

An Alliance Stakeholders Meeting: Building Bridges From Information Technology and Health Informatics to CME

Jane B. Eckstein, MA, Almanac Editor-in-Chief

The Alliance Board and a group of stakeholders from the health informatics field met in May to discuss ideas and options for fostering collaboration among the information technology, informatics and CME communities.

Among the organizations represented at the meeting were the American Medical Informatics Association (AMIA), the Society for Academic Continuing Medical Education (SACME), the American Medical Association (AMA), the American Board of Medical Specialties (ABMS), the American Academy of Family Physicians (AAFP), the Joint Commission, the Iowa Foundation for Medical Care, CE City, and the US Food and Drug Administration.

Jann T. Balmer, PhD, President of the Alliance, started the meeting by noting that a transformation is underway in the field of CME. The emphasis is moving from didactic lectures and a system of credits to performance improvement (PI), which is a patient-centric model for developing education and connecting to the larger health care community. To move toward the new model, she said, the CME/continuing professional development community needs to build a bridge to medical informatics technology experts. Thus, the Alliance brought together stakeholders from the fields of CME and medical informatics to:

- Discuss how to create common understanding that accurately reflects the critical elements in each field

- Identify common goals and objectives focused on improving the delivery of health care services
- Clarify the differences between performance data and claims data as measures for improving patient care
- Identify linkages between patient improvement oriented continuing medical and health care education initiatives with data tracking systems to monitor changes in health care team performance
- Develop frameworks for collaboration that can create work opportunities for pilot implementation and analysis of combined education and information technology efforts
- Link the data collection to the new movements in maintenance of certification and/or maintenance of licensure for physicians.

Don E. Detmer, MD, President and CEO, AMIA—a 4,000-member organization with the mission of using information and communications technology to create a health care system that is safe, equitable, effective, efficient, timely and patient-centered—set the stage for the discussion with a description of the role of medical informatics/information technology in improved physician and health care team performance. He defined health informatics as a “scientific field that draws upon the information sciences and related technology to enhance the use of the knowledge base of the health sciences to improve health and health care, research, education, management, and policy.”

Dr. Detmer explained that those engaged in biomedical and health informatics harness technology to enhance the use of the burgeoning health sciences knowledge base. AMIA seeks to receive major federal funding to build a collaborative national informatics network that will promote the use of electronic health records for a range of functions—from recording data to sharing results and evaluating outcomes to engaging potential patients. Improved

Inside

- **THE FUTURE OF MEDICAL RELICENSURE AND THE RESPONSIBILITY OF CME PROVIDERS, PART 2 OF 2** [3]
- **REALITY CME: YOUR GUIDE TO WHICH WAY IS UP!** [5]
- **DON'T COUNT ON MOC TO DRIVE PI-CME** [6]
- **CALENDAR OF EVENTS** [8]

Educational Opportunities

Alliance 35th Annual Conference

January 27–30, 2010

Establishing Continuing Medical Education as a Pathway to Better Patient Care

Hilton® New Orleans Riverside
New Orleans, Louisiana

For New Alliance Programs and Products Visit the Alliance Website: www.acme-assn.org

decision-making at the time and point of care is a central objective for improving professional performance across the entire care team. Public health should also be benefited from this investment.

Informatics, he said, by its nature is collaborative, integrative and inter-professional. He also noted that AMIA offers a variety of live and online courses to train professionals about health informatics. Recently, AMIA received a \$1.2 million grant from the Gates Foundation to develop a Global Informatics Partnership program to support educational and research centers of excellence around the world, especially to help low resource nations and regions.

Next, Shahir Kassam-Adams, Chief Strategy Officer, Decision Resources, described the current data on information technology and CME. Until the last few years, he said, CME was generally delivered at live meetings, and grants for CME programs were obtained because of personal relationships between commercial supporters and CME providers. But now, he added, the most successful CME programs are delivered online and supporters and accrediting bodies are demanding data to prove the value of CME. In the future, he argued, the most successful CME providers will be the ones who use technology such as e-prescribing and smart phones to reach physicians and improve care.

Mr. Kassam-Adams pointed out that standards are needed for metrics that inform medical education, and MedBiquitous is in the process of establishing these standards. He noted that CME providers need data that prove learning is occurring and neither electronic medical records nor claims data by themselves are useful in that regard. Claims data, which are currently the only consistent source of data, are useful for showing a history of drugs that were prescribed and excellent for demonstrating adherence. However, claims data can not show how well care was delivered because they don't provide evidence of how decisions are made.

He also postulated that commercial support for CME is dwindling and, in the future, funding will go directly to physicians as pay for performance. For CME to be successful, providers must prove that education improves clinical practice and, to accomplish that goal, they need large databases that can be mined.

A spirited discussion followed about the ways the CME field can benefit from using health informatics. Paul Schyve, MD, Senior Vice-President of The Joint Commission, stated, "We are creating more and more information, and health care professionals have to translate that information into knowledge. Simply stuffing information into people's heads is not a worthwhile endeavor. Instead we need to teach health care professionals how to access and apply the information that is available."

Jack Kues, PhD, Alliance Board Member, agreed. "The system is becoming increasingly complex, but the amount of data individuals can manage at one time is limited. The best we can hope to achieve is to provide physicians with the ability to manage the complexity."

It's time for the CME field to rethink the way it does business, said David Newkirk, CEO, Executive Education, Darden Graduate School of Business, University of Virginia. "We need to ask the questions: *Who gains from having a better educated physician? How do we document the gains that are made?* Those who gain should pay for CME."

Mike Speight, Senior Director of Operations, Iowa Foundation for Medical Care, noted that payors benefit when physicians provide evidence-based care and suggested that funding for CME might come from payors.

Ultimately, the group suggested a series of actions to help CME offices integrate health informatics/information technology into their planning processes (see Figure 1).

Figure 1. Tactics To Help CME Professionals Use Health Informatics

- Engage hospital quality improvement groups in the development of performance improvement activities.
- Work to build habits of lifelong learning, starting at the undergraduate level.
- Use informatics data to identify educational gaps.
- Add members of the informatics community to CME committees.
- Build an outcome evaluation framework that links education to quality improvement.
- Begin (or continue) to collaborate with other health care professionals in developing educational programs.
- Develop an understanding of how informatics technology can help CME professionals.
- Create a communications campaign to educate CME professionals on the need to collaborate with those in health informatics.

Green Tip

Highlight your commitment to the environment by printing marketing materials, syllabi, and other items distributed to learners on recycled paper and including that fact in the footer (ie, *Printed on recycled paper—80% minimum postconsumer*).

—Submitted by Brooke Taylor

Part 2 of 2

The Future of Medical Relicensure and the Responsibility of CME Providers

Bruce J. Bellande, PhD, FACME, CCMEP, President, CME Enterprise, Inc.

Heather Flynn, BS, Manager, Technology Integration and Training, CME Enterprise, Inc.

Maintenance of Licensure and Maintenance of Certification

The medical profession must respond to the public's demands for greater accountability for physicians' competence throughout their careers, as well as assurance of patient safety. Although the two major constituents involved, state medical boards and practicing physicians, have legitimate concerns regarding the operational and financial impact of such changes,¹ through proactive regulation on the part of state medical boards and professional obligation on the part of physicians, a more appropriate and effective approach to maintenance of licensure (MOL) and competency can surely be achieved.

There has been and will continue to be considerable discussion regarding how autonomous state medical boards will choose to endorse ABMS and American Osteopathic Association-Board of Osteopathic Specialists (AOA-BOS) medical specialty boards' maintenance of certification (MOC) programs and tools as a requirement for relicensure or MOL, which depends in part upon the specifics of their statutory authority. There seems to be consensus that the use of MOC for relicensure would further standardize regulatory requirements for practicing physicians and eliminate multiple and disparate requirements (and thus the burden on the physician) that seek to achieve the same desired result of competence in clinical practice.

The Federation of State Medical Boards' Recommendations

The position of the Federation of State Medical Boards (FSMB) is that the regulatory system does in fact need to change, which will require collaboration between the organizations representing the education, training, licensure, certification and public arenas. The final report from the FSMB Special Committee on MOL was submitted to the FSMB Board of Directors in February 2008, recommending that *state medical boards take a proactive role in improving the quality of care patients receive by requiring licensed physicians to participate in programs that enable*

them to maintain or improve their competence in the scope of their daily practice. A special MOL task force also convened in October 2008 to evaluate the potential impact on medical boards, physician licensees and other key stakeholders and the overall feasibility of implementing the proposed MOL requirements.² At the FSMB House of Delegates meeting in May 2009, five recommendations in Board Report 09-2 were adopted.

1. Conduct, collect and disseminate research on, and give additional consideration to the evidence for, the need for initiating an MOL program and the effects of such a program on patient care and physician practice.
2. Conduct further analysis of outstanding issues that surfaced as a result of the MOL impact analysis report and state medical board and other stakeholders feedback to this report.
3. In collaboration with appropriate stakeholders, develop recommendations for how MOL, MOC, and other continuous improvement activities could be aligned to support state medical boards in achieving a regulatory system that assures the public of a physician's competence while minimizing duplication and burden on the physician community.
4. In collaboration with appropriate stakeholders, support/fund one or more pilot projects centering on issues relevant to MOL discussions.
5. Actively engage state medical boards, the public, physicians and other stakeholders in discussions about MOL, and solicit their input in the evolution and development of related policy recommendations.³

The Certifying Boards' Response

These specific requirements are closely aligned with MOC requirements adopted by the ABMS, including the six core competencies originally developed by the Accreditation Council for Graduate Medical Education (ACGME) and the four-part process for continuous learning, the linkage of which in essence minimizes the regulatory burden on board-certified physicians seeking to fulfill both MOL and MOC requirements. All 24 of ABMS's certifying boards and all 18 AOA-BOS osteopathic certifying boards are expected to have MOC programs fully operational by 2012.⁴ Accordingly, it is not a question of what MOL will require but when and how these new requirements will be enacted by the individual state medical boards.

As the FSMB's draft report conclusion section effectively conveys, MOL is of critical concern for both state medical boards and physicians. *State medical boards are charged to ensure that licensed physicians are qualified to practice medicine safely. . . . By requiring licensees to periodically demonstrate competence as a condition of relicensure, state medical*

boards have an opportunity both to make the health care environment safer and to improve the quality of medical care that patients receive. Physicians, in turn, have an ethical and professional obligation to their patients to maintain their competence in order to provide safe and effective care. Participation in MOL activities will assist physicians in fulfilling that responsibility and in improving the quality of health care.⁵

The Responsibility of CME Providers

There is a tremendous responsibility for CME providers to play a role in helping stakeholders fulfill their respective obligations in implementing an MOL program. The FSMB Special Committee on MOL adopted five principles to guide its deliberations. Two of these principles relate directly to CME.

1. The goal of MOL is to support physician commitment to lifelong learning and to facilitate improvement in physician practice (Principle 1).
2. The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements (Principle 4).⁶

Much of the current focus in CME on utilizing assessment and practice data to assist physicians in identifying and realizing opportunities for improvement clearly serves to complement these foundational principles.

The FSMB Special Committee on Evaluation of Quality of Care and Maintenance of Competence recommended that state medical boards become more vigorous in sponsoring educational programming as one method of achieving continued physician competence. The committee further recommended the establishment of a *statewide consortium* to facilitate meaningful and appropriate CME programming. These developments, in conjunction with the state medical boards' desire to *avoid being perceived as simply a reactive entity*, will certainly encourage them to pursue new relationships and opportunities for collaboration in the CME community.⁶ Moreover, engaging in this type of collaboration enables distribution of cost and accountability, versus singly placing the onus on the state medical boards.²

The Accreditation Council for Continuing Medical Education (ACCME) and its network of accredited CME providers will undoubtedly play a key role in vetting and even determining the acceptability (and, potentially, formal accreditation) of the variety of options available to physicians for meeting requirements. State medical boards are looking to the external community to develop resources for physicians to comply with MOL requirements and will expect CME of the future to focus on competency-based assessment and assurance of maintenance of physician competence.⁶ The need for such tools is particularly important for the special populations

described above—those non board-certified physicians who will not have access to the resources inherent to the ABMS MOC program or the AOA-BOS continuing certification.²

State medical boards stand to benefit greatly from the resources, expertise, technological capabilities, and experience of CME providers relative to self-assessment and competency-based educational interventions. The FSMB's MOL task force also expressed a desire for MOL tools/activities to *be useful for other purposes, such as assisting physicians in meeting quality improvement requirements*, thus further underscoring the need for robust, innovative approaches, such as performance improvement CME (PI-CME) that may serve as an adjunct to MOL-focused initiatives.²

MOL and MOC require highly skilled CME professionals who can demonstrate their competence and proficiency in a variety of areas that will be required and expected by policy makers and regulators. These include but are not limited to:

- Relevance to practice-based learning
- Competence of physicians and CME professionals
- Changes in practice performance
- Translation of existing and emerging research into practice
- Development of evidence-based content
- Customized self-assessment
- Elimination of commercialism and biased expert opinion
- Balanced funding
- Measurable quantitative outcomes
- Metrics to measure learning and change
- Systems-based and interdisciplinary learning.⁷

Now more than ever, it is essential that CME professionals possess and demonstrate their proficiency in designing, developing and delivering high impact education that will genuinely add value to physicians in the evolving requirements for both certification and licensure. The timely convergence of emerging state medical boards' MOL requirements and systems and the present focus in CME on self-assessment and continuous improvement create a prime opportunity for effective collaboration toward what is fundamentally a common goal. The CME provider community, alongside state medical boards, will play a leading role in answering the public's expectations and servicing the medical profession's focus on competency assessment by providing the tools and resources necessary to truly impact and improve upon patient care.

Acknowledgement

The authors thank David Watt, MD, Vice President of Professional Development, Federation of State Medical Boards, for his report to the Conjoint Committee on CME on June 27, 2007; Sandi Trusky, Council of Medical



Your CME activities are certified - shouldn't YOU be?
 learn more at www.NC-CME.org
 Apply now to take the exam Sept 14th-30th
 Earn recognition as a CME professional. Earn the CCMEP credential.



Specialty Societies staff, for transcribing and making available the report in the minutes of the Conjoint Committee on CME; and Barbara S. Schneidman, MD, Interim President/CEO, Federation of State Medical Boards, for her editorial review of this article.

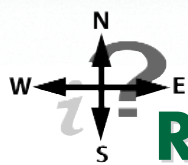
References

1. Adams D. Stricter requirements sought for relicensure as medical boards draft proposal. *AMNews*. 2007;December 24/31. Available at: www.ama-assn.org/amednews/2007/12/24/prl21224.htm. Accessed February 3, 2009.
2. *An Analysis of the Impact of Implementation of Maintenance of Licensure Requirements*. Prepared at the Request of the Federation of State Medical Boards Board of Directors, January 12, 2009. Available at: www.fsmb.org/pdf/mol_impact_analysis_report.pdf. Accessed February 3, 2009.
3. Federation of State Medical Boards. *Actions by the House of Delegates May 2, 2009*. Available at: www.fsmb.org/pdf/annual_meetings/pdf/2009_actions_by_the_hod.pdf. Accessed May 20, 2009.
4. Federation of State Medical Boards. *Board Report 08-3 Assuring the Ongoing Competence of Licensed Physicians*. Available at: www.fsmb.org/pdf/BD_Rpt_08-03_Assuring_Ongoing_Competence_of_Licensed_Physicians_2008.pdf. Accessed February 3, 2009.
5. Federation of State Medical Boards Special Committee on Maintenance of Licensure Draft Report on Maintenance of Licensure. Available at: www.fsmb.org/pdf/Special_Committee_MOL_Draft_Report_February2008.pdf. Accessed February 3, 2009.
6. Johnson D. Role of state medical boards in continuing medical education. *JCEHP*. 2005;25(3):183-189.
7. Bellande B. The CME professional: challenges and opportunities in reforming CME. *JCEHP*. 2005;25(3):203-209.

Points for Practice

1. Emerging state medical board MOL requirements and the present focus in CME on self-assessment and continuous improvement create a prime opportunity for effective collaboration toward what is fundamentally a common goal.
2. The CME provider community, alongside state medical boards, will play a leading role in answering the public's expectations and servicing the medical profession's focus on competency assessment by providing relevant tools and resources.
3. CME professionals must be proficient in designing, developing and delivering high impact education that will genuinely add value to physicians in the evolving requirements for both MOL and MOC.

Email your comments and ideas to the
Almanac Editors at: almanac@acme-assn.org.



Reality CME

Your Guide to Which Way is Up!

Question

We are revising our faculty confirmation letter and are wondering if you have any suggestions for what to include in it?

Answer

A CME provider's faculty confirmation letter can be part of their systematic approach to compliance with ACCME guidelines as a well-composed confirmation letter not only provides faculty with details such as the location, date, time of their CME presentation, honorarium, travel arrangements, and the like, but also serves as an important tool, in concert with the disclosure and attestation process, for providing faculty with the CME provider's instructions and expectations.

I like to see CME providers obtain disclosure and attestation statements from faculty *before* they make their final selection of faculty and send the faculty confirmation letters. With that in mind, one might want to consider incorporating the following into a faculty confirmation letter template (in addition to the aforementioned logistical and business items):

- Target audience (and scope of practice)
- Conference learning objectives
- Learning objectives *specific* to the faculty's presentation
- Requirements for faculty to:
 - Disclose to learners when products or procedures being discussed are off-label, unlabeled, experimental, and/or investigational (not FDA approved) and any limitations on the information that is presented, such as data that are preliminary or that represent ongoing research, interim analyses, and/or unsupported opinion
 - Prepare their CME materials with both Health Insurance Portability and Accountability Act (HIPAA) and patient safety issues in mind
 - Address cultural and linguistic competencies.

Although addressing cultural and linguistic competencies is required by law of California-based CME providers (California AB1195), I encourage all providers to instruct faculty in this regard.

Again, the faculty confirmation letter should be part of a provider's systematic approach to compliance, and this example is just *one part* of such an approach.

By Debra L. Gist, MPH, FACME, Assistant Editor

Are you doing **enough** to demonstrate independence of your CME content?

VISIT: www.cmepeerreview.com CALL: 1-800-508-6385 EMAIL: info@cmepeerreview.com



Don't Count on MOC to Drive PI-CME

Robert L. Addleton, EdD, CCMEP
Executive Vice President, Physicians' Institute for Excellence in Medicine

Floyd Pennington, PhD
President, CTL Associates

By 2010, ABMS member boards will require physician diplomates to provide evidence of participation in practice assessment and quality improvement every two to five years.¹ Will meeting these external requirements lead to sustained improvement in practice? What role, if any, will the CME community have in facilitating physician compliance with these requirements?

There is great hope in the CME community these days about PI-CME. Beyond the description of a process that can lead to up to 20 AMA Physician's Recognition Award (PRA) Category 1 Credits™ being offered, there is little standardization among CME providers about what we mean by PI-CME, but the consensus seems to be that we like it, we want to do it, we hope it will be accepted to meet (MOC) requirements, and we hope commercial interests will fund it. Many believe it is *the core of the new CME*.²

Many CME practitioners have increasing difficulty attracting physicians to time-honored activities like national and regional conferences and even to locally offered grand rounds. What makes us think that we will be more successful in supporting, enrolling or encouraging physicians to engage in practice-based learning such as PI-CME? A common response in the CME community goes something like this: *Well, they are going to have to do it. The ABMS is going to require PI projects for their Board Certification. What is it that the ABMS is requiring? According to their press release quoted above, it is some type of practice assessment and improvement project every two to five years [emphasis added].*

The AMA describes PI activities as *structured, long term processes by which a physician or group of physicians can learn about specific performance measures, retrospectively assess their practice, apply these measures prospectively over a useful interval, and re-evaluate their performance*.³ This definition emphasizes four things: a structured long term process, learning, measurement and performance. It doesn't say what the processes are. While learning is important, so is recognition that knowing is not enough. Measurement of performance is critical and represents a departure from a traditional interest in CME of measuring learning outcomes. Measuring actual learner

performance requires a different set of skills than is usually required of the CME provider. Improvement science offers a wealth of resources that must be used to guide this new emphasis on measuring performance.

Experts in the field of quality/performance improvement know what is necessary to achieve meaningful results in changing performance. The authors of *The Improvement Guide* called for a *science of improvement* that includes four factors:

1. Appreciation of a system: Systems thinking gives learners an appreciation for the complex interactions that result in our outcomes, services and products. Fundamentally, little can be improved without improvements taking place within a system or process.
2. Understanding of variation: Those who wish to improve some aspect of care will need to have tools to allow them to interpret the variation that occurs in the events they are seeking to improve, or even to select what needs to be improved.
3. A theory of knowledge: Making changes based on observation and measurement, learning from those changes, and making more changes builds a deep understanding of the systems of care in place.
4. Psychology: Those who wish to change systems must understand why the people in those systems behave the way they do, why they resist change and how to overcome the resistance.⁴

In *Know Thyself*, quality expert Robert Wanda describes two approaches to quality improvement.⁵ The first he terms *project-centric improvement* (PCI). PCI focuses on identifying low hanging fruit projects, and then executing a cycle of improvement activities to fix the problem. Organizations employing this model move from problem to problem, often in a problem of the month (or year, or every two to five years) fashion. PCI quality improvement is a project, campaign, or focus du jour.

The other approach identified by Wanda is what he calls *culture-centric improvement* (CCI). CCI calls for applying organizational values, providing workers with the proper tools (knowledge) to identify and improve processes, and to empower workers to make changes and improvements on a continuous basis. Wanda argues that CCI must come before PCI in order for true performance improvement to take place. With CCI, an organization prepares for improvement, understands systems, learns tools and processes for improvement, understands why they are seeking improvement, and then applies the project-oriented skills.

PI-CME is in danger of going down the PCI-first (and only) path. The process for earning credit designed by the AMA may be a necessary condition, but it is not sufficient. The emphasis on PI given by MOC requirements may also be important, but



Takeout Tuesdays!

Participate in the 2009 Annual Conference "Best of Sessions"
Webinars every third Tuesday of the month.



incomplete, and require too infrequent use. Those who want to improve the processes that drive their practices and who wish to improve the quality of the care they deliver to patients (and by the way, improve their own working conditions—a nice side benefit) will need to learn the culture-centric skills as well.

To draw an analogy between the limitations of the PCI approach and the promise of the CCI approach, consider the work of Davis and colleagues concerning the effectiveness of CME.⁶ They found that one-off, didactic formats (PCI-like) were not effective in changing physician behavior, while educational approaches that were more involving, such as case-based, group discussion, and multiple-intervention designs were effective. We submit that the same factors may be at work in project-centric PI, which tends to be seen as something to do once in a while or as an *extra*, and culture-centric PI, which becomes an integrated way of approaching work.

For PI-CME to achieve the impact that it could have, physicians will need to look beyond its use as an infrequent adjunct to their practice and see PI as a very powerful learning technology that can be applied as a way of life in their practices.

References

1. New standards adopted to elevate physician life-long learning assessment for the ABMS maintenance of certification (MOC) program [press release]. American Board of Medical Specialties; March 26, 2009. Available at: www.abms.org/News_and_Events/Media_Newsroom/Releases/release_NewMOCStandards_03262009.aspx. Accessed April 22, 2009.
2. Kahn N, Bagley B, Tyler S. Performance improvement CME: core of the new CME. *CPPD Report*. 2007;Spring(22). Available at: www.ama-assn.org/ama1/pub/upload/mm/455/cppd22.pdf. Accessed June 28, 2009.
3. American Medical Association. *The Physicians Recognition Award and credit system*. 2006 revision. Available at: www.ama-assn.org/ama1/pub/upload/mm/455/pr2006.pdf. Accessed April 22, 2009.
4. Langley G, et al. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. San Francisco: Jossey-Bass; 1996.
5. Wanda R. Know thyself. *Quality Progress*. 2009;April. Available at: www.asq.org/quality-progress/2009/04/continuous-improvement/know-thyself.html. Accessed April 22, 2009.
6. Davis D, et al. Impact of formal continuing medical education: do conferences, workshops, rounds, and other traditional continuing education activities change physician behavior or health care outcomes? *JAMA*. 1999;282(9):867-874.

Points for Practice

1. MOC guidelines currently promote periodic performance improvement projects, not a true culture of improvement.
2. To achieve its full promise, PI-CME must provide the tools and approaches necessary to support a culture of improvement.

Help Take Us to the Next Competency Level!

The Alliance will soon be sending out a survey to you and other CME professionals to gather expert opinions! We'll be asking for help in determining which competency-based areas are critical to your job performance. If you supervise CME employees, we'll want your feedback as to whether or not you would send your employees to competency-based education in the future. Be on the lookout for our competency survey this summer!

Correction

The editors apologize for an incorrect photo caption that appeared in the April issue of the *Almanac*. The corrected caption (and photo) appear below.



Award for Innovation in Continuing Professional Development (L to R): seated, NC-CME Board Directors Pam Mason, Karen Overstreet and Laird Kelly, NC-CME Executive Director Judy Ribble, NC-CME Board Director Marissa Seligman, and Paul Weber, representing the Alliance, grantor of the \$2,000 cash award; standing, NC-CME Board Directors Lew Miller, Jon Ukropec, Jack Kues, Marty Cearnal and Greg Thomas, and Mila Kostic, Leader of the Award Selection Panel. Not pictured, recipient Dennis Wentz.

Share your thoughts on Alliance issues
by contacting the Board at:
acmeboard@acme-assn.org.

Calendar of Events

August 12, 2009

Medical Specialty Societies
 2009 Summer Meeting
 Heart House
 American College of Cardiology
 Washington, DC

August 14, 2009

Medical Specialty Societies
 2009 Summer Meeting
 American College of Surgeons
 Chicago, IL

September 9-11, 2009

NIQIE 2009
Mastering Continuous Performance Improvement
 Intercontinental Chicago O'Hare
 Rosemont (Chicago), IL
www.niqie.org

September 14-30, 2009

NC-CME Exam
www.nccme.org

October 14-16, 2009

20th Annual Conference of the National Task Force on CME Provider/Industry Collaboration
 Baltimore Marriott Waterfront, Baltimore, MD
www.ama-assn.org/go/cmetaskforce

January 27-30, 2010

Alliance for Continuing Medical Education
 35th Annual Conference
Establishing Continuing Medical Education as a Pathway to Better Patient Care
 Hilton® New Orleans Riverside
 New Orleans, LA
www.acme-assn.org

Alliance Almanac

Almanac Editors

Jane Eckstein, MA—Editor-in-Chief
 Marissa Seligman, PharmD—Associate Editor
 Derek Dietze, MA—Assistant Editor
 Debra L. Gist, MPH, FACME—Assistant Editor
 Robin Hendricks, MAdEd—Assistant Editor
 Paul D. Weber, MA—Managing Editor
 Mitch Pruitt—Production Editor

Almanac Editorial Board

Linda DuPont, BA
 Paul Frisch, JD
 Paige Green, MEd
 Kevin Heffernan
 Kate Regnier, MBA
 Tiffany Stepien, BS
 Brooke Taylor, MPH
 NaBrina J. Webb, MBA
 Betsy Woodall, PharmD

2009 Board of Directors

Jann T. Balmer, PhD, FACME, President*
 Maureen Doyle-Scharff, MBA, FACME,
 Secretary/Treasurer*
 Sue Ann Capizzi, MBA, FACME, Past President*
 Bob Addleton, EdD
 Winnie Brown, MPA
 Nancy Davis, PhD
 Barbara Huffman, MEd
 Jack Kues, PhD
 Damon K. Marquis, MA
 George Mejicano, MD*
 Greg Paulos, MBA
 Linda Raichle, PhD, FACME
 Mark Schaffer, EdM
 Destry Sulkes, MD

*Executive Committee

© Copyright 2009 by the Alliance for Continuing Medical Education®. All rights reserved.

Headquarters Office

Paul D. Weber, MA—Executive Director*
 Bernie Halbur, PhD, FACME—Professional Development and Meeting Management Director
 Jay Brown, BA—Project Manager and Meeting Planner
 James C. Leist, EdD, FACME—Staff Consultant
 Diane Baker O'Hern—Professional Development Coordinator
 Marissa K. Green—Manager, Membership Information Services
 Anne Marie Smith, BS—Staff Assistant
 Debrah Fisher, BA—Manager of Member Services
 Alison Skinner, BA—Executive Assistant
 Jessica Romano, BS—Product Development/Marketing Specialist
 Jill Real, BS—Bookkeeper
 Amy Guberman, MPM—Staff Consultant
 Megan Pace, BA—Administrative Assistant

The *Almanac* is published monthly by the Alliance for CME, 1025 Montgomery Highway, Suite 105, Birmingham, AL 35216; Phone: 205-824-1355; Fax: 205-824-1357; email: acme@acme-assn.org; ISSN#1076-3899. The views expressed in the *Almanac* are those of the authors and are not intended to represent the views of the Alliance or its membership.

Alliance for Continuing Medical Education®

1025 Montgomery Highway
 Suite 105
 Birmingham, AL 35216

Address Service Requested

Nonprofit Org.
 US Postage
 PAID
 Permit No. 2230
 Birmingham, AL