

Kick Off Your Annual Conference Learning Experience

In the October issue, we invited you to start planning your learning experience for the Annual Conference, to be held January 26–29, 2011 at the San Francisco Marriott[™] Marquis, San Francisco, California. As you begin your planning, be sure to include the many valuable opportunities to learn and network with your colleagues on Wednesday, January 26th, 2011. The day begins at 8:30am with four intensives to select from:

CME Basics Seminar—Whether you are a newcomer to CME or an experienced professional in need of a refresher, this intensive session provides relevant and practical insights into the knowledge and skills needed to develop effective CME. Participants will identify key strategies to take back and apply in their own CME settings. This year includes a self-assessment exercise and the development of a learning plan for continuous improvement.

CE/CME/CPD 501: A Transformational Leadership Workshop Year Two—The target participant for this session is the advanced (10+ years) professional, and it will address the critical needs of the CME arena in the area of transformational leadership. The goal of this intensive session is to help CME leaders understand how to facilitate change that positions CME as a relevant component of practice/performance improvement for health care professionals that leads to improved patient care/outcomes. Developing a transformational change *plan of action* is one of the objectives for participants in this session.

Advanced Program Analysis: Practical Methods to Quantify Learning—Developed for experienced professionals, this intensive session looks at the methods of program analysis with a focus on translating data from individual activities into a quantitative measure of overall program success. Participants will study practical examples of assessment questions, multiple-choice test items, and methods for assessing the success of their organization's Mission.

Informatics Boot Camp with the American Medical Informatics Association and MedBiquitous—Targeted for experienced professionals, this intensive is intended to introduce those with little or no knowledge of informatics to the nature, key concepts and application of the discipline of biomedical informatics. Biomedical informatics is an interdisciplinary field that studies and pursues the effective uses of biomedical data, information, and knowledge for scientific inquiry, problem solving and decision making.

Note: There is an additional fee to attend each of these intensive sessions

From 1:30 to 5:00pm attendees can network and learn with colleagues by attending one of eight *Member Section Meetings*, which are focused on solutions to issues and challenges within similar work environments. Consistently rated as one of the most valuable offerings at the annual conference, member section meetings are intended to provide take home pearls on timely topics, and strategies that incorporate best practices you can use in your CME program. Through group interaction you will also meet peers who can serve as resources or collaborative partners during the conference and beyond.

At 5:15pm you have the opportunity to hear from this year's *Maitland Memorial Lecturer*, Lew Miller, MS, CCMEP. Mr.

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Educational Opportunities

Alliance 36th Annual Conference

January 26–29, 2011

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Miller has a very distinguished career in CME and has mentored many others in the field, both in the United States and abroad. The lecture is an annual event given in honor of Frances Maitland, the first full time executive director of the Alliance and an inspirational mentor to many of today's CME leaders.

Concluding the day's events, at 5:45pm is the *Mentor Mentee Program*. Designed to bring newcomers to CME and/or the annual conference together with experienced CME professionals, this session offers a structured environment to meet. Mentors help mentees address the needs of navigating the conference, selecting sessions to attend, identifying networking opportunities, and finding additional resources. Matches are made according to work environment and/or geographic location. To participate as either a mentor or mentee, check the appropriate box on your conference registration form.

Abstracts for each of these learning and networking opportunities can be found on the 2011 Alliance Annual Conference web page at www.acme-assn.org/11conf.

The American Board of Medical Specialties: Higher standards, Better care[®]

Sylvia McGreal, American Board of Medical Specialties Marketing and Communications Specialist

Mellie Villahermosa Pouwels, American Board of Medical Specialties Program Director, Maintenance of Certification Support Program

Established in 1933, the American Board of Medical Specialties (ABMS) is a highly respected organization consisting of 24 medical specialty Member Boards. The 24 Member Boards that make up the ABMS Board Enterprise include: American Board of Allergy and Immunology, American Board of Anesthesiology, American Board of Colon and Rectal Surgery, American Board of Dermatology, American Board of Emergency Medicine, American Board of Family Medicine, American Board of Internal Medicine, American Board of Medical Genetics, American Board of Neurological Surgery, American Board of Nuclear Medicine, American Board of Obstetrics and Gynecology, American Board of Ophthalmology, American Board of Orthopaedic Surgery, American Board of Otolaryngology, American Board of

Pathology, American Board of Pediatrics, American Board of Physical Medicine and Rehabilitation, American Board of Plastic Surgery, American Board of Preventive Medicine, American Board of Psychiatry and Neurology, American Board of Radiology, American Board of Surgery, American Board of Thoracic Surgery, and American Board of Urology.

In addition, there are nine Associate Members with shared goals relating to the education, training, and certification of medical specialists. Associate Members include: Accreditation Council for Continuing Medical Education (ACCME), Accreditation Council for Graduate Medical Education (ACGME), American Hospital Association (AHA), American Medical Association (AMA), Association of American Medical Colleges (AAMC), Council of Medical Specialty Societies (CMSS), Education Commission for Foreign Medical Graduates (ECFMG), The Federation of State Medical Boards of the United States, Inc. (FSMB), and National Board of Medical Examiners (NBME).

The Member Boards certify physicians in more than 145 medical specialties and subspecialties ranging from family medicine and cardiology to emergency medicine and plastic surgery (for more information on this, visit: www.abms.org/Who_We_Help/Physicians/specialties.aspx). A limited number of ABMS Member Boards also certify non-physician specialists in such areas as radiology and medical genetics. The ABMS Member Boards evaluate candidates who voluntarily apply for certification in a specialty or related subspecialty area, and certify those qualified as a *diplomate* of their Board. Once certified, the diplomates participate in an ongoing professional development program called the ABMS Maintenance of Certification[®] (ABMS MOC[®]) program for re-evaluation by their Board(s).

Board Certification of a medical specialist is distinct from self-declared specialization and state licensing, which is not specialty specific and sets the *minimum* competency requirements to diagnose and treat patients. By definition, Board Certification implies a higher level of expertise in medical practice, and lets the public know that a physician has demonstrated the medical knowledge, judgment, professionalism, clinical and communication skills required to provide quality care in that specialty. Though Board Certification is a voluntary credential, most physicians seek it because it is often needed to obtain hospital privileges and to contract with insurance companies. Additionally, many professional societies require Board Certification for membership. (Individuals may check whether a physician is certified by ABMS at www.abms.org/WC.)

ABMS and the Member Boards are all independent non-profit organizations that establish their processes and standards free of any professional or governmental body. Each Member



CME Basics for Beginners—CD

www.acme-assn.org

Designed specifically for new and early career development, but may also serve as a refresher for experienced CME professionals. Included: needs assessment, instructional design and evaluation, accreditation and regulatory requirements, and CME professional competencies.

Board maintains its own Board of Directors, elected from within the specialty and the public. These leaders and others from the Member Boards and the public make up the ABMS Board of Directors and Assembly. ABMS, the ABMS Member Boards, and the ABMS Associate Members work collectively to maintain and improve the quality of medical care by creating and utilizing educational and professional standards for graduate medical education and continuous learning activities of medical specialists. This agenda progresses outward through various health care quality and educational organizations that share similar goals.

With the rapid changes in medicine today, it is critical for a physician, surgeon or clinician to continually learn new methodologies for diagnosing and treating patients. Recognizing competence is more than the demonstration of knowledge on a periodic test or the accumulation of credits at educational meetings, ABMS and the Member Boards began discussions in the late 1990s on moving beyond the recertification system to one that is a continuous assessment of a physician's abilities.

Future articles in this series will outline the development of the ABMS MOC program, detail its key components and requirements, and highlight the potential role for CME providers in assisting ABMS diplomates fulfill their requirements. Should readers need information prior to the release of these subsequent articles, additional resources are available at www.abms.org.

Regularly Scheduled Series Monitoring: Suggested Best Practices

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Alliance Competency Area 7.5: Develop a management culture of the office that will reflect a collaborative, service oriented, continuous improvement system that meets the needs of the physicians served, the organization of the CME program, and the accreditation standards.

CME departments in hospital and health systems range in staff size, budget and availability of resources. A absence of resources may create challenges in efficiently monitoring regularly scheduled series (RSS). The monitoring process is essential for meeting CME accreditation requirements, but more importantly, it can help the hospital or health system identify additional practice gap areas for quality improvement, and performance improvement opportunities for the organization. As stated in ACCME Criterion 3: *All RSS must be designed to make a change in clinical competence (strategy), performance, or patient outcomes of these learners.*

In years past, all of the sessions of an RSS in a specific department were considered to be individual CME activities requiring the documentation of any one-time CME activity. Now all of the sessions of an RSS conducted by one department are considered multiple sessions of a single topic. This has significantly reduced the amount of time required to gather CME documentation for RSS files. However, CME providers of RSS must still have processes and documentation to demonstrate compliance. In assessing RSS monitoring, some key components to consider, as well as suggested best practices, can be found in Table 1.

Consider the following cases that illustrate how CME providers may approach RSS monitoring challenges:

Case #1: An Internal Medicine RSS activity has a disclosure stating, Dr. Smith has disclosed that he does not have a financial interest or other relationship with manufacturers of any of the products or any of the

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services that they provide. However, the CME provider did not receive the presentation slides prior to the conference. What could you do to ensure compliance?

Suggested Approach: Have the course director review the slides before presentation without the projector on, checking for

all areas of compliance with the ACCME criteria and making sure the disclosure statement for the speaker is the first slide after the title slide. Also, save the presentation, preferably from the speaker's flash drive to the computer desk top, for future printing and inclusion in CME files.

Table 1: Key Components of and Best Practices for Regularly Scheduled Series Monitoring

RSS Monitoring Questions	If the Answer is No	Suggested Best Practices
Evaluate how your RSS CMEs are organized, planned and implemented. Is it working for you?	Review: 1. The RSS CME credit application for your organization 2. The ACCME's <i>Directed Self-Assessment for Readiness to Meet the Updated Accreditation Criteria</i> 3. The Alliance web series <i>Regularly Scheduled Series (RSS): A Bridge to Quality</i> .	Have a sub-section of your CME committee act as an RSS planning committee to work with the CME department on these challenges.
Do you have a process for pre-event monitoring that includes reviewing presentations and disclosures and resolving conflicts of interest (COI)?	Create a process and include this requirement in a policy. Refer to the ACCME's website regarding COI (www.accme.org).	Create and use a checklist. Request presentations and disclosure statements at least 30 days prior to RSS CMEs, in order to allow time for course directors to review for content, COI, HIPAA and other issues. COI should be resolved prior to the activity and documented accordingly.
Are you actively, real-time monitoring your RSS CMEs?	Start monitoring today! Attend the CME and monitor for: objectives, evaluations completed, accreditation statement, disclosures, letter of agreement/exhibitor forms or joint sponsorship agreement, if they are applicable. See 2010 Alliance Annual Conference, Session F69, by Becky Williams, MEd; also see the ACCME's <i>RSS Toolkit</i> .	Have your course director complete a course summary form for Criteria 7-11. A good one is from the 2010 Alliance Annual Conference, Session F10, by Jason Olivieri, MPH.
Are you auditing RSS CME files post-activity?	Schedule post-activity file audits weekly, monthly, quarterly, or whatever works for your department.	Monthly audits allow enough time to tabulate evaluations, settle finances and complete the documentation for RSS CME. To ensure auditing occurs, link it with another task you perform regularly. For example, conduct RSS file auditing when you complete data entry for transcripts.
Do you have a policy for non-compliance with CME documentation?	Create one! Follow the policy process at your organization, and clearly explain your expectations for RSS documentation and the consequences for non-compliance.	Consider a three strikes policy, and then suspend the RSS CME credit until files are completed.



- Information on upcoming conferences and events in your area!
- Resources to help SROs get started, develop, and grow!

Case #2: Post-activity, the CME department receives an old version of sign-in sheets without a disclosure statement on the form. (Current policy requires a disclosure statement on the sign-in form.)

Suggested Response: Contact the responsible party and ask for the documentation they are currently using, update the files and email them back. Consider listing this error on your *three strikes* list. Verify that the presentation had the disclosure statement included to demonstrate accreditation compliance. An additional option would be to have the course director sign a verbal disclosure form that is consistent with ACCME requirements. Be sure the responsible party has the current version of the form and explain why its use is necessary.

Depending on the data entry system utilized, flagging discrepancies, areas of improvement, printing reports and documenting criteria compliance are all essential parts of RSS monitoring. Using an established checklist, such as *A Snap Shot of Your Organization's Level of Compliance* worksheet from the ACCME, or creating your own could be helpful. Great resources to help you in meeting RSS and other compliance challenges include the Alliance member section listserv at: www.acme-assn.org/members_only/listserv, and LinkedIn's CME groups and State Medical Society CME groups at: www.linkedin.com.

When an error or discrepancy is discovered, the best solution is to describe the problem, create the improvement plan needed, and document the outcomes of this intervention. These steps will help you to meet ACCME Criteria 13–15. Alliance member sections, CME consultants, the Alliance and the ACCME all offer best practices, position statements or training on their websites. To improve RSS monitoring and management, providers should engage in learning and collaborating to continually improve their CME programs.

Additional Resources

1. Accreditation Council for Continuing Medical Education. *Insights for Planning Regularly Scheduled Series (RSS)*. Transcript of video FAQ. Available at: http://education.accme.org/files/E139_20091218_transcript_0.pdf. Accessed October 25, 2010.

Points for Practice

- Make sure your program has policies and procedures to demonstrate that RSS are in compliance with ACCME criteria, policies and standards.
- Use checklists to plan and execute RSS.
- When a error is discovered, create and document an improvement plan.

A Community of Practice Leads Analysis of ACCME Level Three Accreditation Criteria: A Summary

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CME Leaders for Change was formed in 2008 and became the resource for a session on leadership at the Alliance 2009 Annual Conference. Its purpose was, and still is, to assist CME providers in leading necessary transformational change in CME.

In the initial year members focused on leadership development and leading change through virtual interaction, and developed a *community of practice* of CME providers. Members took advantage of monthly conference calls and a dedicated website that hosted tools and resource materials to assist in transformational change. The initial project that the members of the CME Leaders for Change community of practice felt was important was an analysis of the Level 3 Accreditation Criteria, since these optional accreditation requirements for CME providers were going to become required for providers seeking re-accreditation after July, 2009. The group proceeded to systematically analyze each criterion, share best practices and challenges with one another, and report to the profession key learning points for each. The community of practice worked with the Alliance to publish its results in the *Almanac*.

The following is a summary of the highlights from the work of the members of CME Leaders for Change that should facilitate transformational change in CME:

Criterion 16: The provider operates in a manner that integrates CME into the process for improving professional practice. Selected best practices included CME providers' involvement in quality improvement (QI) committees and asking key questions about how CME activities could be incorporated into QI initiatives and what resources could the CME office provide to help clinicians incorporate the knowledge, or skill, into their practices. Key takeaways:

- Organize internal staff training at all levels.
- Initiate discussions that lead to outcomes-based action plans.
- Implement tools (eg, grids, reports) to track and sustain improvements.

- Identify key partnerships for CME that will assist with the implementation of improving practice.

Criterion 17: The provider utilizes non-education strategies (NES) to enhance change as an adjunct to its activities/educational interventions (eg, reminders, patient feedback). Selected best practices included the incorporation of reminders with examples in planning agendas, connecting NES to the desired results of the activity, and asking planners to consider what is necessary for the learners to apply the activity content when they return to practice. Key takeaways:

- NES should be a fundamental component to program goals.
- Facilitate access to tools, especially public domain tools, into activity relevant to the CME mission.
- Always ask: *Have we included NES in the planning and implementation of this CME activity?*

Criterion 18: The provider identifies factors outside the provider's control that impacts on patient outcomes. Selected best practices included identifying factors at the program level and developing mission statements accordingly, documenting factors in each activity file, offering staff development to identify factors, and connecting with faculty to address those factors in the planning process. Key takeaways:

- Consider this criterion as an extension of your mission, which can be strengthened by identifying what it is not.
- Staff development is crucial, and planning tools are needed to link criterion and activity execution.
- Seek collaborative partners to expand your reach.

Criterion 19: The provider implements educational strategies to remove, overcome, or address barriers to physician change. Selected best practices included relating this responsibility as part of the program's mission, selecting staff who have clinical work experience in clinical settings and can identify barriers, involving experts and activity planners to consider barriers during early planning stages, and connecting barriers to identified professional practice gaps. Key takeaways:

- Develop processes for internal staff to develop expertise in identifying barriers, and then address those barriers by building the result into your planning documents.
- Collaborate with other units of your organization for recommendation of strategies for addressing barriers.
- Make this a continuous process through outcome surveys that may identify barriers or successes that would be applicable to future activities.

Criterion 20: The provider builds bridges with other stakeholders through collaboration and cooperation. Selected best practices included working with external and internal stakeholders (CME or non-CME) to produce effective results and support clinical needs, considering a long term relationship with an external or internal stakeholder to produce an effective practice outcome, and assuring that the collaboration is of benefit for all stakeholders. Key takeaways:

- When planning an activity to meet a practice need, explore other stakeholders that would benefit from the improvement of a practice need.
- Internal/external collaboration and cooperation are critical elements for success for any activity.
- Consider involvement of physicians in the planning of an activity.

Criterion 21: The provider participates within an institutional system framework for quality improvement. Selected best practices included changing the mindset from needs to practice gaps, building alliances with QI organizations or organizations that have QI systems, collaborating with a certification board to be disseminator of QI and clinical information, and identifying leaders who could communicate the value of QI among key stakeholders. Key takeaways:

- Participate in the design of a QI strategy, with input from multiple stakeholders, to determine how CME can meet the needs of the strategy.
- Incorporate QI tenets into the CME design to address expected outcomes that improve performance of learners and result in improved quality of care.
- Document actions in activity planning documents to demonstrate how QI is addressed at the program and activity levels.

Criterion 22: The provider is positioned to influence the scope and content of activities/educational interventions. Selected best practices included assessing placement, position and involvement within your organization and with colleagues, analyzing compliance with each of the previous 21 criteria, and performing assessment annually. Key takeaways:

- Evidence of control of activity development from inception of the idea to evaluation of the activity.
- Demonstrate integral involvement in *all* activities, especially those that are jointly sponsored.
- In re-accreditation, remember that information flows from three sources: self-study report, interview and file review.

Essentially, these level three criteria require CME providers to change for the better by raising the level and focus on outcomes, not just processes, considering non-educational strategies, and building collaboration within the organization and externally to enhance CME providers and their effectiveness. As you can tell from this brief summary, there are opportunities and challenges for the CME provider in implementing these level three criteria. Yet it was the sense of the community of practice that these criteria are essential to a successful CME program and to continually create value for CME in health care as a significant resource to improve physician performance and, ultimately, patient care.

Members of CME Leaders for Change who took on a leadership role in communicating and disseminating information gleaned from the community of practice collaborative included: Penny Coots, MEd; Jeanne Cornish, RPh, CCMEP; Linda Dupont, BA; Donna Guadagnoli, CCMEP; Brenda Johnson, MEd, CCMEP; Monique Johnson, MD; Susan O'Brien; Jan Perez, CCMEP; Peshia Rubinstein, CCMEP; Sylvia Scherr, RN, MS; Scott Scire; Shari Tordoff, BS, CCMEP; Jo Townson, BA; Richard Vanderpool, CCMEP.

Change is necessary in CME. A community of practice is one effective means to facilitate change—or at least to make people aware that change is essential, how to do it, and how to receive support in the change process through a collaborative community. CME Leaders for Change, an Alliance resource, is ready to tackle the next hurdle for CME providers, and can be a helpful tool for your growth and for leading transformational change in your setting.

Get involved! Reach your leadership potential. Be a part of something transformational that positions CME as a strategic asset in health care. Go online to www.cmeleadersforchange.com to view the website or contact the Alliance for more information.



Question

What wording does the ACCME require be in a CME activity brochure?

Answer

From the ACCME's perspective, the only required language in a brochure for a CME activity is the appropriate

accreditation statement. ACCME does not provide guidance on where the accreditation statement should be located in the brochure.

However, the AMA requires *activity announcements*, whether electronically communicated or in print form, that are *designed to build awareness of the activity's educational content among the target physician audience*. The announcements must include the AMA Credit Designation Statement whenever the number of AMA Physician Recognition Award (PRA) Category 1 Credits™ is included. Notably, beginning July 1, 2011, providers must use the appropriate AMA Credit Designation Statement based on the learning format (eg, live activity, enduring material). The AMA also requires that the providers communicate to prospective learners a *clearly identified educational purpose and/or objectives in advance of participation in the activity*. Practically, this means the brochure should include the learning objectives for the activity.

Interestingly, per the AMA, a save-the-date announcement for an activity that has been approved for AMA PRA Category 1 Credit can state, *This activity has been approved for AMA PRA Category 1 Credit*, but this form of announcement cannot state the exact number of credits. And, of course, if an activity has not been certified for credit then nothing can be stated relative to CME credit.

Providers are free to set their own brochure standards. This certainly makes sense from a branding perspective, as does communicating, for instance, the faculty names and their affiliations, a compelling conference purpose, identification of the target audience, location, and dates (think *common sense*). Some providers utilize a brochure checklist, and use it not only to build the brochure but as a tool for final review and approval of the activity brochure.

References

1. Accreditation Council for Continuing Medical Education. *ACCME Policies*. Available at: www.accme.org/index.cfm/fa/Policy.home/Policy.cfm. Accessed October 25, 2010.
2. American Medical Association. *The Physician's Recognition Award and credit system*. 2010 revision. Available at: www.ama-assn.org/ama/pub/education-careers/continuing-medical-education/physicians-recognition-award-credit-system/full-text-booklet.shtml. Accessed October 25, 2010.

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

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

Calendar of Events

December 1-31, 2010

CCMEP Exam at local testing centers
 Registration closes November 30
www.nc-cme.org

December 8-10, 2010

ACCME CME as a Bridge to Quality™ Workshop
 Westin Chicago River North, Chicago, IL
<http://education.accme.org/Workshops>

January 26-29, 2011

Alliance for Continuing Medical Education
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*The New CME—Blending Adult Learning Facilitation
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 San Francisco Marriott, San Francisco, CA

May 12-13, 2011

Fourth Annual PACME Summit
Common Ground for Better Patient Care
 Sofitel Philadelphia Hotel, Philadelphia, PA
 Registration Information Coming Soon

July 28-29, 2011

Alliance for Continuing Medical Education
 CME Basics Institute
 Hilton Alexandria Mark Center, Alexandria, VA
 Registration Information Coming Soon

Alliance Almanac

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