From the CEO

The CSA as a CME Provider

By Barbara Baldwin, MPH, CAE

The California Society of Anesthesiologists is a physician organization dedicated to promoting the highest standards of the profession of anesthesiology, to fostering excellence through continuing medical education, and to serving as an advocate for anesthesiologists and their patients.

The mission statement above states that one of the CSA’s primary purposes is to foster “excellence through continuing medical education [CME].” For over 30 years, the CSA has been a provider of CME, and for the past 12 years we have been accredited by the Accreditation Council for Continuing Medical Education (ACCME). This designation insures learners will receive CME that meets the standards set by the national accrediting body, and that the credit they earn by participating in learning activities meets the requirements set by state medical boards and other entities. In California, physicians licensed by the California Medical Board must acquire at least 50 credits every two years to maintain licensure. Physicians licensed by the Osteopathic Medical Board of California must complete 150 credits in every three-year licensure period.

In recent years, other entities like hospitals and national boards have come to require CME as an indicator that a physician is engaging in the process of lifelong learning that is necessary to keep knowledge, competence and performance current. The American Board of Anesthesiology requires anesthesiologists who were board-certified after 1999 to recertify every 10 years, and within the 10-year certification period, to complete at least 250 Category 1 CME credits.

The face of CME has changed considerably over the past decade. A new challenge for CME providers is that accreditation is moving from being process-based to being outcomes-based. That is, while previously it was sufficient to document that quality CME was provided, now providers must take steps to ascertain if the activity met the objective of improved knowledge, competence or performance. This can be measured by means such as pre- and post-tests, self-reporting, and faculty assessment. Large, well-funded providers can utilize sophisticated methods to measure outcomes, but many providers use self-reporting as the primary method.
Another important change came with new rules governing in-kind and financial support for CME programs from commercial entities. The ACCME began applying strict Standards of Commercial Support to activities presented by CME providers in 2001 and modified them in 2004. The six standards are to insure:

1. independence in all aspects of activity planning, including selection of educational objectives, content, faculty, educational methods and evaluation,
2. resolution of personal conflicts of interest,
3. appropriate use of commercial support,
4. appropriate management of associated commercial promotion,
5. content and format without commercial bias,
6. disclosures relevant to potential commercial bias.

Adherence to these standards requires providers to have systems and documentation that confirm compliance.

Almost concurrently, the pharmaceutical industry responded to criticisms and allegations of unethical practices by assigning the Pharmaceutical Research and Manufacturers of America (PhRMA) to become a watchdog over its practices. The stated objective was to eliminate behaviors such as paying physicians for “educational” vacations, which were considered inducements to prescribe their drugs. In 2002 PhRMA issued a voluntary code of conduct for interactions with health care professionals, and in 2009 an updated code became effective. These rules set parameters for how pharmaceutical companies may interact with physicians and CME providers with respect to promotion and support of CME activities. In addition, these restrictions add complexity to arranging and receiving commercial support.

The most obvious of these restrictions is the prohibition against giving physicians items that may be construed as inducements to use their products:

Providing items for healthcare professionals’ use that do not advance disease or treatment education—even if they are practice-related items of minimal value (such as pens, note pads, mugs and similar “reminder” items with company or product logos)—may foster misperceptions that company interactions with healthcare professionals are not based on informing them about medical and scientific issues. Such non-educational items should not be offered to healthcare professionals or members of their staff, even if they are accompanied by patient or physician educational materials.
How the CSA Assures Quality and Ethical CME

The CSA has a formal system for planning educational activities and ensuring compliance with all ACCME requirements. Members of the Educational Programs Division (EPD) serve as program chairs for CSA educational activities. In addition, they provide guidance in the development of new delivery methods like enduring materials (Bulletin) and Internet self-study. Moreover, in the past few years, hands-on workshops in regional anesthesia have given anesthesiologists the ability to develop skills that enhance the quality of their practice.

Evaluation of each CME activity helps us learn whether participants’ learning needs were met, and also if the CSA met its overall program objectives in presenting that activity. This enables the CSA to give constructive feedback to faculty on their content, materials and presentations. Evaluation results are kept for several years. When program chairs begin to plan an educational activity, they are given evaluation summaries so that they can work with prospective faculty to insure that presentations are current and of the quality for which our CME is known.

In 2006 the ACCME modified its criteria for accreditation in several ways. It now requires that CME providers consider the best ways of presenting CME based on the content and learning objectives. Reading printed content or attending a lecture, then taking a quiz, is not necessarily the most effective or efficient way to learn new skills. While some well-funded CME providers have the ability to offer state-of-the-art educational videos with 3-D enhancement, the CSA is a nonprofit provider and must limit its offerings to methods more suitable to available resources. However, we continuously evaluate how to provide the best learning environment for our members, with attention to advances in technology and reductions in the cost of learning enhancements that are, at present, prohibitively expensive.

Every four years the CSA is required by the ACCME to do a self-study that reviews all aspects of the overall CME program and educational activities. This process takes months and calls for the EPD to examine many areas. Currently we are gathering information and drafting a report due at the end of March. With this report we will submit 15 activity files selected by the ACCME that show “performance in practice,” with documentation that the planning, development, presentation and evaluation of CME activities meet the ACCME requirements.

The CSA has a long history of providing high-quality, meaningful CME. If you haven’t attended a live educational activity, try the CSA Annual Meeting or one
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of the Hawaiian seminars. There are also online modules on the CSA Web site, free to members. Take advantage of CSA’s great member benefit, and meet your lifelong-learning needs at the same time!

Pediatric Anesthesia Module 2
Pediatric Resuscitation
ERRATUM

The information in Module 2 that appeared in the Fall 2010 issue of the Bulletin should be modified as follows:

On page 67, under “Pediatric Advanced Life Support,” the fifth sentence describing a cycle of cardiopulmonary resuscitation should read: “A cycle of cardiopulmonary resuscitation (CPR) is 30 compressions: 2 ventilations for a lone rescuer and 15 compressions: 2 ventilations for 2 two or more rescuers.” We apologize for any inconvenience or confusion this error may have caused.