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Providers' Experience with the Accreditation Council for Continuing Medical Education Updated Accreditation Criteria: Qualitative Survey Results Part 1

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Complying with the Accreditation Council for Continuing Medical Education (ACCME) 2006 Updated Accreditation Criteria (UAC) has been one of the greatest challenges CME providers have faced in recent years. The implementation of more rigorous outcomes data collection, enhanced documentation, and adherence to additional regulatory guidelines has strained or even overwhelmed many CME providers. The accreditation updates are significant and somewhat complex, and they require additional resources and competencies not traditionally resident within many CME provider organizations. As a result of the challenges, some providers have decided not to pursue reaccreditation. Others, inspired by the UAC, have successfully implemented changes in their structure, procedures, and philosophies—a number of which are reported to have resulted in significant persistent improvements in their CME program's quality, effectiveness and outcomes. Having observed these improvements, we were curious to learn whether the positive program improvements were isolated in their occurrence or more widespread. Were the UAC the catalyst for observed changes, or were the improvements on track to occur prior to their release? If organizations faced specific challenges, how did they overcome them? Moreover, we were interested in evaluating any adverse changes attributed to the UAC as well. Did the criteria serve as a barrier to any positive changes being planned or executed? Were the required advances too strenuous for their organization to bear, or was there little or no impact on their CME program at all?

Methodology

In the fall of 2009, CME professionals were invited to participate in a four-question qualitative online survey designed to provide insights on how the UAC impacted results observed in their respective organizations with regard to implementation of the ACCME 2006 UAC. CME professionals were invited to participate through the various Alliance member listserv groups and a collaborative network of State Medical Society (SMS) accredited providers organized by the Physician's Institute for Excellence in Medicine. A total of 79 complete responses were received from CME professionals from 54 SMS-accredited providers, 23 ACCME-accredited providers and two nonaccredited organizations. The survey questions are shown in Table 1.

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The qualitative results were themed, coded and analyzed using ATLAS.ti software. Themes present across responses were identified in order to reflect shared responses among participants. Themes unique to individual participant data were also noted, and included in the qualitative analysis. Positive themes that emerged from the self-reported data are summarized below. Limitations in the study design include a lack of random respondent selection and lack of control of the quantity of respondents from individual organizations or organizational types (eg, academia, hospitals, medical education communication companies [MECCs]). Nonetheless, the captured data provide a useful snapshot of organizational changes that may be representative of the larger community of CME providers. Part 2 of this series will highlight neutral and negative results yielded from the survey, along with insights into how providers are working to overcome specific challenges.

Implementing the ACCME UAC: Perceived Results by Providers

Specific guiding themes that were revealed in response analysis included:

1. Improvements in grant development
2. Outcomes-related improvements
3. Practice gap/needs assessment-related improvements
4. UAC as a catalyst for learning and innovation
5. Performance Improvement (PI) and/or Quality Improvement (QI)
6. Increase in intra and extra organizational communication/collaboration
7. Regulatory education and improvements.

Improvements in Grant Development

Survey respondents described improvements in grant development, including an increased focus on multi-supported applications/grants, and a general improvement in integrating and applying the criteria in order to clarify grant content.

Outcomes Related Improvements

Respondents reported positive improvements in their understanding of, focus on, approach to, and use of educational outcomes measurement/data. While some provider groups began measuring and utilizing outcomes data for the first time post UAC, others were challenged to improve their existing methodologies as they worked to measure changes in competence, performance and even patient-level outcomes. As reported, *It has [caused] us to thoughtfully consider our performance and, as a result, has improved our patient outcomes, particularly in the areas of diabetes and [congestive heart failure] CHF.*

Certain organizations have successfully utilized outcomes data to inform and target future education. As described, *. . . [We] have revised our CME evaluation process to glean information on how the activity contributed to the physicians' knowledge base and ability to provide quality care. This information is valuable to us because it helps us better develop effective CME courses.*

Practice Gap/Needs Assessment Related Improvements

Respondents described significant improvements in their approaches to the identification of practice gaps and educational needs, as well as using these to inform educational programming. As stated, *They are thinking about practice gaps and the needs of our learners before they begin planning content,* and *The "interesting" case discussion is gone, unless it now addresses a practice gap. The focus is now looking at practice gaps and what we can do to close those gaps.*

UAC as a Catalyst for Learning and Innovation

UAC-inspired improvements were reported in staff knowledge and application of the criteria. As highlighted, *The process of recruiting speakers for our presentations has been a little more clear with the new guidelines from ACCME.*

Table 1: Survey Questions

1. What type of CME provider do you work for?
2. Please briefly describe the *positive results* you've observed in your organization based on efforts to implement the ACCME's Updated Accreditation Criteria.
3. Please briefly describe the *negative results* you've observed in your organization based on efforts to implement the ACCME's Updated Accreditation Criteria.
4. How has your organization *overcome any challenges* brought about by the implementation of the ACCME's Updated Accreditation Criteria?

Respondents also described how the UAC led to other program-related improvements, including positive changes in CME program structure, CME initiative content, faculty recruitment/involvement, and educational innovations/format.

PI and/or QI

Educational providers described performance and QI-related enhancements that have been implemented in their CME programs. As relayed, *Our CME program planning has become more rigorous. We are becoming attuned to a quality improvement point of view, using the QI cycle of plan-do-study-act.*

Several groups reported benefits from improved collaborations with internal PI/QI departments that allowed for data driven improvements in their needs assessment and outcomes measurement protocols.

Increase in Intra and Extra Organizational Communication/Collaboration

Respondents put forth examples of improvements in collaborations with departments within their institutions, as well as with external organizations and stakeholders. Collaborative partners ranged from physician members of QI and CME planning committees, to individual learners, to community clinics. As described, *[We have observed] more thoughtful involvement from the physicians on our CME Committee as we struggle to meet the criteria,* and *[The UAC have] caused our system of hospitals to work together and likely become one provider vs. multiple.*

Regulatory Education and Improvements

Although the updated criteria did not largely focus on commercial support or bias, and did not address disclosure policies specifically in its language, some CME providers reported an impact of the UAC on these domains. Improvements centered on the communication of ACCME standards to joint sponsors, increased oversight of potential commercial bias, improvements in disclosure protocols, and the implementation of more stringent policies regarding commercial support.

Conclusions

Important considerations of increased time, cost, and strain on resources notwithstanding, this sampling of CME provider experiences reveals specific, positive results from the implementation of the updated criteria. Respondents described a range of program-related improvements, many of which were, at the time of the survey administration, already producing observable changes in competence and performance level outcomes. They described strategies that helped them overcome the large UAC challenge, which tended to focus on intra and extra organizational collaborations, and improvements in targeted attention and innovation of staff/stakeholders. An increased level of importance or credibility associated with CME seemed to have emerged in respondent organizations, which tended to assist in rallying staff and allies to help fulfill new requirements. General trends of hopefulness were observed overall, as provider statements trended towards positive recollections and plans for future improvements and outcomes. As we continue to monitor how providers are affected by the changes in accreditation criteria and in the CME industry overall, it is important to keep in mind this telling description of improved processes and results. It is also important to continue to share successes and challenges with educational provider colleagues, as we can be encouraged by one another's successes, and learn collectively from our efforts.

Several groups reported benefits from improved collaborations with internal PI/QI departments that allowed for data driven improvements in their needs assessment and outcomes measurement protocols.

Acknowledgements

Special thanks to Bob Addleton of the Physician's Institute for Excellence in Medicine for assistance in survey distribution, to Alea Bunker of Improve CME for her help with survey and data management, and to all of the survey respondents.

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

CME in Europe: A Trend Towards Continuing Professional Development in Local Systems

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This article is based on the T2, Intensive, presented at the 35th Alliance Annual Conference, January 28, 2010.

Overview

Although CME systems have been implemented throughout Europe, significant differences, often related to local culture and health care systems, exist among these countries. National accreditation authorities (NAA) are responsible for the accreditation of country-specific events while the European Accreditation Council for CME (EACCME), under the umbrella of the Union Européenne des Médecins Spécialistes (UEMS), is responsible for CME activities labeled as European—where two or more countries are represented among the participants. In addition, a number of European medical societies have their own accreditation process under reciprocity agreements with EACCME. Given these complexities, the CME enterprise in Europe may be confusing for nonEuropean CME professionals and providers, but some degree of harmonization is underway, especially through agreements between NAA and the EACCME/UEMS. The purpose of this article is to describe how CME is organized in most of the European Union (EU) countries and the movements towards continuous professional development (CDP) systems that are underway.

What is Europe: 27 or 44 countries?

The EU consists of 27 member countries with around 450 million inhabitants. Europe as a whole, with more than 850 million inhabitants, comprises 44 countries, ranging from tiny San Marino to Russia and former Soviet states as well as the Balkan countries. Not surprisingly, characteristics of the local health care systems have a huge influence on the implementation of CME systems. The EU alone recognizes 23 official languages with 60 other indigenous, regional or minority language communities. These vary from ancient Celtic tongues in the west of Europe, such as Gaelic and Welsh, to minority languages in Eastern Europe, such as Kashubian in Poland and Latgale in Latvia.

Most physician general practitioners (GPs) in the EU prefer to learn in their own language; therefore, the issue of translating CME content arises. This issue is less important with medical specialists, who mostly speak English and are accustomed to accessing CME activities in English. Health care systems vary too—some are public, as in the Nordic countries and the United Kingdom (UK), and some are based on a combination of public and private organizations, as in the southern European countries. In the public-based health care systems, doctors have a fixed salary and the organization and funding of CME tends to be state-based. When the health care system is privately-based, the physicians have no public funding for their CME, and there is an increased dependency on funding from commercial interests.

The distribution of physicians varies throughout Europe, even among the more populous countries. The number of doctors per 100,000 inhabitants ranges from 600 in Italy to 180 in the UK with a GP versus specialist ratio often different too (see Table 1). All these factors have a significant impact on how CME is organized within these countries (Maisonneuve, et al, 2009).

The European CME Enterprise

The majority of CME in Europe is provided by medical societies, with MECCs playing a lesser role in the provision of CME as compared to the US (see Table 2).

Data on the size and scope of the European CME enterprise are not readily available, although the UEMS has gleaned some information from a number of member

Table 1: Demography of Doctors in Five European Countries

Country	Physicians per 100,000 Inhabitants	GPs/Specialists (percent)	Population (millions)
Italy	600	40/60	60
Spain	450	60/40	47
Germany	360	25/75	82
France	330	50/50	64
UK	180	45/55	61

states and has published *Continuing Medical Education and Professional Development in Europe: Development and Structure*. The European CME enterprise includes both educational and promotional events in most countries. The funding varies across Europe with significant variances across countries. Commercial support provides funds for around half of all CME activities, comparable with the situation in the US. Other funding comes from medical societies, employers (eg, hospitals, private institutions, universities) and doctors themselves. Employers fund more CME activities in Northern Europe (Pozniak, 2009).

Absence of a Strong European CME Professional Organization

There are no professional organizations in Europe dedicated to CME, such as the Alliance. However a number of organizations provide a forum for discussion of International CME and continuing professional development (CPD) that includes consideration of the European situation. The Global Alliance for Medical Education (GAME) held two of its recent annual meetings in Europe (Rome 2006, and Lyon 2009), and European CME forums were held in London in 2008 and 2009. The Rome CME/CPD group is a think tank with 15 CME opinion leaders from Europe and North America (supported by the Serono Symposia International Foundation) that meets three times a year and has issued some recommendations on the bridging of gaps between international accreditation systems. GAME will continue to explore international CME requirements, perspectives and trends at its Fifteenth Annual Meeting in Montreal, Canada, June 6–8, 2010, (www.game-cme.org), and the Association for Medical Education in Europe will include sessions on CME/CPD at its meeting in Glasgow, Scotland, September 4–8, 2010 (www.amee.org).

Table 2: Main CME Providers in Five European Countries (by Percentage)

Country	Universities	Medical Societies	Employers	Others
Italy	20	35	25	20
Spain	5	50	20	35
Germany	10	50	10	30
France	15	65	15	5
UK	5	35	30	30

Each National Authority Sets Its Rules

There are some common elements among the European CME systems:

- Most use credits.
- There is a transition from CME to CPD (even if there is no complete agreement on the definition of CPD).
- Some countries have an event-based system, others a provider-based system.
- Some countries have a mandatory CME system, others a voluntary system.

However, few countries have set any formal guidelines for the completion of CME/CPD requirements by doctors.

Some European medical schools have recently set rules for reciprocity that allow students to learn in different countries. Reciprocity agreements for CME between NAA and EACCME/UEMS are still rare. A common system of credits based on European CME credits has been designed by the UEMS, and there is a reciprocity agreement between the EACCME and the American Medical Association for recognition of credits.

Examples of the European Diversity

To illustrate differences between countries, some snapshots of a selection of countries follow:

Italy

The CE system is common to all health professionals, and major changes in regulations had an impact on the number of providers—reducing them from 12,000 in 2005 to 2,000 in 2010.

Lombardia

This region of Italy has its own system that includes Italian speaking doctors in Switzerland.

Spain

The medical societies have been leaders in organizing and implementing a regional CME system. The Spanish Accreditation Council for CME has been established and has signed reciprocity agreements with EACCME.

Belgium

An incentive has been implemented for CME-compliant doctors so that their reimbursement fees are slightly increased.

Germany

The 16 *Lander* (states) have implemented their systems, and there is also a federal organization. Since 2009,

some of the states have applied a close scrutiny of credits, and reimbursement fees can be reduced for noncompliant doctors.

France

The credit system has been designed but never fully implemented. Struggles between various factions, including the medical unions, tend to slow the process. The French government wants to move all CME/CPD towards a PI system.

UK

The Federation of Royal Colleges of Physicians plays a key role—after more than five years of efforts, a revalidation process has been implemented that consists of relicensing (General Medical Council standards) and a specialist recertification (Murray et al, 2009).

Types of European CME Activities

Local meetings, conducted under the supervision of local doctors, are numerous in most of the countries, while large live events are organized by the national medical societies. Planning processes are not well documented, nor necessarily couched in adult learning principles or other parameters familiar to CME professionals in the US. A report from an attendee at the European CME forum in November 2009, for example, indicated that the 120 participants (50% British) were surveyed, and they estimated that needs assessments were not used (6%), properly used (4%), room for improvement was important (63%), and *do not know* (27%). Most CME activities tend to be of the traditional didactic nature.

The EACCME

The EACCME represents an important move for Europe. UEMS was founded 50 years ago in Brussels, and has 30 full state members, four associate members and two observers. It has 37 specialty boards that assess all doctors' activities in Europe, CME being one item of their agendas. Their CME accreditation system is well described on their websites (www.uems.net and www.eaccme.eu). In 2009 a major step was taken, with the decision by EACCME to accredit e-learning programs that may provide opportunities for CME providers from around the world to provide content for European needs. EACCME has also cemented relationships with European medical societies that have established their own CME systems in Europe, such as the European Board for Accreditation in Cardiology (www.ebac-cme.org), the European Board for Accreditation in Pneumology (www.ebap.org), and the Accreditation Council of Oncology in Europe (www.acoe.be) (Maisonneuve and Murray, 2006).

In 2009 a major step was taken, with the decision by EACCME to accredit e-learning programs that may provide opportunities for CME providers from around the world to provide content for European needs.

In conclusion, it is evident that CME is now well organized in most of the EU countries, and that a move towards CPD systems exists. More harmonization could facilitate the accreditation of CME/CPD events and, consequently, the free movement of health care professionals among EU countries. It could also provide opportunities for true international collaboration among providers.

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Points for Practice

- In Europe, CME is moving towards CPD.
- The diversity of the EU countries contributes to the tapestry of CME activities.
- Opportunities exist for harmonization of accreditation and provider collaboration.

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

CME Basics Training for Today's CME

Criterion 1: The Mission Statement

That's kind of the mission statement for the label: to try to do great music that touches people's hearts.
—Ricky Skaggs, singer/songwriter

While the above *kind of* mission statement wouldn't *fly* with the ACCME as meeting their accreditation compliance requirements, anyone who reads it will most likely quickly understand it. ACCME's Criterion 1 (C1) states, *The provider has a CME mission statement that includes all of the basic components (CME purpose, content areas, target audience, type of activities, expected results) with expected results articulated in terms of changes in competence, performance, or patient outcomes that will be the result of the program.*

While compliance with C1 is definitely important, perhaps a beginning point for the reader is her/his personal mission statement, which might be fundamentally more essential to the quality and meaning of day-to-day life. An interesting question is whether or not the question *What is your personal mission statement?* is analogous to the question *What do you do?*

While the latter is one of the first questions asked when meeting someone new, and the answer to this question often does provide both a context and clues about a person's core values (compare these two responses: *I'm a volunteer physician who works with an international relief organization* versus *I'm a cardiovascular surgeon at ABC University and have published over 300 journal articles*). It is offered for consideration that *jobs* are not who a person is but rather a means to fulfill a personal mission and not an end in and of themselves.[1] Similarly, while *profitability* is necessary for a company to exist, profitability often isn't the *end itself for many visionary companies*.[2]

Creating and living a personal mission statement entails much more than a job description and a title. It involves self-examination, determining one's values, deciding on a path, and making ethical (hopefully) choices. In her book, *The Path: Creating Your Mission Statement,* Laurie Beth Jones delineates, *Having a clearly articulated mission statement gives one a template of purpose that can be used to initiate, evaluate, and refine all of one's activities.*

The same could be said for an organization or a CME program. William Gast, who was a professor at the St. Louis University School of Commerce and Finance some decades ago (at least five), proposed that a successful company needs to satisfy the following:

- Produce a want-satisfying commodity or service, and continually improve its ability to meet needs through the economic use of labor and capital
- Increase the wealth or quality of life of society
- Provide opportunities for the productive employment of people
- Provide opportunities for the satisfaction of normal occupational desires
- Provide just wages for labor
- Provide a just return on capital.[3]

Most likely William Gast would be aghast at the recent decade or so of the behavior of Wall Street (and maybe a few CME providers), but what is clear is that having and *living* a good mission statement can assist organizations in achieving *Gast's Laws*.[3] Hopefully, the mission statement isn't just another piece of paper but an important *living, breathing* document.

What are the steps to writing or rewriting a good mission statement? Richard and David O'Hallaron believe that a mission statement should be based on the objectives of the company *and* be based on *Gast's Laws*; they offer the following four steps for writing a good mission statement:

- Organize a mission team
- Use *Gast's Laws* to construct the fundamental objectives of the organization
- Use the fundamental objectives to construct the mission statement
- Use the mission statement regularly and strategically.[3]

Organize a Mission Team

Ideally, representatives from a CME provider's leadership, staff and advisory committees comprise the mission team (or the annual review of mission team). Tip: Ask for volunteers from your leadership (both of and above the CME department/division), staff and committee members. Be certain that someone is designated as the point person and

be certain that all levels, leadership, staff and committee members are represented on the mission team.

Use *Gast's Laws* to Construct the Fundamental Objectives of the Organization

If the CME program is housed within a department or division within a larger organization, determine how it *folds into* and *supports* the parent organization's mission. Incorporate the basic components of C1 (*CME purpose, content areas, target audience, type of activities, expected results)* as the framework and foundation for the construction of the fundamental objectives. Tip: It may be helpful to gather and review (with permission, of course) the mission statements of similar CME providers.

Use the Fundamental Objectives to Construct the Mission Statement

Then compare the draft mission statement to ACCME requirements and make revisions as needed to assure full compliance. Determine your *mission metrics* (how you will measure achievement of these objectives). Tip: Access the ACCME website (www.accme.org) for education and guidance regarding compliance with C1. If there are questions about C1, contact ACCME accreditation staff and ask them for clarification.

Use the Mission Statement Regularly and Strategically

Live the CME mission statement every work day. Tips: Frame the mission statement and display it prominently throughout the CME department. Reduce the mission statement to pocket size and laminate it for every member of the department. Perform at least an annual review and analysis of how well the CME program's mission statement has been met. Decide what improvements need to be made, if any, to the mission statement during this review and analysis and then make them. Certify only those activities that fully align with the mission statement.

In their book, *The Mission Primer*, the O'Hallarons nicely point out, *The nobility of the mission statement is the use of the mission statement.*[3]

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

Are Leaders Born, or Are They Made?

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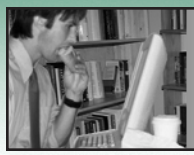
Adapted from materials prepared for the CME Leadership Institute, to be held September 23–25, 2010.

> *Only recently do I think I've come to understand leadership. That understanding, based on my own experience, has led me to some surprising conclusions, but I suspect others have had similar inklings . . . The leadership journey is first and foremost an intensely personal one. I now believe it is impossible to define leadership without linking one's own life; the most important Lost and Found Department is inside.*[1]

The question of whether leaders are born versus made, or lost versus found, is not an easily answered one. But there is no question that it is one, in this new environment faced by CME professionals, that must be addressed . . . *now*. Innovative and talented leaders will be required to facilitate change to position CME as a valued resource within the health care system. The Alliance for CME has joined the American Association of Medical Society Executives (AAMSE) in an innovative collaboration to offer the CME Leadership Institute to CME professionals. This Institute will be taught by AAMSE faculty (some of whom are also Alliance members), but tailored to meet the particular needs of the CME professional's world. The format and content are based upon the highly successful and well-respected American Academy of Pediatrics' Pediatric Leadership Alliance (PLA) that has trained more than 1,000 pediatric leaders and the AAMSE Leadership Academy that grew from the PLA to focus leadership skills for medical association leaders. CME is the next frontier.

This Leadership Institute is being held in Chicago, September 23–25 and includes:

- Completion of a *360-degree* personal assessment (leadership practices inventory) prior to the formal leadership professional development activity.



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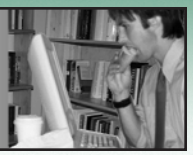

- A three-day leadership development experience, based upon Kouzes and Posner's book, entitled *The Leadership Challenge*, and focusing on five leadership tenets:
  - Model the way
  - Inspire a shared vision
  - Challenge the process
  - Enable others to act
  - Encourage the heart
- A highly interactive format that recognizes the roles of leadership at all levels, from front, middle to end, and in situations as varied as the workplace, home, school or church, educational system, and community.
- Participation in a *leadership community of practice* (CME Leaders for Change) that facilitates and supports the application of the learned leadership skills in practice.

The current environment for practicing CME professionals is very challenging, not only because of the economic situation, but also because the multi-level needs to change the role and the function of CME in health care must be tackled now. Our profession requires effective leaders to shape a future in which CME can be effective and successful in ultimately improving health care.

This unique opportunity will provide you with leadership skills, strategies, tools and techniques that will allow you to assess, enhance and apply learned leadership skills in practice. Working with fellow attendees and peers, you will seek and identify solutions to challenging problems through team-building tasks, exchanging ideas, sharing experiences and developing relationships with colleagues who are striving toward common goals. This group will become resources for years to come. You'll also have fun!

Leadership is needed in CME and health care more now than ever before. The Alliance's CME Leadership Institute will be of value to you in leading the CME profession and in other aspects of your life. Nelson Mandela stated, *We have two choices in life. We can accept things as they are, or we can change them.* Now is the time to accept leadership responsibility for leading change in your life, your profession and society. The Alliance is proud to offer this innovative collaborative Leadership Institute . . . watch here for more information and registration details.

Reference

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The Alliance Board Seeks Nominees

Jann Balmer, PhD, President, Alliance for Continuing Medical Education

Mark Schaffer, EdM, CCMEP, FACME, Chair, Governance Committee, Alliance for Continuing Medical Education

The Alliance is seeking members with demonstrated leadership skills and strategic vision, and service to the Alliance to apply to serve on the Board of Directors, with terms beginning at the 2011 Annual Conference. Each year the Board identifies selection criteria, which can help to strengthen the leadership characteristics and facilitate our service to the Alliance membership. Members may nominate themselves or an interested colleague. Nominations must be submitted in writing by July 2, 2010. Members will vote for the new Board members in writing or online in the fall. Specific criteria and expectations may be found on the Alliance web site at www.acme-assn.org.

How to Apply for a Position on the Board

Written nominations must be received at the Alliance office by July 2, 2010. The candidate must complete and submit the Fact Sheet, with a brief biographical sketch and answers to questions addressing how the candidate meets the desired attributes. The Fact Sheet must be accompanied by curriculum vitae and three letters of reference from individuals who know the candidate in a professional capacity. Please forward submissions to Robin Prentice at the Alliance office either by email at rprentice@acme-assn.org or by mail at 1025 Montgomery Highway, Suite 105, Birmingham, AL 35216.

Candidates will not be considered if this information is not submitted by July 2, 2010.

Process of Election

The Governance Committee will select a slate of candidates from the nominations submitted. Alliance members will be asked to vote for these candidates on a ballot mailed or available on the website in October. If you have questions, please call the Alliance office at 205-824-1355, or email rprentice@acme-assn.org.

Calendar of Events

June 6–8, 2010
15th Annual GAME Meeting
Innovation in CME
Montreal, Quebec, Canada
www.game-cme.org

June 13–30, 2010
CCMEP Exam at local testing centers
Registration closes May 31
www.nc-cme.org

June 23–24, 2010
Alliance for Continuing Medical Education
CME: The Basics Institute
Hyatt Rosemont, Rosemont (Chicago), IL
Registration Now Open!

August 4–6, 2010
ACCME CME as a Bridge to Quality™ Workshop
Westin Chicago River North, Chicago, IL
http://education.accme.org/Workshops

August 11, 2010
Medical Specialty Societies Summer Meeting
American Society of Clinical Oncology
Washington, DC

August 13, 2010
Medical Specialty Societies Summer Meeting
American College of Surgeons
Chicago, IL

September 12–14, 2010
National Institute for Quality Improvement and Education
NIQIE 2010
InterContinental O'Hare, Rosemont (Chicago), IL
www.niqie.org

October 13–15, 2010
21st Annual Conference of the National Task Force on CME Provider/Industry Collaboration
Baltimore Marriott Waterfront, Baltimore, MD
www.ama-assn.org/go/cmetaskforce

October 15–17, 2010
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