



CPPD Report

The Division of Continuing Physician Professional Development
Newsletter for the Continuing Medical Education Community

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AMA Pilot Projects Conclude Work

In February and April of this year, the steering committees of the Physician directed, interactive Internet CME and Performance improvement pilot projects each held their last formal meeting to review data and develop AMA PRA recommendations for these learning modalities. Although not new – many physicians have for some time actively engaged the Internet for timely retrieval of relevant clinical information – recognizing this as a learning activity and awarding AMA PRA category 1 credit for it is. Likewise, performance measurement and improvement activities have already emerged as a mechanism for physicians to systematically assess their practice, and to some extent, their patient outcomes.

Both committees have recommended these be structured as provider driven activities. Salient features of the proposed Internet CME activities will include a small amount of credit for an initial, structured inquiry (usually short, at the point of care) with a larger increment of credit for a deeper search. In the latter case, providers would not award credit for time spent searching; however, physicians must interact with the online materials for a minimum period and then answer targeted questions (describe inquiry, sources reviewed and application to practice) to obtain credit. Providers will be expected to develop or access robust, evidence based database sources that stick to the AMA PRA definition of educational content and the ACCME content validity guidelines.

For Performance improvement (PI), the steering committee recommended three learning stages: first, standard identification and current practice assessment; second, application of performance improvement to patient care; and third, evaluation of the performance improvement effort. The proposed PI schema, for the selection of appropriate measurement sets, would invoke the same content guidelines described above. Physicians can claim credit for partial completion, although completing a well designed PI activity will offer the best opportunity for reflection on practice. Providers will award credit based not on time spent, but on documented movement through a planned assessment process. Documentation requirements remain a challenge and under discussion: how much is enough to establish face validity but not unduly burden participants?

Our pilot participants have provided vital data and feedback in the development of these recommendations. In addition, the American Academy of Family

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Physicians has been at the table throughout as they develop a consonant set of recommendations for their credit system. The AMA Council on Medical Education reviewed the principle points of both activities at their June meeting, discussions regarding accreditor guidance for these activities will begin with the ACCME in July, and approval of final AMA PRA language is planned for the Council's September meeting.

This is an exciting time, as the AMA PRA credit system prepares to integrate these interactive, practice-based modes of learning. They will not replace but instead augment traditional forms of CME, and accredited providers, in tandem with their physician audience, will be able to choose when and how to implement these educational tools.

Manuscript Review Approved for AMA PRA Credit

The AMA Council on Medical Education, at their September 2003 meeting, formally recognized manuscript review activities for AMA PRA category 1 credit. To accomplish this, the AMA formulated a set of standards for designating manuscript review activities for AMA PRA category 1 credit (see full text below) that providers can use while working with a medical journal indexed by the *Index Medicus*.

The American Institute of Ultrasound in Medicine, and then the Radiological Society of North America (RSNA) contacted the Council in 2001 requesting the approval for Category 1 credit of peer-review for medical journal manuscripts. The Council decided at that time that this activity did not satisfy criteria for Category 1 credit, primarily because a content expert generally does the peer-review (offering little incentive for new knowledge acquisition) and the process lacks enough interaction among participating physicians. As always, Category 2 credit could be self-claimed by physicians who found educational value in the peer review process.

Resolution 311 (A-02), "Category 1 CME Credit for Scientific Review," introduced by several medical specialty societies, asked the Council to

reconsider their decision. In a follow up letter to the Council, the RSNA detailed their argument for learning associated with this activity: the manuscript review process increases the reviewer's critical reading skills, foments fresh thinking about future topics (either articles or research), broadens reviewer knowledge of current developments in their field, and encourages reviewer interaction with the editors.

The Council provisionally approved the concept but asked CPPD to convene a meeting of journal editors to examine issues surrounding manuscript review for Category 1 credit. Representatives from the American Academy of Pediatrics (AAP), American College of Obstetrics and Gynecology, American College of Physicians (ACP), Journal of the American Medical Association, New England Journal of Medicine, and RSNA met in May of 2003 to assess physician learning achieved through manuscript review, determine whether this activity could fit the current AMA PRA credit system, and based on their deliberations make an informed recommendation to the Council.

Since last September, CPPD has disseminated these AMA PRA guidelines to the physician and CME provider communities. CPPD will integrate this language with the next version of the AMA PRA information booklet for providers, slated for release by early 2005. As always, we want to hear your comments and feedback about the utility and application of these CME/CPD activity guidelines.

Standards for Designating Manuscript Review for AMA PRA Category 1 Credit

The manuscript review activity must meet the guidelines for AMA PRA category 1 credit as detailed in the *AMA Physician's Recognition Award: Requirements for Accredited Providers* booklet (version 3.2). Additionally:

- Manuscript review activities must be sponsored by an accredited provider working collaboratively with a medical journal indexed by the *Index Medicus*.

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Mercury: A Persistent Environmental Hazard

Barry D. Dickinson, PhD, Director of Science Policy, American Medical Association

On April 28-30, 2004 in Tampa, Florida, the U.S. Department of Health and Human Services (HHS), U.S. Environmental Protection Agency (EPA), and U.S. National Oceanic and Atmospheric Administration joined with the American Medical Association to provide a state-of-the-art CME program on the medical and public health aspects of mercury exposure. This symposium brought together members of the healthcare, scientific, public health and environmental professions. Medical specialty partners included the American Academy of Pediatrics, the American College of Preventive Medicine, the American Public Health Association, as well as the American Nurses Association and the Association of State and Territorial Health Officials. More than 150 participants sought to improve their understanding of how the medical, public health, and environmental communities can collaborate on mercury-related issues and assist practitioners in better advising their patients on mercury exposures. Among other topics, the symposium examined sources and case studies of mercury exposure, risks and health impacts in pregnant women and infants, and the possible role of mercury as a cardiovascular risk factor in adults.

Mercury (Hg), particularly methylmercury (MeHg), is an established, worldwide environmental pollutant and is concentrated in the food chain, especially in larger predatory fish. MeHg is ultimately derived from Hg that is elaborated by industrial sources (coal-fired utility plants, incinerators) in a series of reactions involving bacteria and sediment in aquatic systems. Chronic low-dose prenatal MeHg exposure from maternal consumption of fish has been associated with decrements in several measures of neurological development in two large epidemiological studies. More recently, concerns have been raised about the potential adverse effects of MeHg on the adult cardiovascular system, and the possible contribution of mercury burdens to various neurodegenerative diseases. Subpopulations at the higher end of the continuum of fish consumption include sport fishermen, commercial fishermen and their families, coastal and regional populations, Asian and Pacific Islanders, Native American populations, individuals pursuing a more healthy diet, and subsistence populations.

In 2001, the EPA established a reference dose (RfD) for MeHg of 0.1 $\mu\text{g}/\text{kg}/\text{day}$. This represents an estimated daily intake that is likely to be without appreciable risk of harmful effects. The corresponding blood concentration is 5.8 $\mu\text{g}/\text{L}$. Based on a cross-sectional national survey (NHANES) conducted by the Centers for Disease Control and Prevention, approximately 8% of women of childbearing age have blood mercury concentrations exceeding those associated with the EPA's RfD. Values were 4-fold higher in those who had eaten fish in the last 30 days. Extrapolating recent data on mercury exposure obtained from NHANES to the overall U.S. population, it is estimated that more than 300,000 newborns each year in the United States will have blood mercury concentrations greater than those associated with the EPA's RfD. Regional and population variations may be significant. In a one-year survey of an internal medicine practice in San Francisco, a substantial fraction of patients had diets high in fish consumption; of these, a high proportion had blood mercury levels exceeding the maximum level recommended by the EPA. The mean level for women in this survey was 10 times higher than the mercury concentrations found in the CDC population survey; some children had levels greater than 40 times the national mean.

Challenges remain in characterizing population risks, communicating individual risks, addressing adverse health effects, and getting to prevention. The public believes that environmental factors are a major cause of health problems and disease. Because fish is promoted as a healthy alternative to red meat, physicians are faced with the task of crafting an effective message that reduces fish consumption in those at risk, but does not alter healthy alternatives in those who are not at risk. Some physicians may be interested in learning how to conduct an occupational and environmental history on their patients. Sample case studies are available at: www.atsdr.cdc.gov/HEC/CSEM/exphistory/using_form.html

Manuscript Review (cont'd from page 2)

- The texts to be reviewed must be original contributions to the medical literature that require multiple reviewers, e.g., not book reviews.
- The journal editor, working with the accredited provider, will need to educate reviewers about the CME process – establish objectives and criteria for content review, and provide all needed instructions.
- Manuscript review assignments must be at a depth and scope that require a review of the literature and a knowledge of the evidence base for the manuscripts reviewed. To the extent possible, this review of the evidence base should be documented.
- Providers may designate each accepted manuscript review, as documented by the journal editor, for a maximum of three credits. Physicians may claim credit for a maximum of five reviews per year.
- The accredited provider, working with the journal editor, should have an oversight mechanism to evaluate the quality of reviews submitted. This process should assure that physicians who submit substandard reviews do not continue to participate or receive credit for subsequent activities.
- Organizations that are not accredited providers, but that publish journals indexed by the *Index Medicus*, may arrange joint sponsorship agreements with an accredited provider so that their manuscript reviewers can obtain AMA PRA category 1 credit.

For more information on new activities recently approved for AMA PRA category 1 credit, please visit: www.ama-assn.org/go/cmeselect

15th Annual Conference Explores Boundaries in CME Funding

Program development is well underway for the 15th Annual Conference of the National Task Force on CME Provider/Industry Collaboration, scheduled for September 27th- 30th in Baltimore, MD. Titled “Effective CME and Industry Collaboration: Understanding Boundaries,” this year’s conference will explore the impact of recent and ongoing changes in the CME community related to industry support and partnership.

In a time of turmoil in the CME community, this event offers a timely venue for vital dialogue between CME providers and industry. Expert panels will address topics from diverse viewpoints, such as ensuring the independence of CME activities, measuring educational effectiveness and return on investment, and the future of CME. Additional sessions will provide practical tips for collaborating with Industry, as well as take-home strategies for implementing new guidelines (such as the revised Standards for Commercial Support, the OIG guidelines and the new AdvaMed Code of Ethics).

This year’s conference, chaired by Sue Ann Capizzi, has a strong emphasis on interactive learning methods, including the audience response system, real world case studies, assessment tools, and plenty of time for questions and answers with faculty. Specific questions will be solicited from registrants prior to the event to help tailor sessions to the audience’s identified needs. In addition, a pre-conference will be offered titled “Paving the Way to Collaboration: A Beginner’s Guide.” This half-day session, offered on September 27th, is intended to provide a foundation for attendees who are new to CME, or to Provider/Industry collaboration.

The Industry Conference typically attracts over 400 participants from education and communication companies, medical specialty societies, academic medical centers, and pharmaceutical and device industries. Ample time is provided for networking, both through facilitated workshops and casual events.

To view the complete program and to register online, and to find information for exhibitors, please visit: www.ama-assn.org/go/cmetaskforce

Physicians Around the World Earning AMA PRA Category 1 Credit

Since the establishment of a process for providers who wish to award credit to physicians not licensed in the US in early 2003, over 2000 activities have been approved by the AMA. In order to obtain approval, providers submit a brief request form and a processing fee. A mechanism for submitting multiple activities is available at a reduced per activity fee (when submitting over 10 activities).

So, do international physicians have use for an AMA PRA category 1 credit certificate? It's a question commonly asked. Like physicians who hold a US medical license, physicians outside the US report completed CME to multiple different authorities, from their country or regional licensing body, to their employer. International physicians may report to many different entities, or possibly none at all. The value they may see in holding a Category 1 credit certificate is often in the communication to patients and colleagues that they have participated in high quality, US accredited CME programs.

For more information on obtaining approval to award Category 1 credit to physicians not licensed in the US, visit: www.ama-assn.org/go/intlpracredit

PRA Q & A

Can providers award AMA PRA category 1 credit to faculty of CME events?

This is a question we get all the time. In short, the answer is no. Providers should not award AMA PRA category 1 credit to faculty for teaching. However, providers may award credit to faculty for the sessions in which they participated as learners.

Faculty can claim credit for teaching at an activity that is certified for AMA PRA category 1 credit by applying directly to the AMA. Two credits are awarded for every hour of interaction, up to 10 credits per year. The AMA PRA Category 1 Credit application is available at: www.ama-assn.org/go/cme

As a courtesy, many providers print the AMA PRA Category 1 Credit Application and provide it to faculty at CME events so physicians may promptly request credit. E-mail pra@ama-assn.org with and questions related to this application or the Physician's Recognition Award credit system in general.

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CPPD on the Web

www.ama-assn.org/go/cme

CME Select, your complete resource for CME

www.ama-assn.org/go/pr

Physician's Recognition Award information for physicians and CME providers

www.ama-assn.org/go/intlpracredit

Request approval to award AMA PRA category 1 credit to physicians not licensed in the US.

www.ama-assn.org/go/cmetutorial

Test your knowledge of the AMA PRA credit system.

The CPPD Report is published 3 times annually. The AMA Division of CPPD welcomes your suggestions and comments. To subscribe or unsubscribe, and for all other correspondence, contact:

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Past editions of the CPPD Report can be viewed in PDF format at:

www.ama-assn.org/go/cmecppd

Calendar of Events

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July 30-31, 2004

Alliance for Continuing Medical Education
CME: The Basics
Rosemont, Illinois
www.acme-assn.org

September 27-30, 2004

The 15th Annual Conference of the National Task
Force on CME Provider/Industry Collaboration
Baltimore Marriott Waterfront Hotel
www.ama-assn.org/go/cmetaskforce

November 5-7, 2004

Society for Academic Continuing Medical Educa-
tion (SACME) Fall Meeting
Boston, Massachusetts
www.sacme.org

January 26-29, 2005

Alliance for CME Annual Meeting
San Francisco, California
www.acme-assn.org

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