential teaching events that were designed to instruct, apply, and actively reinforce key concepts in the diagnosis, treatment, and management of multiple myeloma (see Figure 1). This *bundled* approach sought to ensure that participants would be engaged in the activity over a period of time. Throughout the four teaching events, evidence-based data and recurring key treatment principles were reinforced and supported through the sequenced case scenarios.

The activity began with a one-credit *core* activity presented in an interactive didactic video format. Upon successful completion of the core activity, the system automatically emailed participants a series of three relevant clinical case scenarios that asked them to utilize and correctly apply key concepts and data from the core

**Figure 1. QuestMedEd TLC® Educational Design/Process Overview**



program. Each case was eligible for 0.25 credits. By reinforcing the principles of the core activity, the case studies assisted the participant to apply the knowledge and data learned in practical, relatable terms for implementation in daily practice.

As participants progressed through the activities, embedded question and answer components enhanced the learning experience with active links to the relevant data housed within the core didactic activity for reference. Upon answering test questions participants were re-directed to the specific slide containing the pertinent data to reinforce teachings from the core activity. This type of interactive feedback and reinforced learning is a proven method of adult learning principles shown to give the best results for knowledge gain and retention.<sup>2</sup>

***As participants progressed through the activities, embedded question and answer components enhanced the learning experience with active links to the relevant data housed within the core didactic activity for reference.***

Additionally, as this was a web-driven activity, data were automatically collected regarding participant progress through the series, and several reference points were obtained throughout the activity:

- The participant was tested prior to the activity (Instrument #1).
- The participant proceeded through the activity and was again tested on key teaching points to determine learning (Instrument #2).
- Finally, that knowledge was tested in the clinical case scenarios that followed the core activity (Instrument #3).

Instruments #1 and #2 were identical tests allowing for consistent result comparisons. Instrument #3 consisted of clinical questions relating to the core content. These datasets allowed for a robust analysis regarding educational gaps and program effectiveness, yielding far more useful outcomes data than traditional CME testing methodologies.

The TLC process provides a sequenced, modular curriculum to support knowledge translation, resulting in:

- Evidence-based learning activities
- Knowledge retention/application measurement

- Pre and postactivity gap analysis
- Level 4 Outcomes (using cases as surrogate *practice*).

In addition, multiple formats were utilized to meet the needs of different learner types, (eg, auditory/visual/print) and included optimized instructional design processes for participant engagement such as:

- Downloadable slides
- Printable transcripts/speaker notes
- Additional related content (eg, care flow and diagnostic summary sheets).

At the request of the faculty planning committee, the content was designed toward the entire myeloma care team, which included physicians, nurses, and pharmacists. However, this first module was focused on treatment planning and, although accredited for all three professional groups, was deemed most relevant to the needs of the practicing physician.

The complexity of the activity called on the expertise of several organizations to collaborate in the overall design and execution of the project:

- Accreditation and oversight: Creative Educational Concepts
- Design and implementation: QuestMedEd
- Performance and competency measures: NIQIE
- Technology and distribution: CE City.

## **Evaluation**

Outcomes analysis for the activity has demonstrated the TLC format (core content followed by short, follow-up cases with built in pretest and posttests) actively engaged the learners. The high proportion of certificates as well as the large number of repeat learners speaks to the high level of engagement of a very busy target audience addressing a relatively rare tumor type. This finding supports the value of the curriculum-based learning and the power of the Internet with respect to convenience and learner engagement. Other important outcomes were observed:

### *The Educational Design Worked*

Learning was reinforced and learners showed a higher level of competency as they progressed through the activities. Those who participated in the core activities showed higher levels of competency on the cases compared to controls, demonstrating the value of reinforced learning in the core activities. Further, the improvement in outcomes as well as the remarkably high participation in the cases

validates the use of performance goals generation as well as the relevancy of the cases.

### A Community of Learners was Built

The increasing participation in the curriculum over time is consistent with the building of a community of learners. This is particularly challenging for a busy group of professionals managing a relatively rare tumor type, but the high user return rate, the active engagement, and the in-depth review of topics using a disease-state approach keeps the participants engaged.

### The Integrated, Interdisciplinary Approach Worked

Support of an interdisciplinary expert planning group and faculty resulted in development of a well-designed cross-disciplinary activity. The remarkable educational gap seen among physicians in the supportive care module, traditionally the role of nursing and other professionals, followed by significant improvement lends credibility to the team approach and the need for interdisciplinary education of physicians on supportive care issues.

### Validation that Education Should Address Nonclinical Barriers

The high user satisfaction scores, the consistent reference to nonclinical barriers to care among the faculty, and the verbatim response (ie, *I will prescribe patient education*) support the essential role of addressing nonclinical barriers to care as part of performance-improvement CE.

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## Appendix: Participation and Outcomes

Tables 1 and 2 demonstrate the utilization and outcomes of the Multiple Myeloma TLC Module 1 initiative in terms of participation and educational impact.

Postactivity evaluations have yielded ~95% of participants rating the activities as *Good to Excellent*.

### Analysis

The proportion of correct answers overall rose from 55.5% pretest activity to 62.2% postcore as measured by Instruments #1 and #2. Instrument #2 provided information

to the learner as to whether he/she answered right or wrong and the rationale for the answer, but did not allow the participant to correct his/her answer. In the follow-up period, individuals who completed the core plus the associated cases answered 89.7% of the case-associated questions correctly overall. This represents a large delta from the precore assessment.

A unique output from the TLC activity design is Level 4 (competency) outcomes. Our project demonstrated that participants have a sequential improvement in knowledge as they progress through the activities, with an impressive 89.7% (overall) correct with regards to retaining and correctly applying knowledge in surrogate case examples. A *control group* consisting of participants who accessed the same cases without the initial core educational activity scored substantially lower, with an average of 54.9% (overall).

The proportion of correct responses in the case controls (individuals who completed the cases but who did not complete the core activity) was actually similar (54.9%) to the proportion of correct responses among the individuals at the precore assessment (55.5%). This suggests:

**Table 1: Demographics of Multiple Myeloma TLC Module 1\***

Profession	Core	Case 1	Case 2	Case 3	RPh Cases**	Total
MD's	1312/309	298/213	249/192	207/185		2066/899
RN's	526/66	196/40	144/40	65/30		931/176
RPh	433/87	–	–	–	122/39	555/126
Other	118/9	38/6	26/7	13/4		195/26
Total	2389/471	532/259	419/241		122/39	3747/1229

Time (mean) between core and cases: 12 days

\*Key: Accesses/Certificates

\*\*RPh completed all three cases at once as required by ACPE

**Table 2: Outcomes Results (Correct Responses)**

Profession	Pretest	Posttest	Cases	Control * n = 78
Overall	55.5	62.2	89.7	54.9
MD	42.6	53.4	97.0	71.8
RN	53.1	82.3	56.7	53.3
RPh	40.4	72.7	59.4	54.8

\*Control: individuals who completed the cases but did not complete the core activity

1. The case answers are sufficiently difficult to challenge the participants and measure knowledge/competency.
2. Individuals who progressed through the core activity demonstrated a real and substantial improvement in retained knowledge and competency.

The data trends of sequentially increasing scores over time is consistently repeated in similar activities in other therapeutic areas, and we believe that the TLC model has a substantial educational impact on the learners that goes far beyond traditional CME activity designs.

## 2010 Award for Outstanding Educational Collaboration

**In Recognition of Those Organizations Best Demonstrating Innovation or Uniqueness in Achieving Effective Educational Collaboration**

**Curtis A. Olson, PhD, Head of Research and Development, Office of Continuing Professional Development, University of Wisconsin-Madison**

**An Innovative Pilot Project to Enhance Clinical Reasoning in Treatment and Management of Cardiovascular Risk Factors**

### Background

A significant challenge for CME professionals is how to develop and assess the impact of educational activities in what might be called the *gray zones* of clinical practice—the areas in which decisions about diagnosis, treatment, or management require a heavy measure of professional judgment. In these aspects of practice there are no right answers. Even experts will disagree on the best approach for a given patient. There is no single right answer or unambiguous clinical practice guideline that can be used to describe the right approach. In such matters, deliberations over what should be done resembles ethical discourse—what matters most are the reasons behind the decisions and the persuasive power those reasons carry.

The treatment and management of cardiovascular risk in patients with complex conditions is an example of a gray zone of practice. Decision making cannot be reduced to straightforward, algorithmic approaches but instead



Award for Outstanding Educational Collaboration (L to R): seated, Joe Green of the American College of Cardiology, Suzanne Murray of AXDEV Group, Curt Olson of the University of Wisconsin School of Medicine and Public Health, and Marcia Jackson of CME By Design; standing, Sean Hayes of AXDEV Group, Michelle Klinke of the American College of Cardiology, George Mejicano of the University of Wisconsin School of Medicine and Public Health, and Elizabeth Yarboro of the American College of Cardiology. Not pictured, recipients Martin Dupuis of AXDEV Group, Tricia Tooman of the University of Wisconsin School of Medicine and Public Health, and Steve Ommen and Rick Nishimura of the Mayo Clinic.

requires a high degree of professional judgment, careful reasoning and adaptation to the needs and preferences of the patient. The challenge, at least in part, is due to the fact that guidelines highlight general practice recommendations but do not describe how those recommendations can be applied at the point-of-patient-care to complex patients. It is even more challenging when results from large, prospective studies lead to divergent recommendations.

### Purpose

This project, funded by an unrestricted educational grant from Pfizer, was designed to enhance the clinical reasoning skills of practicing cardiologists treating patients with complex conditions. To accomplish this goal we developed and pilot-tested an innovative educational approach that provides participants with a series of realistic clinical vignettes and poses questions designed to help participants make more explicit their clinical reasoning process and compare their reasoning to not only that of other participants in the workshop but also nationally recognized experts in the field. As a secondary goal we sought to provide a model for effective collaboration between academia, the private sector and practicing physicians in developing and evaluating an educational intervention.



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## Partners

Four organizations collaborated to develop and pilot test an innovative educational intervention model based on the *script concordance (SC) approach* (see definition below) to optimize a critical aspect of clinical care in cardiovascular health: the University of Wisconsin (UW) Office of Continuing Professional Development in Medicine and Public Health—lead, AXDEV Group International (AXDEV), American College of Cardiology (ACC), and Mayo Clinic.

## The SC Approach

Bernard Charlin and colleagues at the University of Montreal developed an approach that we believe has promise as a tool for providing education in gray zones of practice.<sup>1</sup> Called the SC test, this tool was originally developed as an evaluation method for assessing the clinical reasoning of health care professionals. A clinician's capacity to perform effectively requires that he or she has the relevant knowledge and that the knowledge is cognitively organized for effective and efficient application to clinical problems.

The mental organization of knowledge for the purpose of effective clinical practice is called a *script*.<sup>1</sup> In an SC test, examinees are presented with a problem scenario or vignette to which they are asked to respond as a means of activating the relevant script (see Figure 1). The task is designed to be challenging, even for an expert, because the vignette either lacks data needed to provide a clear definition of the problem (for example, a diagnostic test) or because several alternative actions are defensible. The structure of the test items follows what is known about the clinical reasoning process and includes questions that experts ask themselves as they progress toward a solution.<sup>2</sup>

As part of the development process, the test is administered to a panel of experts who provide their answers to the test questions along with a description of their reasoning. It is assumed that the experts will not agree on all items. Instead, expert answers are used to develop a scoring rubric that can be used to measure how well the learner's response agrees (is *concordant*) with the range of responses given by the experts. The testing process is designed to yield a numerical score that reflects the proportion of the expert panel that agreed with the learner's answer.

## Educational Goals and Project Strategy

The *educational goal* of the SC workshops was to enhance the clinical reasoning of participants in regard to the assessment and treatment of cardiovascular risks in

patients with commonly occurring, yet complex and challenging, clinical problems in the following specific areas:

1. Treatment and management of patients with multiple concomitant complications and cardiovascular risk factors
2. Balancing the benefits and risks of complex treatment regimens
3. Integrating unclear treatment evidence.

Our *strategy* was to use a research and development approach to designing and testing an educational intervention. The intent of this approach was to bring results from research into practice by translating them into usable educational approaches and subjecting them to rigorous evaluation. This initial phase of the project was designed to assess the feasibility of SC as an educational and outcomes measurement approach, obtain information useful for revising and improving the workshop, and to inform decision-making about the advisability and direction of a second phase, which would focus on implementation on a wider scale.

## Educational Activity

Developed around the SC test we developed, the activity was designed to facilitate discussion and debate among

### Figure 1. Sample SC Test Item

A 52-year-old male patient is referred to you for hypertension and a family history of premature cardiovascular disease. He is active and completely asymptomatic. He does not smoke and never had any other medical problems. On exam he has a BP of 155/95 mmHG both arms, pulse of 72 bpm and a normal cardiac exam. His BMI is 29 and he has a 40" waist circumference. A lipid panel reveals a total cholesterol of 240 (normal range <200), LDL of 165 mg/dl, HDL 38 mg/dl (normal range 40–85) and TRIG of 142 mg/dl (normal range <150). A fasting blood sugar was 101 mg/dl (normal range 70–105). He has started a daily low-dose aspirin.

If you were thinking of . . .

Starting the patient on a HCT

And then you learned that . . .

His creatinine ratio is 2.7 mg/dl (normal range 0.5-1/3 mg/dl)

You would consider this approach . . .

- Strongly contraindicated
- Contraindicated
- Neither more nor less indicated
- Indicated
- Strongly indicated



practicing cardiologists in relation to several cases that are typical of their routine clinical practice.

Each live activity was facilitated by a cardiology expert from the Mayo Clinic. At the beginning of the 90-minute workshop, participants took a paper and pencil version of the test. The remainder of the session focused on exploring with the participants what their answers were and why they answered the way they did. The facilitator read the test question and the participants used an audience response system to indicate how they answered on the test. The results were then displayed allowing participants to see how their colleagues in the room responded. The facilitator led a discussion with the group about the rationales behind their choices.

The process was designed to encourage participants to make explicit the reasons behind their choices and to encourage them to consider their choices and rationales in light of the reasons given by other participants, allowing them to critically reflect on their clinical reasoning process, comparing the factors that go into their decisions and the weight each factor is given in the decision making process. After five minutes or so of discussion, participants are shown how the expert panel responded and the reasons the experts gave to support their decisions. Finally, the participants were given an opportunity to change their answers if they had been persuaded to change their minds based on what they heard. This provided us with a pre/post comparison to see if we had an impact in the short term. At about two months after the activity, the test was administered to the participants a third time to see if changes endured over time.

Workshops were conducted in two locations, one in Texas and the other in Nevada, and were held in conjunction with national CME symposia. A total of 37 participants took part in the workshops.

### Evaluation Approach

This pilot program is being evaluated at Levels 1–4 using a mixed-methods approach.<sup>3</sup> A quantitative component was included to tell us if the educational activity resulted in learning and had any impact on clinical reasoning and involved obtaining and comparing test scores at three intervals (pre/post/follow-up). The qualitative component was designed to explore why and how the activity had (or did not have) an impact. It is giving us information about what factors influenced learning and brought about change in the cardiologists' knowledge, attitudes, and clinical practice behaviors. We are in the final phase of data collection and analysis and anticipate that results will be

***The task is designed to be challenging, even for an expert, because the vignette either lacks data needed to provide a clear definition of the problem (for example, a diagnostic test) or because several alternative actions are defensible.***

available in spring 2010. Preliminary results indicate that there was some improvement in scores on both the post and follow-up measures. Until the remaining data are collected, we are unable to determine if the change was statistically significant.

### Partner Roles

This project would not have been possible without the close collaboration of the four partners involved. Each group brought a unique portfolio of knowledge and resources to the table. The UW team provided overall leadership and served as the accredited provider. It also provided project management and on-site logistical support and was in charge of the development of the SC test. The UW team also designed and conducted the quantitative component of the evaluation. AXDEV brought its in-depth understanding of the needs of cardiologists in this area of clinical practice, served as the liaison with ACC leadership (helping to secure ACC's participation in the project), co-facilitated the educational activities, and designed and implemented the qualitative aspect of the evaluation. ACC was heavily involved in planning the educational activity and was instrumental in recruiting two nationally-recognized cardiology educators from Mayo Clinic to take part in the project. The Mayo Clinic faculty helped identify and recruit the expert panel, helped design the educational activity, served as expert panelists, assisted with the development of the SC test, and were the lead facilitators during the educational activities.

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# 2010 Award for Outstanding Industry-Supported CME Activity

**In Recognition of Excellence in an Industry-Supported CME Activity that Most Effectively Illustrates an Appropriate Relationship between a CME Provider and an Industry Supporter**

**Dion Richetti, General Manager, Discovery Institute of Medical Education**

## **iPointOfCare: Applying Evidence-Based Information About Multiple Sclerosis to Clinical Care in the Real World**

In September 2004, the then Secretary of the US Department of Health and Human Services, Tommy Thompson, declared the first decade of the 21st century as the *Decade of Health Information Technology*.<sup>1</sup> Although the focus of this initiative is on the adoption of electronic health records nationally, using technology to improve patient care overall is a priority, and CME is expected to keep pace.

The introduction of point-of-care (POC) CME in 2006 by the AMA created a new paradigm of learner-centered education. CME providers now had an opportunity to help physicians improve patient care by empowering them to use the time they spend researching information for CPD. Since 2006, the challenge for CME providers has been to create activities that are useful and accessible to the physician in practice and that follow the spirit and intent of the AMA Physician's Recognition Award (PRA).<sup>2</sup> This article describes how evidence-based information was used to develop a POC, technology-based education activity on multiple sclerosis (MS).

### **The Need for POC CME in MS**

As in any other area of medicine, physicians who treat patients with MS need to supplement their clinical experience by keeping current with voluminous data, continual additions to the medical literature, evolving treatment guidelines and perspectives, new treatment options, and drug interactions and contraindications. When working with patients, clinicians require access to data in real time, often when they are in the examining room with a patient. In the course of clinical practice, the typical physician will generate three clinical questions for every two patients.



Award for Outstanding Industry Supported CME Activity (L to R): Cynthia Guerra of Bayer HealthCare Pharmaceuticals and Dion Richetti representing the Discovery Institute of Medical Education. Not pictured, recipients Adrian Rabinowicz of Bayer HealthCare Pharmaceuticals and June Halper of the Consortium of Multiple Sclerosis Centers.

literature, although they are geared toward physicians in general practice.<sup>5,6</sup>

Physician errors, which significantly affect quality of care, are often the result of failures in judgment, problems retaining information, and lack of knowledge.<sup>7</sup> Ready access to information at the time of decision making is a way to prevent these errors. For physicians who work in a subspecialty such as MS, the ability to access evidence-based materials specific to the patient's disease can provide a level of certainty that supports clinical decision making and enhances patient care.<sup>8</sup>

### **iPointOfCare in MS**

The Discovery Institute of Medical Education (DIME), an independent, ACCME-accredited medical education provider, working with the Consortium of Multiple Sclerosis Centers (CMSC), realized that the POC format could help close professional practice gaps for neurologists who specialize in the treatment of patients living with MS.

In 2009, DIME and the CMSC jointly sponsored an Internet-based CME activity designed to help close identified professional practice gaps in MS. The result was a POC CME activity that serves the subspecialty of MS through a focused search function that uses only peer-reviewed, evidence-based sources.

The activity, named MS iPointOfCare®, is supported by an educational grant from Bayer Healthcare Pharmaceuticals. iPointOfCare is an evidence-based, clinical resource that provides answers to clinical questions

at or near the POC—where and when clinicians need information relevant to a patient’s disease. iPointOfCare is a learning tool that allows physicians and other health care professionals to quickly search a variety of resources, find answers to their POC questions, and obtain CME credit. iPointOfCare is available online and an Internet connection is required. A desktop widget supports multiple users and separately houses each clinician’s CME data.

DIME is accredited by the ACCME to provide CME for physicians. A total of 0.5 credit hour is awarded for each completed search. DIME designates this educational activity for a maximum of 0.5 AMA PRA Category 1 Credits™. The process requires that physicians:

1. Document a clinical question
2. Access clinical information resources
3. Apply the information (or not) to a patient’s care and treatment and document the outcome.

**How iPointOfCare Works**

As shown in Figures 1 and 2, the learner opens the desktop widget and enters one or more search terms. Search results appear quickly in an outline of relevant topics. Clicking a topic then displays a list of deeper resources. Opening a resource brings the learner to *the section of that resource* that best correlates with the search term(s). A long search through separate documents is not necessary. The search also provides links to external resources including MEDLINE, the Merck Manual, MS consensus statements, PubMed, PubMed journals database, and others. Once learners find the information they need and a search is complete, they can simply close the widget and return to patient care.

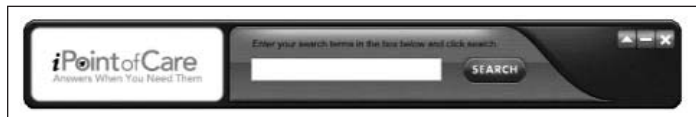
**Obtaining CME Credit for iPointOfCare**

The *Earn CME Credit* page (see Figure 3) gives learners direct access to their iPointOfCare record, which includes a summary of the clinical searches they have conducted. Learners may access and print out the CME credit page at any time by opening the widget and clicking on *CME Credit*. iPointOfCare sends quarterly emails to all registered users, reminding them to review their CME credit history and complete any searches that are unfinished. The email includes a link to the *Earn CME Credit* page.

The learner can print a CME certificate for each search immediately, and there is no limit to the number of searches a learner may conduct. Drop-down menus and check boxes make it possible for learners to evaluate each search,

reporting if the clinical question was answered, and describing how they applied this new knowledge in clinical practice. The first time a learner submits a search for CME

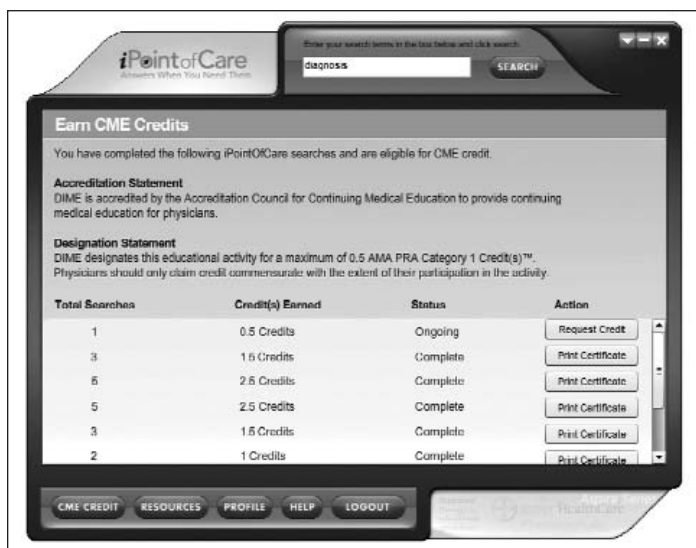
**Figure 1: The iPointofCare Widget Minimized—As it Appears on a Computer Desktop**



**Figure 2: The iPointofCare Widget Expanded—Showing the Search Bar and Search Results**



**Figure 3. iPointOfCare Screen Showing a Record of Searches and the Number of CME Credit(s) Earned for Each One**



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credit, a short activity evaluation is required. An additional evaluation is not required until the next calendar year.

In February 2010, we launched a smartphone application that allows physicians to access iPointOfCare from handheld devices including iPhone, Blackberry, and Android.

## Additional iPointOfCare Features for Learners

In addition to the search function and credit summary, iPointOfCare gives learners access to additional relevant features. In MS, for example, learners can find the following:

- Links to other organizations that are sources of relevant information (CMSC, International Organization of Multiple Sclerosis Nurses, National Multiple Sclerosis Society)
- Links to other websites whose resources and activities align with DIME's CME goals
- Downloads of physician tools and patient information
- A content-rating feature.

An editorial board provides oversight for iPointOfCare CME. In iPointOfCare for MS, all members of the editorial board must be members of CMSC, which supports the activity through a link on its website ([www.ms-care.org](http://www.ms-care.org)). DIME also features the activity through its Internet MS Education Resource Center ([www.multiplesclerosisprofessional.org](http://www.multiplesclerosisprofessional.org)).

## Success of iPointOfCare for MS

In January 2010, at its annual meeting, the Alliance honored DIME and the CMSC, along with the commercial supporter, Bayer Healthcare Pharmaceuticals, with the 2010 Outstanding Industry-Supported CME Activity Award for MS iPointofCare.

In the past year, as part of its CME Program, we expanded iPointOfCare activities to include cardiology (acute coronary syndrome) and diabetes, each with its own editorial board. iPointOfCare for other specialty areas is planned.

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## Points for Practice

- Focus first on physicians' need for an Internet CME activity, determine their motivation for using iPointOfCare of technology to find information, and design the application to meet their needs.
- Consider the depth of the activity and design educational objectives that are realistic—should objectives be narrow and detailed or broad and nonspecific?
- Ensure that adequate resources exist to keep the activity up-to-date with content that is current, evidence-based, objective, and balanced.
- Investigate the smartphone application as a way of bringing CME activities closer to the POC for many physicians.

## Congratulations to the Winner of One Complimentary Registration to the 36th Annual Conference

Everyone who was a paid participant for the 35th Annual Conference and filled out the evaluation/needs assessment form, as well as provided a name and email address on the form, was included in the drawing for one complimentary registration to the 36th Annual Conference, *The New CME—Blending Adult Learning Facilitation and Individual/Organizational Performance*. This conference is scheduled for Wednesday-Saturday, January 26-29, 2011, at the San Francisco Marriott® in San Francisco, California. Congratulations to the winner of that drawing, Trish Stern, CME Coordinator at the Guthrie Clinic in Sayre, Pennsylvania.

## Additional 2010 Annual Conference Photos and Award Winners



President's Awards (L to R): seated, Suzanne Ziemnik, Jane Eckstein, Greg Paulos, Sue Ann Capizzi, and Charmaine Cummings; standing, George Mejicano, Billie Dalrymple, Moss Blachman, Susan Cantrell, Jan Perez, Richard King, Anne Marie Smith, and Sterling North. Not pictured, Gayla Bruner.



Alliance Fellow Recipients (L to R): seated, Bob Addleton, Jeanette Harmon, and Melinda Steele; standing, Jack Kues, Al Aparicio, and Michael Lemon.



Member Section Great Idea Awards (L to R): Bill O'Neill representing the TCL Institute, LLC, Jack Kues representing the University of Cincinnati Center for Continuing Professional Development, Elaine Gangel representing the American Academy of Family Physicians, Marilyn Peterson representing the Texas Health Research and Education Institute, and Betsy Woodall, representing Wyeth Pharmaceuticals.



Alliance Distinguished Member Recipients (L to R): seated, Jackie Mayhew, and Mila Kostic; standing, Sharyn Lee, Mindi McKenna, William Mencia, and Elizabeth Mullikin. Not pictured, Don Young.



Awards Ceremony Hosts: Lawrence Sherman and Jann Balmer.



Thomas G. Pearson Memorial Award: Jack Kues, 2010 Alliance Annual Conference Chair.



Distinguished Service Award: Don Moore, Jr.

## Acknowledgement of Alliance Contributors and 35th Annual Conference Grantors, Supporters and Exhibitors

The Alliance gratefully acknowledges its contributors, as well as grantors, supporters and exhibitors for the 35th Annual Conference. We appreciate these organizations' and individuals' support of the Alliance and its conference, as well as their interest in CME.

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## The Loss of a Founding Father of Continuing Medical Education

**Debra L. Gist, MPH, FACME, Assistant Editor**

George T. Smith, MD, MS, FACC, one of the visionary founders of continuing medical education (CME) in America, passed away on March 20, 2010. Dr Smith earned his MD from the University of Maryland and interned at McGill University in Canada. Called to duty he interrupted his training and served as a Battalion Surgeon with the 101st Airborne Division in Germany. Following his military service he completed a residency in pathology at a Harvard teaching hospital ultimately achieving the position of Chief Resident. He then joined the Desert Research Institute in Nevada and went on to become Founding Dean of the University of Nevada Medical School. As a Sloan Fellow, Dr Smith was awarded a Master of Science degree from the Massachusetts Institute of Technology.

In the course of his extensive and varied career in medicine and CME Dr Smith also served in positions around the country and the globe. These included advisor to the Institute for Paramedical Sciences in Tehran, Iran; professor at Tufts University; Associate Chief of Staff for Education at the Boston Veteran Affairs Hospital; Director of the Southeastern Regional Medical Education Center for the Department of Veteran Affairs; Professor of Pathology and Associate Dean for CME at the University of Alabama; Director of the Southeastern Regional Medical Education Center for the Department of Veterans Affairs; Director of the Office of Health Extension, Public Service and Research at UAB; Editor of the Alabama Journal of Medical Sciences; Chairman of the Birmingham Jefferson Convention Complex Medical Advisory Board for the development of the Medical Forum; President of the Society of the Directors of CME and the Foundation for Continuing Medical Education, and Chairman of the Third Congress on Continuing Medical Education. Doctor Smith actively participated in the Alliance and the Society for Academic Medical Education (SACME), and as

President oversaw a pivotal strategic planning process and guided SACME's incorporation.

Dr Smith is remembered not only for his leadership, accomplishments, and mentoring of numerous CME professionals . . . but also for the man himself:

"George knew that a leader was a facilitator. George displayed humor, humanity and intelligence but in his own style. He believed that teams of physicians and educators were the secret to success. His support and encouragement enabled many of the achievements of our field in the recent past. He was my friend."

—Robert Fox, EdD

"George Smith, MD was one of the first true visionary CME leaders. He had a way to see connections between continuing professional education, the larger health professions education environment and the improvement of health care. This is his legacy to our profession."

—Joseph S. Green, PhD

"With the passing of George Smith, we have lost one of the dedicated founders of modern CME. We will miss him, and for years to come we will continue to benefit from the contributions he made through his decades-long commitment to lifelong learning and the profession of medicine."

—Murray Kopelow MD, MS(Comm), FRCPC

"George Smith's death marks the end of an era—he was a one-of-a-kind physician and I'm so thankful to have known him as a friend. I know that his daring vision changed medical education, from his innovations as Dean of the new University of Nevada Medical School to his commitment to develop team-based CME that would truly help doctors in their daily practice of medicine. George made a difference and created change, nationally and internationally, that we'll better understand someday. What a loss for medical education at all levels."

—Dennis K. Wentz, MD, CCMEP

### Our Thanks!

The 2010 Awards Ceremony was funded by Wyeth Pharmaceuticals and CECity. The Alliance Awards Program is supported in part by an endowed grant from Audio Digest Foundation.

## Calendar of Events

### May 13-14, 2010

Third Annual PACME Spring Summit  
Common Ground for Better Patient Care  
Sofitel Philadelphia Hotel, Philadelphia, PA  
[www.acme-assn.org](http://www.acme-assn.org)

### June 6-8, 2010

15th Annual GAME Meeting  
Innovation in CME  
Montreal, Quebec, Canada  
[www.game-cme.org](http://www.game-cme.org)

### June 13-30, 2010

CCMEP Exam at local testing centers  
Registration closes May 31  
[www.nc-cme.org](http://www.nc-cme.org)

### June 23-24, 2010

Alliance for Continuing Medical Education  
CME: The Basics Institute  
Hyatt Rosemont, Rosemont (Chicago), IL  
Registration Now Open!

### August 11, 2010

Medical Specialty Societies Summer Meeting  
American Society of Clinical Oncology  
Washington, DC

### August 13, 2010

Medical Specialty Societies Summer Meeting  
American College of Surgeons  
Chicago, IL

### September 12-14, 2010

National Institute for Quality Improvement and Education  
NIQIE 2010  
InterContinental O'Hare, Rosemont (Chicago), IL  
[www.niqie.org](http://www.niqie.org)

### October 13-15, 2010

21st Annual Conference of the National Task Force on  
CME Provider/Industry Collaboration  
Baltimore Marriott Waterfront, Baltimore, MD  
[www.ama-assn.org/go/cmetaskforce](http://www.ama-assn.org/go/cmetaskforce)

### October 15-17, 2010

Association for the Behavioral Sciences and Medical  
Education (ABSAME) Annual Meeting  
AVIA Savannah Hotel, Savannah, GA  
Registration Coming Soon!  
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