

**Changes in the CME Environment ... What Does This Mean For the Future
Relationships Between AAFP and Industry?**

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F O U N D A T I O N

60 Year View of AAFP CME

1948: CME credit system for Family Physicians launched by AAFP

1968: AMA PRA credit system for MDs launched by AMA

1972: CME credit system for DOs launched by **AOA**

1980: CME provider accreditation, delegated to **ACCME** by AMA

2002: Evidence-Based (EB) CME launched by AAFP

2004: ACCME's updated Standards for Commercial Support (SCS) immediately adopted by AAFP (*and by AMA, AOA etc at various times*)

2005: Performance Improvement CME stds adopted: AAFP, AMA, AOA

2005: Point-of-Care (PoC) CME standards adopted: AAFP, AMA

2008: ACCME Updated Criteria & Policies

2008: U.S. Senate Finance Cmte, HR2123 / S2029 (*Waxman /Grassley bills*)

2008: AAMC Paper, Macy Foundation Report, AMA CEJA

2008: Updated PhRMA code

What's the Controversy in CME?

Who pays for what? When? Why? How?

Who benefits? Who is harmed? How?

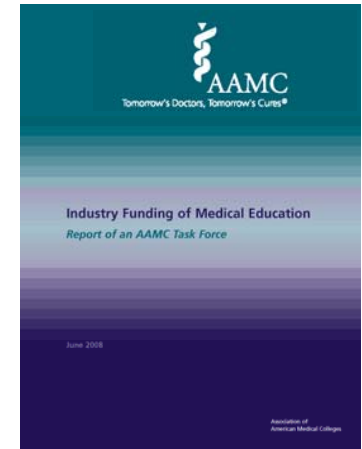
**CME should improve patient health
outcomes**

by improving clinician competence / performance

In the last 18 months ...



The Josiah Macy, Jr. Foundation



AAPF FOUNDATION

Traditional CME

**Passive learning opportunities,
on randomly selected topics,
offered as “one-and-done” activities
to professional silos of learners.**

Appropriate CME

- Certified CME, distinct from non-certified education
- Compliant with ACCME's 2004 Standards for Commercial Support and various CME accreditation requirements
- Planned and provided independently, without bias or inappropriate influence
- Conflicts of Interest are disclosed & resolved
- Improves physician competence, practice performance, and patient health outcomes

CME to which we all aspire

Needs-driven, learner-centric
interactive learning opportunities

via evidence-based curriculum and
evidence-based educational methods

focused on clinically relevant objectives
enhancing: professional competence,
practice performance & patient outcomes

AAFP's position re: industry support for CME

AAFP has clearly and consistently recognized industry's value in supporting the translation of research to education to practice ... for patients' sake!



Research



Education



Practice

AAFP's position on industry support for CME

- **AAFP has been a long-standing member of AMA's National Task Force on CME Provider / Industry Collaboration**
- **Has recognized industry's value via AAFP policies and publications for over 60 years**
(e.g., Ostergaard 1992 article in Journal of Family Practice)
- **AAFP continues to publicly voice its views:**
 - *AMA CEJA testimony June 2008*
 - *ACCME call for comments Sept 2008*

Excerpts of
AAFP's testimony to AMA's CEJA
(Council on Ethical and Judicial Affairs)
6/15/08

“... physicians have the right and the responsibility to be trained in the appropriate use of clinically sound products to provide appropriate quality care for their patients. To offer patients anything less would be socially and professionally irresponsible.”

Excerpts of

AAFP's Response to the call for comments by ACCME
(Accreditation Council on Continuing Medical Education)

9/12/08

“...further restrictions on communication could jeopardize best practices in patient care by restricting or slowing the translation of medical research into education and practice.”

AAFP is involved in most all national discussions
toward improved CME

An ACCME request that ALL health
education accreditors adopt the
ACCME's Standards for Commercial
Support as The One National Standard
in the accreditation of continuing
professional education

- AOA: American Osteopathic Association
- ANCC: American Nurses Credentialing Center
- ACPE: Accreditation Council for Pharmacy Education
- ARBO: Association of Regulatory Bodies of Optometry

What Can We Expect in the Future

- Institute of Medicine (report due February 2009) *funded by Josiah Macy Foundation*
- U.S. Govt (*Obama Administration, Senate, HHS, OIG*)

Which types of CME provider organizations will industry most likely support?

- 0% 1. Professional medical associations.
- 0% 2. Accredited medical education companies.
- 0% 3. Non-accredited medical education companies.
- 0% 4. Hospitals or clinics.
- 0% 5. Academic medical centers.
- 0% 6. Other.

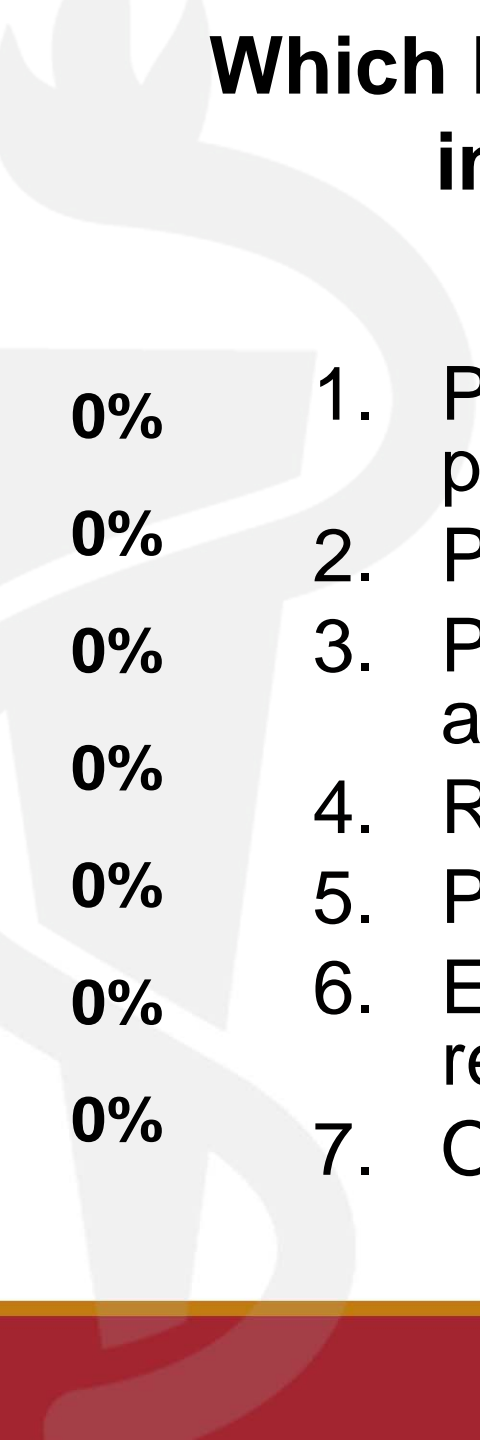
If regulations stipulate that industry can fund CME only via a centralized pool, what would your organization do?

- 0% 1. Continue support via undesignated educational grants.
- 0% 2. Stop funding CME altogether.
- 0% 3. Continue support if you can specify the therapeutic area.
- 0% 4. Continue support if you can specify the patient population.
- 0% 5. Other.

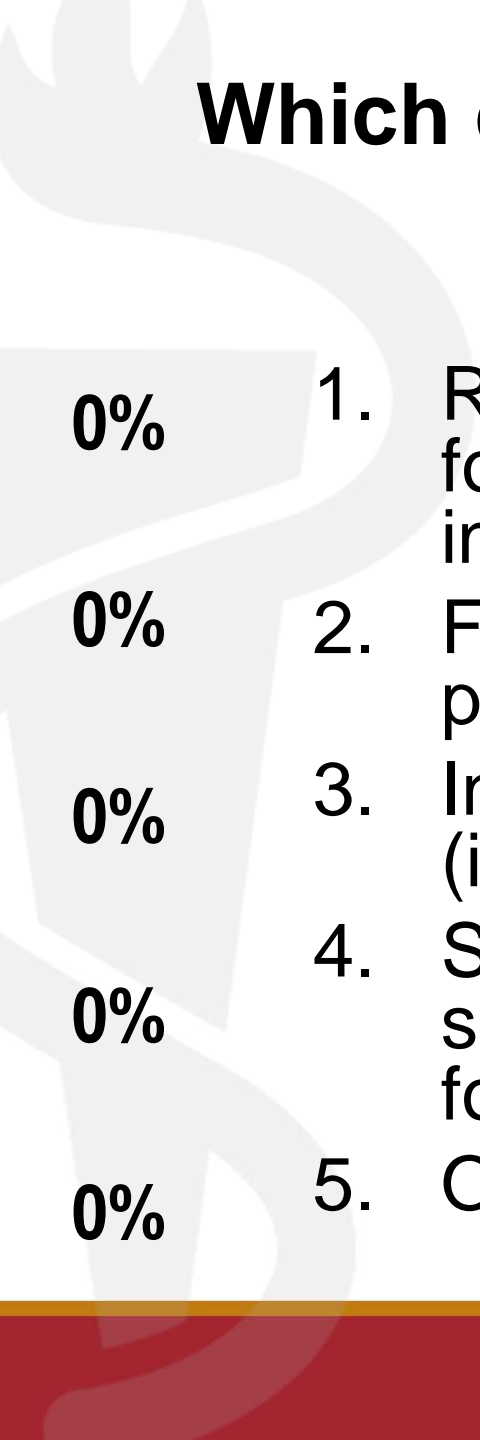
Which scenario will industry most likely pursue in its relationship with CME providers?


- 0% 1. Stop all support of CME.
- 0% 2. Shift funds from CME into DTC (e.g. detail reps, patient ed).
- 0% 3. Limit the types of CME it supports (e.g. topic or format).
- 0% 4. Limit the types of organizations it interacts with.
- 0% 5. Evolve the relationship into one that is better for patient care.
- 0% 6. Other.

Which NON-CME programming is of most interest to your organization?

- 
- | | |
|----|---|
| 0% | 1. Patient Centered Medical Home programming. |
| 0% | 2. Patient education. |
| 0% | 3. Professional education (NOT accredited CME). |
| 0% | 4. Research. |
| 0% | 5. Practice enhancement. |
| 0% | 6. Electronic health records, patient registries. |
| 0% | 7. Other, or all of the above. |

Which do you believe AAFP should do?

- 
- 0% 1. Reduce emphasis on CME (e.g. focus on patient ed or advocacy instead).
- 0% 2. Focus on CME and tools for performance improvement.
- 0% 3. Increase coordination with chapters (i.e. regional CME).
- 0% 4. Seek funds from non-industry sources (e.g. government or private foundations).
- 0% 5. Other.



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for the future
relationships
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AAFP and industry?