

Academic CME: balancing the scorecard?

Dave Davis, MD, FCFP

Senior director, continuing education and
improvement,

Association of American Medical Colleges

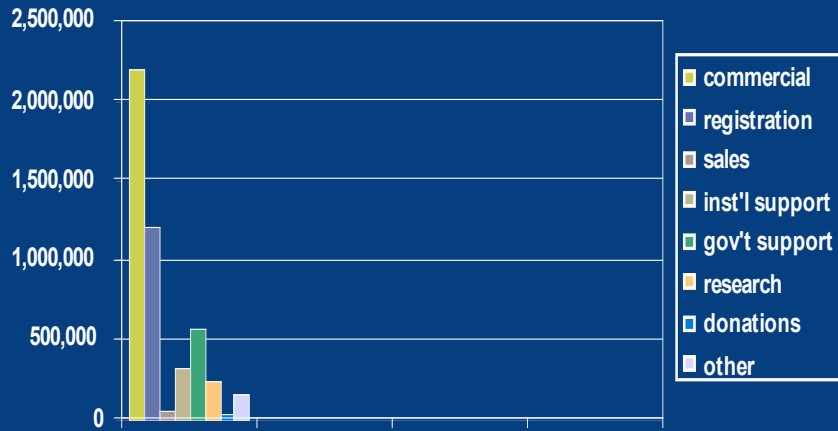


Overview: three easy questions (maybe not so easy)

- 1) Who pays for CME? Results from the AAMC/SACME (Harrison) survey
- 2) Guarding the henhouse? The AAMC and ACCME
- 3) If not commercial support, then what? Answers from academic CME's value equation



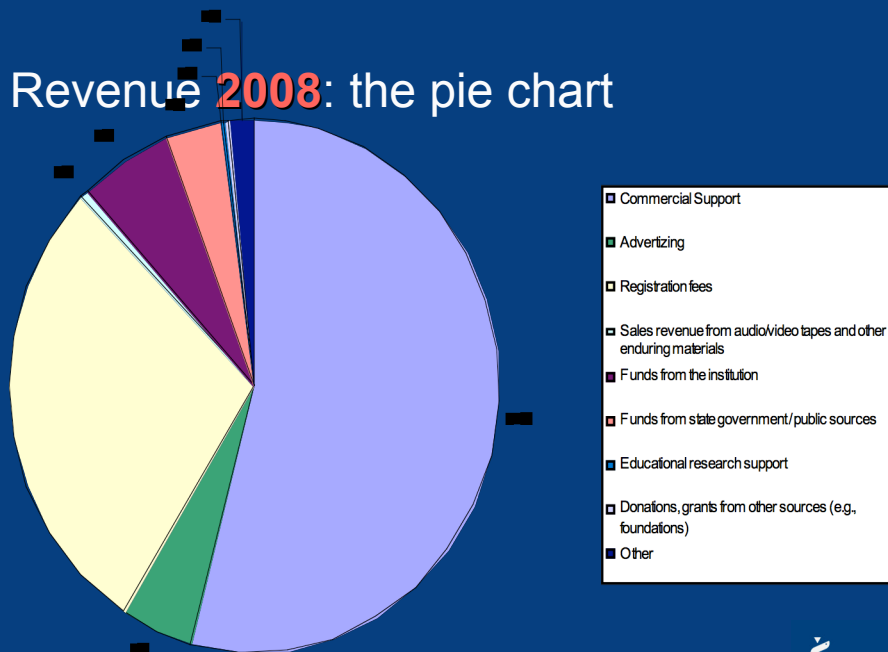
The Revenue Question: how *DO* we pay for CME??



Mean income, The Harrison Survey, 2008 (SACME & AAMC)



Revenue 2008: the pie chart

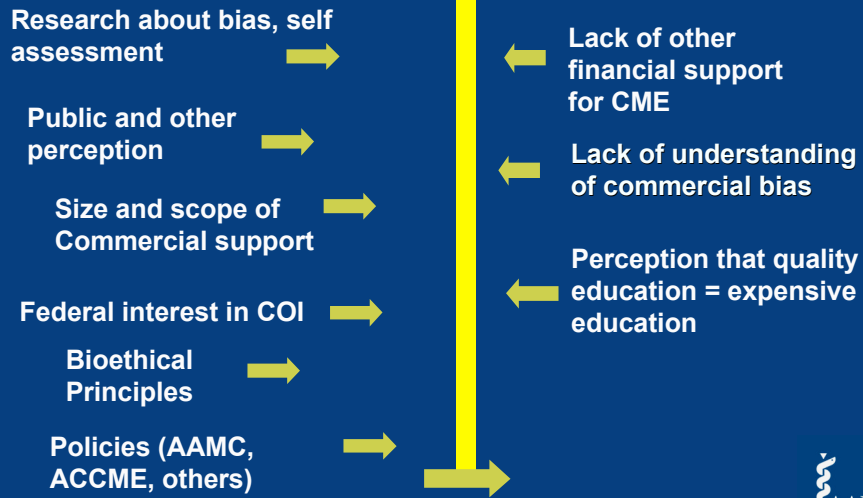


2009 Revenue (2008 survey data in red)	Mean	Median	Range	Number of Programs Reporting Amounts
Commercial support (i.e. gifts and grants)	\$1,485,126 \$1,899,802	\$373,570 \$589,805	\$1 to \$24,919,538	102
Advertising and exhibits	\$209,511	\$80,087	\$1 to \$2,270,582	92
Registration Fees	\$898,173 \$1,068,281	\$315,648 \$616,155	\$1 to \$10,922,921	97
Sales revenue from audio/video tapes and other enduring materials	\$29,637	\$19,315	\$1 to \$169,529	20
Funds from your institution	\$298,437 \$340,166	\$136,530 \$207,566	\$1 to \$4,690,328	72
Funds from state government/ public sources	\$207,922	\$120,000	\$1 to \$800,294	21
Educational research support	\$114,280	\$31,347	\$1 to \$400,000	7
Donation, grants from other sources (e.g. foundations)	\$101,763 \$35,056	\$30,186 \$22,500	\$1 to \$702,096	33
Other	\$327,158 \$157,715	\$80,000 \$81,856	\$1 to \$2,625,395	29
Total * Does not include missing data or responses of zero	\$2,707,296	\$1,042,898	\$4 to \$32,690,388	110

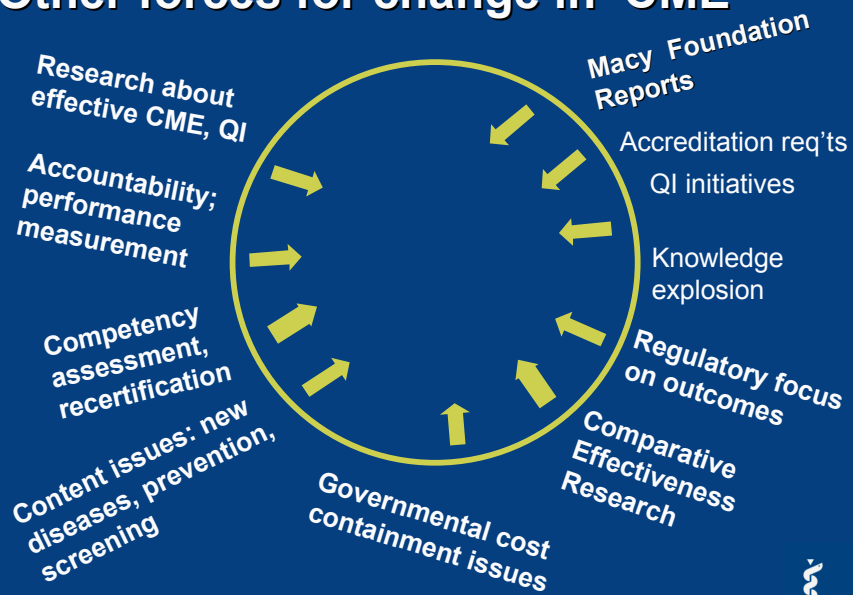
Commercial Support and CME: 2008/2009

Of the total number of CME activities offered in your last reporting year to the ACCME....	Mean	Median	Range	Number of Programs Reporting Amounts
How many received financial support from commercial sources?	82 145	32	1 to 2,144	99
How many would not have been offered had commercial support not been available?	47 121	15	1 to 536	81

Forces for and against in COI



Other forces for change in 'CME'



Response 1: the AAMC Task Force on COI

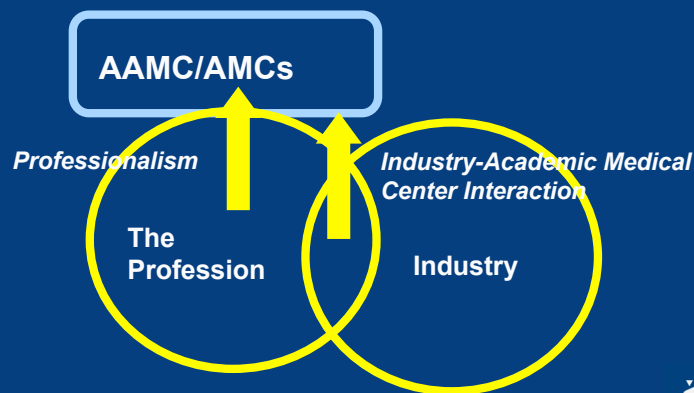
The Goal:

“An **effective and principled partnership** between academic medical centers and health industries is critical to realize fully the benefits of biomedical research and to **ensure continued advances** in the prevention, diagnosis and treatment of disease.....both partners are fundamentally dedicated to the **welfare of patients and the improvement of the public health**”



The Terrain of COI, AAMC and academic medical centers...

implications for policy



Major recommendations of the AAMC Task Force

Professionalism

- important considerations include the hidden curriculum and unconscious bias
- need for education across the continuum about the strengths and challenges of industry and the industry/academic interface

Industry-academic interactions

Individual:

- limits to... gifts to individuals
- pharmaceutical samples
- reduced site access by company representatives

Programmatic:

- discourage speakers' bureaus
- define participation standards
- administer scholarships and other programs centrally
- restrict items as food, travel, purchasing
- andCME



CME-focused recommendations of the AAMC Task Force on COI

- CME programs should develop audit or review mechanisms to assure compliance
- Academic medical centers must establish *central* CME offices
- Only ACCME accredited providers should offer education to physicians
- Schools should discourage faculty participation in commercial speakers' bureaus
- AAMC, SACME and others should develop mechanisms to assure sound, timely, objective content
- **New findings generated by industry should find a forum for unbiased communication to faculty**



Product use-focused education vs. scientific exchange

Product-level
Specialist –generalist teaching
Low interactivity



Development/discovery-level
Peer-peer * discussion
Open-forum, interactive

**NB: need for more EBM/critical appraisal skills*



Response 2: The VALUE of CME: its roles, place and potential in the academic medical center

$$\text{Value} = \frac{\text{Benefit}}{\text{Cost}}$$



The Value equation...

**Always skate to where the puck
is going to be...**

Wayne Gretsky,
Canadian (okay, now he lives in the US, but
he's really Canadian) hockey star



The *new 2011* Academic CME models:



- the conference model
- the academic department model: *education, research and service*
- the knowledge hub in a regional wheel model: *community-oriented, service-driven, pop health-based*
- the integrated academic health center model: *QI-based, service and system driven*
- the shopping basket, build-your-own model



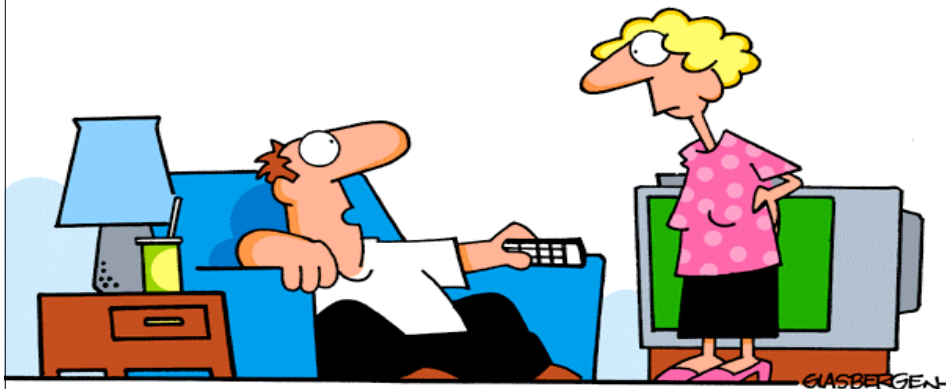
Model	Integration with	Value	Funding
QI/PI	Hospital, system QI	Use of CE vehicles to improve performance	Hospital, health system
Regional outreach	Referral base, regional hospitals,	Appropriate referrals, evidence based quality of care, ?alumni	State, region, health system
Faculty Development	UME, GME, CME	Marrying best practices in CME to improve teaching skills	Medical school
Public	Hospital, medical school public relations	Community development, relationship building	Advancement offices, disease groups
Academic CME	Health services, informatics, educational research	Scholarship, grant capture, career development	AHRQ, RWJF, VA, others

See www.aamc.org/cme >research



One step at a time

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“My doctor told me to start my exercise program very gradually. Today I drove past a store that sells sweat pants.”

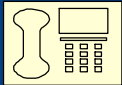


One of the many differences
between Canada and the US: a
different CME accreditation
system

Dave's contact info:



ddavis@aamc.org



202-862-6275



www.aamc.org/gea/cme

