

# CME BRIEFING

NEWS, OPINIONS, AND PERSPECTIVES IN CONTINUING MEDICAL EDUCATION ~ SUMMER 2001

A Service of Professional Postgraduate Services®, a division of Physicians World/Thomson Healthcare

## Leading the Pack in Essential Element 2.2

First article in the series *Exemplary Compliance in the Essentials*

CME BRIEFING recently met with a few CME providers to learn more about the steps they took in achieving the highest rating—exemplary compliance—in Essential Element 2.2. Here's what we found out.

### A Society Serving Two Distinct Needs

"It was the number of different

ways we looked at needs, bringing them all together, sifting through them, and coming up with priorities from a variety of sources," recalled Jeannine Meloon, MS, Director of Education and Research, American Association for Geriatric Psychiatry (AAGP), Bethesda, Maryland. This process at AAGP is right in line with ACCME's

criterion for exemplary compliance (see box). The AAGP consists of about 2,000 members, mostly geriatric psychiatrists. It has a two-pronged mission: education programs for geriatric psychiatrists, a distinct subspecialty, and education programs for other physicians who see geriatric patients—two very different needs.

"Because most geriatric patients are seen by primary care physicians," said Meloon, "we do needs assessment in two directions: for geriatric psychiatry and primary care." Different activities are planned accordingly.

### Broad Coverage of Needs Is the Foundation

The collection of needs assessment information is a continuous process, fueled by the committee structure that exists within the association. The Clinical Practice, Pub-

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#### Essential Element 2.2: Use needs assessment data to plan CME activities

Rating	Criteria
Noncompliance	Needs assessment data are not used.
Partial compliance	Needs assessment data are inconsistently used.
Compliance	Needs assessment data are consistently used.
Exemplary compliance	<i>Needs assessment data from multiple data sources are consistently used to plan and evaluate activities.</i>

ACCME's Essential Areas, Elements and Decision-Making Criteria, July 1999.

### IN THIS ISSUE

CME BRIEFING is back  
with more news, more insights,  
and more information to  
keep you up-to-date on what  
you need to know.



PROFESSIONAL  
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## MECC Providers Now Can Unite Under a New Support Association

It comes from the need for one voice to speak for the common goals and interests of medical education and communication companies nationwide," said Richard Tischler, Jr, PhD, President and CEO of Viator Medical Communications, Inc., Mount Airy, Maryland, echoing the sentiments of the three other founding members of the newly established North American Association of Medical Education and Communication Companies (NAAMECC). The association is in its earliest stage of incorporation and planning. Charter membership will help strengthen the organization and

formalize its mission and goals.

### Change in Attitude Sets the Stage for NAAMECC

"The idea of business competitors collaborating and cooperating with one another didn't surface right away," noted Jacqueline Parochka, EdD, Vice President and Director of Education, Discovery International, Deerfield, Illinois, speaking about early discussions that eventually led to NAAMECC. It was serendipity. The founding members had met over the past several years at various provider meetings, when

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## CME BRIEFING

CME BRIEFING is published by Professional Postgraduate Services® (PPS), a division of Physicians World/Thomson Healthcare. The mission of this newsletter is to disseminate news and information about CME and to foster dialogue among the concerned parties, including the medical profession, government, industry, and CME sponsors.

PPS is dedicated to health-related education for physicians, paraprofessionals, and patients.

PPS is accredited by the ACCME to sponsor continuing medical education for physicians.

We are proud of our 25-year history of medical publishing, and feel a responsibility to enhance medical education by improving communication among interested parties. Our proactive relationship with the government, the medical profession, industry, and CME sponsors will benefit from the input of our readers. Please send comments or questions to the address listed below, attention CME BRIEFING Editor.

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## Leading the Pack in Essential Element 2.2

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lic Policy, Communications, and Research Committees all feed information about needs into the Education Committee, which develops the objectives for an activity. Areas of need also may be identified by the Government Relations Department (eg, Medicare reimbursement issues) and the AAGP Board. The association also reviews 8 to 10 monthly journals that are of key interest to other specialists, tracks feedback and questions from their websites, and uses comments obtained from previous programs for a comprehensive approach to assessing needs.

The development of objectives is followed by a CME Committee review. At that time, the committee also looks at how best to evaluate the objectives.

### Bringing It All Together

Meloon commented on the links in the CME process and how needs assessment data are used to plan an activity. "Once we see a question and identify a broad category of need," she explained, "we take the information gathered from the needs assessment to do our curriculum design. We ask 'What is it about that topic that the audience needs: diagnostic tools, treatment options, referral guidelines?'"

The activity may take the form of an "ask the experts" meeting, if research is to be communicated, or case-based interactive sessions, if tools are to be introduced. Documentation for the files completes the process, accomplished through simple notes after a telephone conversation, email printouts, meeting notes from conference calls, or minutes from CME Committee meetings.

### Educational Division With a Constant Eye on Needs

"Over time, as we work on more activities, we have discovered differ-

ent types of information that will serve as needs data we can use," said Belinda Rose, Manager, Oxford Institute for Continuing Education, Inc. (Oxford Institute). The Oxford Institute, located in Newtown, Pennsylvania, is the educational division of OCC, North America, Inc, a healthcare communication company. Oxford Institute is also accredited by the American Council on Pharmaceutical Education. The institute has multiple methods for identifying needs.

### Uncovering Needs

The Oxford Institute combines online literature searches with comments from past programs to flesh out gaps in knowledge and to substantiate existing needs. The review

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*"Once we see a question and identify a broad category of need," Meloon explained, "we take the information gathered from the needs assessment to do our curriculum design."*

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of the literature, conducted on an ongoing basis by several staff members, for example, on the subject of Alzheimer's disease, addresses unmet medical need issues such as quality of life, caregiver concerns, cost of illness, and morbidity and mortality. Faculty comments on their perceived need for the activity are obtained during the planning stages to refine the learning objectives and content to ensure that the activity is designed to meet the needs of the target audience. "The comments are summarized and distributed to members of the planning team, who consider these comments as the activity is further defined," explained Rose.

### Support From Faculty Throughout

Not only are the faculty involved with developing their part of the

activity (ie, preparing slides for a symposium presentation), but they also provide full support in planning the entire activity, with the assistance of the Oxford Institute. Faculty involvement may be:

- Responding to questions on a brief needs assessment form (developed by the Oxford Institute) that asks about their perceived needs for the current activity. With this, the link to activity development is enhanced.
- Commenting on needs, objectives, and content as activity planning moves forward.
- Reviewing a summary of comments from past related programs, which often contain notations of ongoing need.

#### **The Link**

A solid process helps establish the link to activity planning. “We consistently include the faculty in all aspects of developing the activity content,” said Rose, “and consult with them when designing the logistical aspects of a live activity.”

Coming full circle, the ideas that will be implemented are consolidated again and sent back to faculty members for their information. “We emphasize the scientific data we have available to us and pass along any valuable material to the faculty, which may help more clearly define the link back to needs,” Rose concluded.

Potential follow-up programs such as enduring materials (targeting wider audiences with other learning tools) are considered throughout the activity process. The specific medium that may be used postactivity is carefully considered for its value to learners. The options are also discussed with the faculty of the current activity. “Others involved in patient care—nurses, case managers, or pharmacists—are considered,” commented Rose.

Of course, planning notes (eg, faculty conference call minutes or status meeting notes) are continually added to the files. Rose con-

cludes, “There can never be enough information in your needs file. Think about how you can get more information and get it out to your team. We are always looking for the reasons that confirm why we are doing something.”

#### **In Texas, It Starts With Two Questions**

“Any activity always begins with a planning group, where we ask two simple questions: ‘What is the need for this activity?’ and ‘Why does the group feel that educating physicians will address that need?’” stated Mark Gregg, MA, Director of the Texas Department of Health’s Public Health Professional Education (PHPE) Program. Established in 1993, PHPE has three components: (1) an accredited CME program; (2) a morbidity and mortality newsletter for health professionals (*Disease Prevention News*); and (3) liaison with the health department preventive medicine residency program and oversight of state headquarters’ rotations for other preventive medicine and occupational medicine programs.

#### **Battling Healthcare Issues of Public Concern**

The mission of the program is to educate public health and primary care physicians on public health and preventive medicine concerns for all age groups, “even the afterlife,” said Gregg, speaking about the program’s on-line CME enduring material on the proper completion of the death certificate.

In satisfying the mission, Gregg noted, “We are always challenged by the size of our target audience in primary care and by doing more for our public health physicians.” About 16,000 primary care physicians are in active practice in the state. The program’s self-study provided the opportunity to refocus more of its energy toward physicians in the public health arena.

To this end, PHPE is currently working with other health department staff on assessing the nature and role of the local health authori-

### ***Tips from the Best of the Best: Working Towards Exemplary Compliance in Essential Element 2.2***

- Start with two simple questions: What is the need for this activity? Why will a formalized educational intervention (CME) address that need?
- Look at a variety of sources for needs; encourage others involved in the CME process to be on the lookout for needs.
- Educate your planning partners on the types and quality of sources available.
- Remember: comments on evaluations don’t always provide information on needs; therefore, they may not always provide what you need to design curricula.
- Take advantage of local, state, and national sources that are available to everyone (county agencies, state departments of health, CDC, and related publications).
- Ask the faculty experts, as part of their role, to comment on perceived needs for the activity and use this information to enhance the activity.
- Add notes to the file; don’t be overly concerned with format, as long as the note explains activity changes and when and why they occurred.

ties within the state, who perform a variety of duties and responsibilities, from a full-time physician at the local health department to a medical consultant appointed by a rural county judge. The initial needs assessment is being conducted using a 360°-type analysis, where input from everyone *surrounding* the person is obtained.

Once the roles and responsibili-

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## Leading the Pack in Essential Element 2.2

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ties have been defined, the planning team's next goal is to develop a curriculum, looking at all possible avenues for performance improve-

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***“There can never be enough information in your needs file,” said Rose. “Think about how you can get more information and get it to your team.”***

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ment, skill enhancement, task mastering, and knowledge building. Referring back to those “simple questions,” Gregg said, “Sometimes, training is not the solution. We may need legislation on this issue.”

### **A Network of Resources on Finding and Meeting Needs**

A good portion of program success is attributed to the active participation by CME Committee members. “Part of our goal is to have a good representation of physicians from a variety of areas of public health, as well as from partners we work with on a regular basis,” noted Gregg.

In addition to getting ideas for an activity from the committee, PHPE seeks input from other sources, including local health departments, organizations (for

joint sponsorship) such as the American Heart Association, other state agencies, and physicians via yearly targeted surveys to identify gaps in knowledge. All this information is reviewed during planning group sessions for possible activity and curriculum design. Meeting minutes are an important part of the planning process.

Gregg and others in the program also have access to a wealth of other data. “A basic purpose of a department of health is to collect morbidity and mortality data,” said Gregg. Gregg also mentioned *Healthy People 2010*, another reference tool on general needs and the health of the population. *Disease Prevention News*, one of the three components of PHPE, is published biweekly, with an on-line version available at [www.tdh.state.tx.us/phpep/dpn/dpnhome.htm](http://www.tdh.state.tx.us/phpep/dpn/dpnhome.htm). (A national version of this is the CDC's *Morbidity and Mortality Weekly Report*.)

### **An Important Activity Takes Shape**

The CME process came through in an innovative and much-needed enduring material on proper completion of a death certificate. The activity planning process included representatives from forensic pathology, the National Center for Health Statistics, and the CDC, as well as an American Medical Association (AMA) pathologist and a physician professor with knowledge and expertise in writing board exams. Gregg worked with graduate-level instructional designers. (He sees use of formal instructional design models as the next phase in CME.) He also consulted with data coders (who enter data from a completed death certificate) to incorporate examples of and solutions for the most common errors physicians make.

The activity educates physicians about the proper completion of the death certificate, helping them differentiate information that should and should not be part of the record. Information from the Bureau of Vital Statistics will be used to measure long-term outcomes. Its success and value are evident now;

other states have expressed interest in working on future revisions of the activity.

### **An Organized Process at VCU**

At Virginia Commonwealth University (VCU) Office of Continuing Medical Education in Richmond, methods for needs assessment collection are varied in type and broad in scope. And they are organized! As explained by John Boothby, Director, Conferences and Alternative Instruction, “For individual activities, we have a system of training our staff—and through them, training our ‘planning partners’—on how to identify and capture a broad range of needs assessment data. Each of our activities includes that as a formalized part of the planning process.”

“We are often very specific on the *types* of data we encourage people to put their hands on,” said Karen Sanders, MD, Director of Extended Learning and Professional Development in the office of CME. She also is Associate Chief of Staff for Education at the Hunter Holmes McGuire VA Medical Center, where she also is in charge of the quality management program. “It’s great to have evaluations from your last conference,” continued Sanders, “but we look for risk-management data or information on standards of care.” She added that it is not only awareness of the data but also the ability to process the data that make the difference at VCU.

Interaction between the Office of CME and the Quality Management Department is a given, offering a wellspring of needs assessment data. Completing the triad of collaboration on assessing need is Paul Mazmanian, PhD, Associate Dean for Continuing Medical Education, and editor of *The Journal of Continuing Education in the Health Professions*. He also has an active role with the Pharmacy and Therapeutics Committee, helps to guide undergraduate medical education programs, and chairs the Master of Public Health Curriculum Committee. “There are very specific issues from

### **Healthy People 2010**

**H**ealthy People 2010: *Understanding and Improving Health* contains national health objectives for reducing preventable aspects of disease. To learn more about *Healthy People 2010* and to view the document, visit the website at <http://www.health.gov/healthypeople/>.

these committees we're on that can be used for program planning," said Sanders.

The CME process at VCU identifies a jointly shared responsibility for needs assessment between the Conference Manager and the Program Planning Committee. The committee chair is usually a member of VCU's clinical faculty; committee members may be physicians or other health professionals. The faculty and staff of the CME office are present throughout the planning process. At VCU, needs assessment is not a time-limited process. It is ongoing, up to the day of the activity.

### **Tools of the Trade Help the Process**

Tracking and documenting activity planning is made easier by a collection of tools developed at the VCU Office of CME. Developed through the efforts of the entire staff, these tools help to standardize and encourage the best practices. They guide people through the entire accreditation review process, giving them fundamental information that follows a logical activity planning timeline. The tools are organized into a manual for quick reference. Their *Guide to Minutes* for program planning has a section on Essential Element 2.2. It guides the planning partners on the documentation and justification of their planning process, and it gives them a comprehensive list of sources to consider.

### **What's Next?**

"We know we are good at *identifying* what they need," said Meloon, "but did we *deliver* what they need?" Meloon, Rose, and Gregg plan to focus their next efforts on the evaluation process—Essential Element 2.4—with an eye toward obtaining long-term evaluation responses in addition to assessing relatively immediate effects of an activity.

### **Evaluating a "Commitment to Change" at VCU**

The VCU Office of CME also received exemplary compliance in Essential Element 2.4, a perfect prelude to *CME BRIEFING's* next article in

this series, *Exemplary Compliance in the Essentials*.

As explained by Mazmanian, "The study we implemented involved a clinical guideline for diabetes, a system called the 'change readiness inventory' and a 'commitment to change' model." The readiness inventory helped to predict physicians' need for guidelines information and level of commitment to change, as well as potential barriers to change.

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### ***Tracking and documenting activity planning is made easier by a collection of tools, which can standardize and encourage the best practices.***

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The community-based study started with a local group of about 150 primary care physicians. Chart auditing was conducted before distribution of the guideline, the readiness inventory, and the commitment form to the "experimental group" of physicians. The "control group" received the change readiness inventory and the guideline only.

Mazmanian commented on the evaluation process: "About 9 months later, we surveyed physicians and we audited charts to see whether those who made the commitment to change [in the direction of the clinical guideline] were different from those who received only the guidelines." He concluded, "We have looked at the value of information only, compared to information *and* a commitment to change." And they looked at them with both self-report and objective methods for assessing change.

**Watch for more practices, techniques, and planning processes that can bring you closer to exemplary compliance, as *CME BRIEFING* continues this series. Next issue: Essential Element 2.4 ~**

## **MECC Providers Now Can Unite Under a New Support Association**

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"friendships solidified the opportunity to work together in a different perspective," continued Parochka. Through this friendship, they realized that one didn't have to divulge trade secrets or proprietary information in order to offer advice and guidance to a counterpart. "There seems to be now a real spirit of trust and collaboration and recognition that all of us have common goals," said Karen Overstreet, EdD, President, Meniscus Educational Institute, West Conshohocken, Pennsylvania. Completing the foursome of NAAMECC founding members is Mark Schaffer, EdM, Vice President, CME, Professional Postgraduate Services®, a division of Physicians World/Thomson Healthcare, Secaucus, New Jersey, and publisher of *CME BRIEFING*.

### **Time Was Right for the Collective Voice**

Now numbering more than 100—which includes medical education and communication companies (MECCs), as characterized and reported by each entity\*—these companies now have a chance to band together. "We are the only group of providers that is not represented by a separate organization," noted Overstreet. Other provider categories—such as hospitals, medical schools, or societies—have larger, independent associations as umbrella support. NAAMECC will foster and support this growing MECC community. "It is the right time for this kind of organization," remarked Tischler, "and we are hopeful that we'll get the support we need."

### **The Making of a Mission: Direction for NAAMECC**

"Somebody has to be the champion of the MECCs," said Parochka, "and the association will certainly have that as one of its primary goals." Although a statement of purpose and a mission statement have not been finalized,

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\*At present, there are no specific characteristics that differentiate a medical education company from a communication company.

## MECC Providers Now Can Unite Under a New Support Association

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ideas are generated frequently by its founding members. The association can speak out on behalf of its members and substantiate and/or publish information based on data and facts. "There is no evidence that the CME [from other providers] is any better than that provided by the MECCs. We have to dispel that myth," noted Tischler.

All founding members concur that the misperception and myths surrounding MECCs are reinforcing the need for and value of the association. The MECCs are one of the "new kids on the block" to be accredited by the ACCME. Perhaps because they are a new entity in the mix of medical education or perhaps because of the amount of commercial support received from the pharmaceutical industry, MECCs have been the recipients of less-than-positive press in continuing medical education (CME) circles. "The assumption," noted Tischler, "is that we must be doing something wrong to receive these funds. Our association will show that we do a lot of things right."

NAAMECC will be an organized vehicle for the dissemination of data and information. Data can come from organizations like the ACCME, for example, which can show how different provider categories work within ACCME Essential Areas. Additional information on practices can come from the membership. Overstreet added, "It can be a daunting task for an individual to write a response to an issue or to gather research to counteract an accusation. We are hoping that, collectively, we can do something about it."

But more than this is planned for NAAMECC, because more than this is needed by MECCs nationwide. To maximize support and benefits, NAAMECC will do what its members do best. "We need to identify our educational needs and then provide products and services for our members that meet those needs," explained Overstreet. Other avenues for the association include fostering education and communication

among MECC providers via Internet chat rooms and educational programs.

"Educational venues," said Parochka, "can help to validate the quality of the work done by MECCs," demonstrating that MECCs are viable contributors to the field of CME that meet the criteria of ACCME accreditation. "All this can help explain to physicians, the CME community at large, and the general public the work of MECCs in CME, encouraging mutual understanding and respect," continued Parochka. "Relationships with related

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***"We need to identify our educational needs and then provide products and services for our members that meet those needs," explained Overstreet.***

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organizations will be important," emphasized Overstreet. "We don't want to be isolationists. We want to be a part of the larger CME community."

A code of ethics will be developed that member organizations can endorse and practice. The code will originate from "the best of the best" practices, as detailed by member organizations, which often face unique challenges in the delivery of CME. "The Standards for Commercial Support are out there," noted Parochka, "but they are not necessarily clear in terms of what those words really mean. We exercise an interpretation on a daily basis." With NAAMECC and the interaction among its members, the existing standards can go higher and deeper, making them less open to interpretation.

### **Charter Membership, the Board, and Association Status**

Founding members emphasized that charter members will have a chance to shape the association. Charter membership is open for 1 year only (closing summer of 2002). Charter members will be recognized in a prominent way by the association, and they will be able initially to nominate candidates for the Board of Directors, whose members will be elected.

The ability to serve in a leadership

role will be critical to board participation. Those who serve must have an understanding of the MECC environment, because these are the situations for which they will be asked to speak out on behalf of the members. It is expected that most members of NAAMECC will be MECCs. Tischler explained, "With an organization that is intended to advocate on the part of MECCs, it would be realistic to expect that its members would be those organizations that benefit from such advocacy."

### **Fall Kickoff Is Planned**

The founding members have tested the waters on an idea such as NAAMECC with a number of potential members and results have been favorable so far. A meeting is scheduled for October 16 (*see Calendar*), at which time any interested MECCs will gather for the first time under their umbrella support, NAAMECC. The October meeting, which will be held immediately prior to the *12th Annual Conference of the National Task Force on CME Provider/Industry Collaboration* in Baltimore, Maryland, caps a 5-month roll-out process for introducing the association. The October meeting is open to all parties interested in helping to shape the organization in ways that would benefit the collective group. Preliminary topics for meeting discussions include the Board of Directors, the mission statement, and the code of ethics. This will be a landmark event for MECCs nationwide. ~

**To learn more about NAAMECC and about becoming a charter member, contact one of its founding members by phone or email:**

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# Task Force on CME Provider/Industry Collaboration

The 12th Annual Conference of the National Task Force on CME Provider/Industry Collaboration is set for October 16–18, 2001 (see *Agenda and Calendar*). This year's meeting is primed for discussions on some of the major guidelines and policies governing continuing medical education (CME).

## Standards and Gifts: Guiding Principles Undergo Some Changes

The first plenary session and its breakout groups look at the ACCME's Standards for Commercial Support, addressing timely issues,

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*“This year's meeting,” said Marty Cearnal, Meeting Chair, “will be a highly concentrated update on the critical issues facing the CME community, from those closest to the late-breaking information.”*

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such as how providers and supporters can work better together in the current environment, and the status of the FDA's Final Guidance. Breakout sessions provide a chance for small groups to discuss obtaining commercial support, maintaining appropriate relations with commercial supporters once educational funds are provided, and understanding the lines of demarcation for compliance within standards. Norman B. Kahn, Jr, MD, vice president, Science and Education, American Academy of Family Physicians, and Lucy Rose, PA-C, MBA, and Minnie Baylor-Henry, JD, RPH, both former directors of the FDA office of Drug Marketing, Advertising, and Communications, conduct this session.

Participants will be interested to hear the latest from Alan Nelson, MD, chair, Working Group on Communication of Ethical Guidelines for Gifts to Physicians From Industry. The policy

side, the legal side, and many other “sides” will be revealed, including perspectives from every angle on Gifts.

## Seeing the Big Picture

The “big picture” view of the role of CME is impressive, with significant potential and opportunities for improving healthcare in the United States. Issues to be discussed include using CME to improve physician/patient relationships and motivate change for better outcomes. Also, broad-based education initiatives on

the Internet will be described by George D. Lundberg, MD, former editor of the *Journal of the American Medical Association* and now executive vice president and editor-in-chief at Medscape. Kenneth Shine, MD, president, Institute of Medicine, will discuss the quality of the healthcare system overall.

After feedback and perspectives from these and other faculty members and workshop leaders, meeting participants can continue discussions with colleagues during evening social functions. Meet old friends, make new contacts, and get your questions answered. This year's meeting should not be missed! ~

## A G E N D A H I G H L I G H T S

### Plenary Session I

Commercial Support of CME: Collaboration and Accountability

Revisions of ACCME Standards for Commercial Support

*Norman B. Kahn, Jr, MD*

Status of FDA's Final Guidance

*Lucy Rose, PA-C, MBA*

Environmental Scan

*Minnie Baylor-Henry, JD, RPH*

### Plenary Session II

Ethical and Legal Issues in Gifts to Physicians

(Interactive session using cases and an audience response system)

Report on “Gifts” Working Group and Current Political Environment

*Alan Nelson, MD*

Gifts: An Ethical Issue for Physicians—Recent CEJA Activities

*Frank Riddick, MD*

A Government Perspective on Gifts

*James E. Adams, JD*

### Plenary Session III

New Challenges and Opportunities in Continuing Medical Education Collaboration

Improving Healthcare in America: The Role of Continuing Medical Education and the Internet

*George D. Lundberg, MD*

The Role of Continuing Medical Education in Enhancing Physician/Patient Relationships

*Greg Carroll, PhD*

Successfully Motivating Change: Healthcare Systems Use of Data and Education to Improve Outcomes

*David Schutt, Patty Estes*

### Plenary Session IV

Crossing the Quality Chasm: Improving the American Healthcare System

*Kenneth Shine, MD*

**Breakout discussion sessions on related topics follow**

**Plenary Sessions I, II, and III.**

## FOR YOUR CALENDAR— *Upcoming CME Meetings*

**Baylor College of Medicine**  
***“Pursuing Excellence: Raising the Bar for  
Continuing Medical Education”***

*September 14–15, 2001*

*Houston, TX*

**To register, contact:**

Office of Continuing Medical Education

Baylor College of Medicine

**Phone:** 713-798-8237

**e-mail:** [cme@bcm.tmc.edu](mailto:cme@bcm.tmc.edu)

**12th Annual Conference of the  
National Task Force on CME Provider/  
Industry Collaboration**

***“Converging Pathways:  
Finding Common Ground”***

*October 16–18, 2001*

*Baltimore, MD*

**For more information, contact:**

Regina Littleton

**Phone:** 312-464-4637

**e-mail:** [cme@ama-assn.org](mailto:cme@ama-assn.org)

**Accreditation Council for  
Continuing Medical Education**

***ACCME Workshop:***

***“Understanding ACCME Accreditation”***

*December 7–8, 2001*

*Chicago, IL*

**For more information, contact:**

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**Alliance for Continuing Medical Education  
2002 Alliance for CME 27th Annual Conference**

***“Creating Communities of Practice through  
Personal, Professional, and Organizational Renewal”***

*January 30–February 2, 2002*

*Orlando, FL*

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