ALLIANCE for CME
The International Association of CME Professionals

Almanac

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President's Corner

George C. Mejicano, MD, MS, FACP, FACME, President, Alliance for Continuing Medical Education

Greetings! I am delighted to share my thoughts with the members of the Alliance through my first article in the *Almanac*. During my term as your president, I hope to lead the organization to new heights related to advocacy, professional development opportunities, and collaboration. These three themes are reflected in our new mission and strategic commitments. The latter have been formulated over the past year under Jann Balmer's superb leadership and they will serve as a touchstone for the Alliance as our volunteers and staff work on new and exciting opportunities for all of our members.

Our newly revised mission states, *The Alliance is a community dedicated to accelerating excellence in health care performance through education, advocacy, and collaboration*. In addition, the Board of Directors has set the wheels in motion for the Alliance to fully embrace its potential as a dynamic, proactive and critically relevant organization by embracing the following eight strategic commitments:

1. Expand the focus of the Alliance beyond certified CME
2. Broaden the focus of the Alliance to include health care-related continuing education (CE) and continuing professional development (CPD)
3. Be visionary and proactive in strategically aligning the Alliance with the emerging health care environment while remaining sensitive to current needs
4. Model innovative leadership to shape the future
5. Actively develop strategic relationships with other health care organizations
6. Build a strategy to be the recognized voice for CPD in the health professions
7. Be the professional home for health professionals in CPD
8. Advance the field of CPD through research and other scholarly activities.

Throughout the year, you will be reading and hearing about specific ways that the Alliance will transform each of these strategic commitments into concrete and tangible products and processes. Each of the Alliance's committees will be involved with this effort and we hope that you will be fully engaged in the process as well! As such, please send me your ideas, thoughts, comments and questions regarding the new mission and strategic commitments. In particular, we are interested in your ideas about how we can move each of the eight strategic commitments from a theoretical concept to a suite of workable tactics. Feel free to contact me by email (mejicano@ocpd.wisc.edu) anytime, because the Alliance needs our collective energy and ideas in 2011 and beyond.

Of course, our dedicated volunteers and talented staff have already started working on a variety of innovative projects that will build upon the excellent products and services we already have in place. From this foundation, the Alliance will develop and roll out many exciting new member services and professional development opportunities.

Indeed, I am very proud that we have already released the first component of a major new initiative focused on the professional development of CE professionals: the Alliance's Competency Assessment and Lifelong Learning Series (CALLS). Under the direction of Mary Martin Lowe, PhD, the Alliance's new Director of Learning and Competency Development, CALLS has been designed as a state-of-the-art, competency-based professional development program that provides the modern continuing health professions educators the skill set needed to function at the top of their game. As we all know, the dynamic and challenging health care environment requires highly competent professionals to

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design, deliver and evaluate practice-changing educational activities—CALLS will help position our members to do just that.

Throughout 2011, I hope to interact with you through a wide variety of forums. In turn, I strongly encourage each of you to reach out and have your voice heard. The Alliance is our collective professional home and we need your help! Together, we will contribute to organizational transformation with the ultimate goal of improving and enhancing the health of individuals and society through education, advocacy, and collaboration.

It's an honor and a privilege to be your president for the next 12 months.

The Alliance Welcomes New Board Directors

The Alliance Board of Directors is pleased to welcome two new Directors. Elected by the membership to serve 2011–2014 terms are Debra Gist, MPH, FACME, and Ed Dellert, RN, MBA. Ms. Gist and Mr. Dellert began their service during the Alliance Annual Conference in San Francisco.

Ms. Gist has worked in a variety of roles in CME during her career, beginning in CME as a coordinator for a large hospital and moving into a corporate role as CME administrator at a large health care delivery system in San Diego. She served as director of CME at Duke University Medical School from 2001 to 2005, worked for five years as an independent CME consultant providing assistance to medical schools and medical specialty societies in their CME efforts, and currently serves as director of education at the American Academy of Dermatology. Debra has been published numerous times in the *Almanac*, has served on the Editorial Board of the *Almanac* for several years and recently served as an Assistant Editor. She has presented at national CME meetings. She was awarded the President's Award by the Alliance in 2006 and was awarded an Alliance Fellowship in 2008.

Mr. Dellert is Senior Vice President, Clinical Education, Informatics, and Research for the American College of Chest Physicians (ACCP), a division that encompasses continuing medical education, evidence-based guideline development, quality improvement, practice management, global initiatives and government affairs. Responsibilities within the division include the development and implementation of strategic initiatives related to educational interventions designed to facilitate physician knowledge and practice change. He has developed his education divisional responsibilities within the ACCP to efficiently manage multiple educational projects at once. Mr. Dellert has budgetary responsibilities for all aspects of the division under the ACCP $20 million dollar operating budget umbrella. He also volunteers with, and presents to, various professional organizations such as the Alliance, the Illinois Alliance for CME, the Society for Academic Continuing Medical Education, and the Accreditation Council for Continuing Medical Education (ACCME). His clinical background and experience include critical care and transplant nursing.

The Alliance welcomes these two new Directors and looks forward to their contributions to the association.

Evolution of the Competency Movement: American Board of Medical Specialties Certification and Maintenance of Certification Programs

Sylvia McGreal, Marketing and Communications Specialist, American Board of Medical Specialties

Mellie Villahermosa Pouwels, Program Director, Maintenance of Certification Support Program, American Board of Medical Specialties

For more than 75 years board certification has been an evaluation performed by American Board of Medical Specialties (ABMS) Member Boards and endorsed by the medical profession. This self-generated measure has provided assurance to hospitals and health plans, government and the public that the physicians identified as *board certified* have met specific criteria. Through the years, the process of board certification has been assessed and revised to incorporate a broader and more comprehensive evaluation of the physician and his or her practice.

At a meeting of the ABMS Advisory Board in June 1934, basic and general physician qualifications were required, but by the late 1960s and early 1970s, it became evident that the public was demanding assurance of the continuing competence of physicians. Responses to this public attitude consisted of a rather massive expansion of medicine, teaching hospitals, and regional and national medical societies. State medical boards and societies as well as national medical societies began to require similar involvement in CME and self-assessment for continued membership.

Recertification

The ABMS and the specialty boards responded to the challenge of assuring continued competence by addressing the subject of recertification. In 1969, the Boards of Family Practice and Internal Medicine were the first to develop policies on recertification. In 1972, ABMS established the Committee on Certification, Subcertification and Recertification to develop general guidelines for a recertification process. ABMS then adopted a resolution urging the specialty boards to accept a policy that would make voluntary, periodic recertification an integral part of all national medical specialty certification programs, and to establish a reasonable deadline for when this would become the standard policy of all Member Boards.

By 1973, the existing 22 boards had adopted the principle of recertification, and in 1975, ABMS provided guidelines on recertification to the specialty boards. By 1980, 12 Boards had received ABMS approval of their recertification plans and by 1982, nine boards had administered recertification examinations. By 1995, 21 boards had proposed time-limited certificates requiring recertification at intervals of seven to ten years.

Maintenance of Certification

Recognizing that clinical competence is more than the demonstration of knowledge on a test every seven to ten years, or the accumulation of credits for attendance at educational meetings, ABMS began considering ways of restructuring the recertification process to be a more ongoing and comprehensive evaluation process.

In March 1998, ABMS appointed its Task Force on Competence, with David L. Nahrwold, MD as chair. Under his leadership, the Member Boards came together to plan the implementation of a system that, when fully functional, would become a better way of evaluating the continuing competence of a certified specialist. The system eventually came to be known as ABMS Maintenance of Certification (ABMS MOC®), a program where all Member Boards' certificates are time-limited and physicians holding them must meet a series of requirements during that cycle.

As the idea for the ABMS MOC program began to develop, it was necessary to establish some basic benchmarks. The Member Boards agreed that maintenance of competence should be demonstrated throughout the physician's career. Being active stakeholders in graduate medical education, ABMS partnered with the Accreditation Council for Graduate Medical Education to develop a common set of six competencies important for all specialists to possess and maintain throughout their professional careers. These competencies are to be developed and/or refined during residency training, evaluated during initial certification, and subsequently further refined, updated and reassessed as they participate in programs of maintaining certification.

The Task Force on Competence then concentrated its efforts on developing standards and methods to evaluate physician specialists after initial certification. This became the basis of ABMS MOC, which was adopted by ABMS and the Member Boards in 2000. ABMS MOC consists of four essential components embedded within the six general competencies. To maintain certification, a diplomate must provide:

1. Evidence of professional standing
2. Evidence of commitment to lifelong learning and involvement in a periodic self-assessment process
3. Evidence of cognitive expertise
4. Evidence of evaluation of performance in practice.

While ABMS guides the process, the Member Boards set the criteria and curriculum for each specialty. In 2006, all Member Boards received approval for their ABMS MOC program plans.

By following the ABMS MOC program, physicians demonstrate their commitment to live the standards by which medical care is

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The Alliance's New Certificate Courses: Learning in Communities of Practice

Mary Martin Lowe, PhD, Director of Learning and Competency Development, Alliance for Continuing Medical Education

This article is the second in a three-part series about the Alliance's new online learning program—CALLS. In this issue, I am highlighting the three CALLS Learning Tracks that can result in Certificates from the Alliance in specific Competencies:

- Best Practices in Assessment and Evaluation *(Alliance Competency 3.2)*
- Directing Physician Self-Assessment for Learning and Change *(Alliance Competency 3.6)*
- Facilitating Improvements in Health Care by Addressing Barriers *(Alliance Competency 4.6)*.

Why Learning Tracks and Certificates for Alliance Competencies 3.2, 3.6, and 4.6?

The Alliance developed these specific Learning Tracks and Certificate Courses as a result of a 2009 learning needs assessment survey. Survey results indicated that the most signficant learning needs were related to Alliance Competencies 3.2, 3.6 and 4.6.

What Can You Expect from Each Certificate Course?

The Alliance's Certificate Courses are offered in six-week sessions with enrollment limited to 25 learners per cohort. In 2011, there are three sessions for each Certificate Course over the following dates:

- Cohort #1: April 4–May 15
- Cohort #2: July 11–August 21
- Cohort #3: October 10–November 20.

During a Certificate Course's six-week session, learners will progress through online content that includes self-directed exercises and engage with other cohort members in a community of practice that includes conference calls, online learning forum discussions, and course assignments. To support your professional development, I will serve as the Learning Guide for each session. You will also have opportunities to hear from experts and colleagues who have direct experience in topics related to the courses.

What are the Objectives and Content Covered?

The ultimate objective for each Certificate Course is to help learners develop proficiency in each of the corresponding three Alliance Competencies:

- Use measurement data to assess educational outcomes/results of the learning intervention as a basis for determining future learning needs and the application of the educational knowledge and skills (Alliance Competency 3.2)
- Provide measurement tools and utilize reliable data to enable physician-learners to compare present levels of performance with optimum performance (Alliance Competency 3.6)
- Identify and help modify processes that are barriers to change and the implementation of new knowledge (Alliance Competency 4.6).

All CALLS Learning Tracks are comprised of individual modules and units that focus on specific Alliance Competencies and issues that are important to CME professionals. In the Certificate Courses, learners engage in lessons related to numerous issues, including the current CME environment, assessment and evaluation. The Certificate Courses in Competencies 3.2 and 3.6 include a unit on research methods, while the Course in Competency 4.6 includes a unit on effective communication strategies.

In order to receive a Certificate from the Alliance in the Competency related to the Learning Track, participants must develop plans for a project they could implement in their own CME program. Learners will have an additional six weeks to complete and submit their plans.

Remember, enrollment is limited. If you are interested, register soon!

For more details about the Certificate Courses, including their costs, visit www.acme-assn.org/calls.html. I look forward to working with the learners in each course.

How to Overcome Resistance to Using an Audience Response System

Derek Dietze, MA, FACME, CCMEP, President, Improve CME, LLC

Some course directors and speakers at live meetings are resistant to administering the pre/post questions that are important to outcomes measurement through an Audience Response System (ARS). How can a CME professional overcome this barrier to obtaining solid outcomes data?

Among the reasons given for this resistance are that the outcomes measurement questions take away from the precious time speakers have to cover their content, that the questions seem repetitive and boring, and that you cannot really measure anything of importance using these *soft* forms of measurement. In addition, some course directors have the perception that questions are really only being asked to secretly extract information from participants, which somehow will be used in marketing efforts by commercial supporters. Sometimes, a speaker tries to close the meeting before the post activity survey questions are asked, and the CME professional has to run to the front of the room and reinforce the need to ask the post questions.

Given these challenges, below are some suggestions on how to get faculty members on board with outcomes measurement.

1. At the earliest planning stages, explain the specific measurement methodologies being used, why measurement is important to you as a CME provider, and faculty's role in the measurement (eg, helping with question writing, asking the questions in the live meeting). These can be verbal discussions, but outcomes responsibilities should also be included in agreement letters with faculty members.
2. Explain to your faculty members, that while the approaches being used may not meet the same standards as the double-blinded, placebo-controlled trials they are used to presenting, they do employ proven, evidence-based measurement methodologies from the social sciences and adult learning research. (Note: Make sure you're actually using the evidence-based measurement methodologies you profess!)
3. Take the time to explain the importance and value of outcomes measurement to your faculty members. For instance, here are some things you might say to them at early planning stages, and again on site before they present.
   a. The outcomes measurement is actually part of the instructional design for this CME activity, and it helps you, as a speaker, apply the principles of adult learning. According to the research in adult learning, when asked pre questions, the participants are reflecting on their own knowledge, confidence and performance (assuming that those question types are used). This predisposes them to the content they are about to hear/engage with. As you engage them with the content, they may see the difference between their answers to the pre questions and the ideal or best answers presented in the content. This creates a cognitive dissonance that is a precursor to behavior change and performance improvement. Post questions help them reflect on what they have just learned, and reinforces correct knowledge and clinical practice. The questions can also further cement their commitments/intentions to change performance.
   b. Responses to ARS pre questions can help you, as a speaker, better understand the nature of your audience, their knowledge levels, and their current practices. The demographics questions on degree, specialty, practice type, and number of patients they see weekly with this disease can certainly do that, and the other pre knowledge and case questions being used will give you a sense of how they currently treat their patients.
   c. ARS questions engage your learners, making this event more interactive and interesting.
   d. This approach to measurement helps us quantify the extent to which you, our faculty members, have been able to fill the knowledge and competence gaps you helped us identify during early planning stages. Our collective success is, in part, being measured using this approach.
   e. We use this measurement to improve and better craft future content on this topic. We turn the results into needs assessment information for planning, and the results become part of the continuous quality improvement for our CME.
   f. This approach to outcomes measurement was promised to the commercial supporter. Without it, we would not have received the educational grant. The results we obtain will help us obtain future grant funding, so we can have the opportunity to better address the educational needs of this target audience.
   g. We are obligated to measure changes in at least competence (defined as knowledge with a strategy) by the ACCME. This is one way that we are doing this.
4. Specifically include time in the meeting agenda for asking the pre and post ARS questions, and set expectations with speakers on how long they should

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take to comment on the polling results. You may want to allot up to one minute per question, depending on how much you want them to say about the results.

5. Integrate the ARS questions into your content. Instead of simply asking a bunch of questions pre, then repeating them post, try sprinkling your pre questions over the beginning of the presentation before the associated content is covered.
6. Consider reducing the number of pre/post questions you are asking. Sometimes there is a tendency to ask too many questions. Each question used for measuring changes in your learners should be linked to your content, to your learning objectives, and to the gaps you identified in your needs assessment. Carefully consider the value of each question.
7. Enhance the quality and variety of your questions. Instead of just using multiple choice knowledge questions, use other interesting types of questions such as agreement scale questions, confidence scale questions, and case questions. Even consider using a *parallel* case question post—changing the sex, age, and name of the patient (if it does not change the correct response), with the same response options and correct answer.
8. Practice the ARS questions with speakers. Some faculty members simply aren't comfortable with the technology, or have not had experience with it as much as you might expect. Demonstrate it to them, and show them how the results appear on screen.
9. Leverage the interest/willingness of one faculty member to convince the others to properly use the ARS. Ask the one faculty member who is excited about the use of ARS to help you convince the others about its importance and value. If some faculty members aren't submitting ARS questions as you would like, send the questions you've received from your champion faculty member to the others, saying, *These are the kinds of questions we're looking for*. The sense of competition seems to draw in the other faculty members to submit their questions.
10. Get faculty buy-in on the ARS questions you are using. If you've decided to write the pre/post questions yourself, ask the presenters to review and provide feedback on the questions. Help them take ownership.
11. If you know in advance that certain faculty will not appropriately administer the ARS despite your use of all the above strategies, then perhaps have the moderator or someone else very comfortable with and committed to your measurement, administer the questions.
12. Share the results of your outcomes measurement with your faculty members. If you asked them to administer the questions, then show them the results report, and ask for their opinion/interpretation of the results. When you do this, some of them may even express an interest in writing an article and submitting it to a journal for publication.

As a final note, don't give up! It will take time to optimally engage your faculty members in outcomes measurement, but the results are essential for your success in CME.

Points for Practice

- Make sure your faculty members understand why outcomes measurement is important and their role in planning for outcomes measurement.
- Include time in the agenda for asking and discussing ARS questions.
- Share the results of your outcomes measurement with faculty.

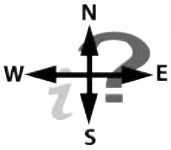
The 37th Alliance Annual Conference Call for Educational Abstracts

On behalf of the Board of Directors and the Annual Conference Committee (ACC), we invite you to submit an educational abstract for the 37th Alliance Annual Conference, which will be held Wednesday–Saturday, January 21–24, 2012, at the Grande Lakes Orlando—The Ritz-Carlton® and JW Marriott®, Orlando, Florida. The theme of the conference is *Improving Professional Competence, Provider Performance, and Patient Care.*

As there are increased demands on health care providers, so are there increased demands on CME/CPD professionals. It is critical that both enhance their competency and improve their performance with the ultimate goal of improved patient care, if we are to move forward in the ever-changing landscape and regulatory requirements. The 37th conference seeks to provide tools and resources to meet the challenges for both health care and CME/CPD professionals in addressing the needs, targets and requirements of these fields.

The ACC encourages you to submit an educational abstract related to performance improvement and/or professional competencies. The complete call for abstracts, with defined content areas, can be found on the Alliance website at www.acme-assn.org. Your abstract must be received in the Alliance office by 5:00 pm CST, Friday, March 18, 2011.

We look forward to receiving your abstract and to seeing you during the 37th Alliance Annual Conference.



Reality CME *Your Guide to Which Way is Up!*

Question

The March 31, 2011 deadline for the ACCME's new Program and Activity Reporting System (PARS) is making me anxious. What should I do to transition calmly to the online reporting system?

Answer

Change is never easy, and it's great that your goal is to be calm about this one. The ACCME's PARS replaces two documents that have been part of the accredited provider's template portfolio:

1. The annual report
2. The activities list submitted with each reaccreditation self-study.

All that has changed is the way the information is submitted. The required data fields are exactly the same as they have been for the past few years.

Take the following three steps to familiarize yourself with what PARS means for you.

1. First, view the six modules on PARS which you can find on the *education* tab of the ACCME website (http://education.accme.org/getting-started-with-pars). These brief videos are no more than five minutes long, and they walk you through the online data submission system. The content in the videos will be familiar to anyone who has completed an annual report or activities list in the past. CME staff who have not been responsible for these reporting tasks should view the videos to have a more well-rounded view of what your colleagues are responsible for and what data the ACCME will aggregate to provide a national CME picture.
2. Now, read the *frequently asked questions* on PARS on the ACCME website (http://education.accme.org/help/pars).
3. Finally, have staff who are responsible for these data collection tasks study PARS, practice using it without saving entries, and make a 10-minute presentation to the CME office. The best way to overcome any anxiety about this change is to—like Nike—just do it!

by Pesha Rubinstein, BA, CCMEP, Almanac Assistant Editor

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evaluated and demonstrate leadership in the national movement for health care quality and patient safety. The ABMS MOC program represents measured, thoughtful and proactive professional involvement in setting quality standards for medical practice. Principles such as those contained in the ABMS MOC program can be at the forefront of the quality medical care movement.

Future articles in this series will outline the development of the ABMS MOC program, detail its key components and requirements, and highlight the potential role for CME providers in assisting ABMS diplomates to fulfill their requirements. Should readers need information prior to the release of these subsequent articles, additional resources are available at www.abms.org.

Calendar of Events

March 13–30, 2011
CCMEP Exam at local testing centers
Registration closes February 28
www.nc-cme.org

April 6–10, 2011
SACME 2011 Spring Meeting
New York, NY
http://cme.med.nyu.edu/sacme

May 12-13, 2011
Fourth Annual PACME Summit
Common Ground for Better Patient Care
Sofitel Philadelphia Hotel, Philadelphia, PA
Registration Now Open

July 28-29, 2011
Alliance for Continuing Medical Education
CME Basics Institute
Hilton Alexandria Mark Center, Alexandria, VA
Registration Information Coming Soon

August 10, 2011
Medical Specialty Societies Summer Meeting
American Society of Clinical Oncology
Alexandria, VA
Registration Information Coming Soon

August 12, 2011
Medical Specialty Societies Summer Meeting
American College of Surgeons
Chicago, IL
Registration Information Coming Soon

January 21–24, 2012
Alliance for Continuing Medical Education
37th Annual Conference
Grande Lakes Orlando—
The Ritz-Carlton® and JW Marriott®, Orlando, FL

Online Resources

CME Career Center
http://careers.acme-assn.org

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An easier way to find a job.
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http://www.rdrb.utoronto.ca

rd rb Research and Development Resource Base

Free bibliographic database of literature searches in the fields of medicine, nursing, dentistry, physical therapy, occupation therapy, and other allied health professions!

National Faculty Education Initiative
www.nfeinitiative.org

Free online training designed to teach medical education faculty the differences between certified CME and promotional activities, plus free access for Alliance members to a searchable database of medical education faculty who have completed the program!

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