

# CME BRIEFING

NEWS, OPINIONS, AND PERSPECTIVES IN CONTINUING MEDICAL EDUCATION ~ WINTER 2002

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

REPORT FROM THE 12TH ANNUAL CONFERENCE OF THE NATIONAL TASK FORCE ON CME PROVIDER/INDUSTRY COLLABORATION

## Destined to Show Impact of Activities on Outcomes, the CME Community Turns to the Data

Those new to the field of CME will soon learn what long-timers already suspect. The trend in CME is moving toward demonstrating outcomes derived from CME-based activities. For success on this path, it is essential to understand how data can be used to drive change. David C. Schutt, MD, Associate Medical Director of The MEDSTAT Group, used an

example of a health plan's focus on coronary artery disease (CAD) among its population as an avenue for change and potential improvements in both clinical and economic outcomes. Many CME providers are sure to recognize similar ways in which they've been using data in their educational activities, as they garner ideas for forging ahead.

The MEDSTAT Group, part of The Thomson Corporation, is a health information company that provides decision support systems, market information, benchmark databases, and research for managing the purchase, administration, and delivery of health services and benefits.

### Finding a Starting Point: Process Measures and Outcome Measures

The decision for the example health plan on which condition/disease state to focus on within its population was made after reviewing several factors:

- High-cost conditions
- High-volume conditions
- Conditions that show variation in diagnostic/treatment methods
- Conditions for which performance measures or guidelines exist
- Clear process/outcome link is evident
- Action plan is clear after measurement is done.

The health plan decided to focus on high-cost conditions, of which CAD fit the bill, *as shown by the data*: within the plan, CAD affected a relatively small number of patients, but incurred a large

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*How can data be used*

*to effect*

*change in CME?*



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## Healthcare Delivery Improvement and Lessons for CME

Larry Staker, MD, an internist now serving as Chief Medical Officer for Deseret Mutual Benefit Administrators, Salt Lake City, Utah, was a champion for healthcare delivery improvement while he was in clinical practice. He enrolled in The Advanced Training Program under Brent James, MD, at the Intermountain Health Care Institute for Health Care Delivery Research in 1994. It was then that he began a study among his diabetic patient population. *CME Briefing* recently met with Staker to learn more about this study, its outcomes, and its basis in continuous quality improvement (CQI) the-

ory, with particular attention to the "Plan-Do-Study-Act cycle" (PDSA) and rapid cycle testing (RCT).

### A Method for Practice-Based Learning for Improvement

PDSA progressing to RCT is a widely known and accepted method for achieving improvement in clinical practice. It starts with three questions:

- What do I want to accomplish or what is the goal?
- How will I measure and know that what I do is an improvement?
- What change can I make in the

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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, para-professionals, 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 about this newsletter to the CME BRIEFING Editor.

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# CME BRIEFING IS GOING ON-LINE SIGN UP TODAY!

ACCME Standards for Commercial Support have withstood the test of time for the past decade. What kinds of changes are in store and when can we expect to see them? Read about it—on-line—in the next issue of *CME Briefing*.

## Old Roots, New Routes

**C***ME Briefing* was started in 1991 in direct response to a growing need among CME providers for an improved understanding of the principles that govern the field and the practicalities that often challenge those principles.

As these needs in CME grew, the scope of the newsletter grew, and so, too, did our mailing list, which now reflects the many specialties and disciplines involved in CME. Professional Postgraduate Services, a division of Physicians World/Thomson Healthcare, is proud of the dedicated and ever-growing following for *CME Briefing* and of the diversity of the groups deriving their CME news and information from it.

In 2002, *CME Briefing*, a publication with old roots, takes off on a new route—the Internet. The benefits are obvious. It's immediate, readily accessible to the reader, and can be passed along to key e-mail CME contacts and colleagues. Subscribers will receive advance notice of upcoming issues.

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## CME Community Turns to the Data

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share of costs and could make a big difference if changed.

According to Schutt, a clear connection between process measures and outcome measures, and then a clear plan of action afterwards, are key issues. A *process measure* is a measure of what is done to, for, or by a patient. An *outcome measure* is measuring the result of that process. Outcome measures may prove extremely difficult to capture—the “outcome” may not be clearly defined, it may be too far down the road to consider, or there may not be an obvious link between the outcome and the processes needed to improve it. In contrast, process measures are easier to capture, are closer to real-time, and are measures that providers have some control over.

If plans call for a process measure, there must be a clear link between the process measure and the outcome measure, otherwise the measurement is futile. In other words, will performing the process lead to a better outcome in the patient? Likewise, once a measure is determined, there should be a clear plan for the change that is desired.

Here's an example of how this may work:

Glycosylated hemoglobin, or HbA1c, provides a long-term view of glycemic control in a patient with diabetes. In this case, the process measure and the outcome measure are indeed linked, because control of HbA1c levels (the process measure) has been linked to reduced diabetes complications (an outcome measure). Likewise, two clear plans of action for change would follow: (1) those patients who have not had the test can be identified and tested at a future visit, and (2) those patients who have had the test and found to have elevated HbA1c levels need to be managed more closely, perhaps with adjustments to diet, medication, and/or lifestyle. (This may be where a CME-based education activity would help.)

### Where Do the Data Come From and How Can They Be Used?

In his example, Schutt used medical claims information as a data source for the patients with CAD within the health plan, in part because it is a readily available and relatively inexpensive data source. Other sources could include medical record abstractions and survey information, in addition to countless other sources.

These data were then used to:

- **Target** the educational/quality improvement initiatives
- **Implement** the educational/quality improvement initiatives
- **Monitor** the impact of educational/quality improvement initiatives

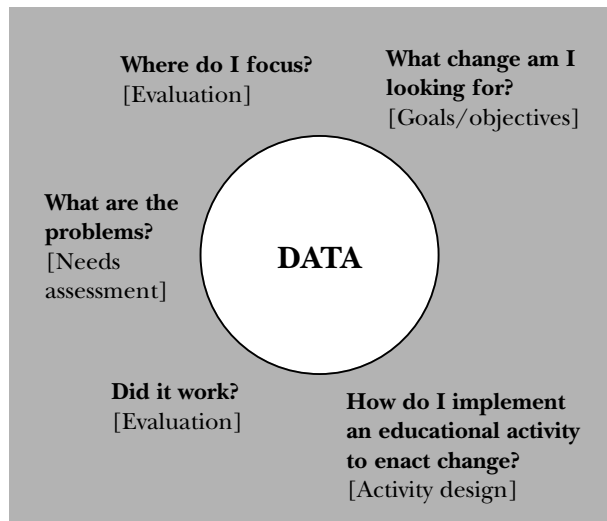
### Using the Data to Define and Refine Activity Direction

With CAD the prime focus for the health plan, as borne out by data findings, the data were used again to find out more about the people in the plan with CAD. These data showed that the total payments for patients with CAD were high, in part because some patients were experiencing flare-ups, defined as acute episodes (acute myocardial infarction) that required intensive (more expensive) treatment to control the condition.

Conclusions were drawn from here:

- What the data showed: Patients managed at the lower severity of CAD (stable angina) cost 90% less to the plan than those at the more serious, uncontrolled level.
- Goal: Control stable angina patients better to avoid the more serious condition that requires higher costs of care.

This is a point where CME providers, noted Schutt, would focus



Data were used to answer the questions pertaining to the CAD patient population in the example health plan. By replacing the questions with the information in brackets, it is clear that CME providers can use data in much the same way.

on a CME initiative that could help physicians achieve this goal.

### Impact Down the Road? Let the Data Show the Way

The same data used to identify the problem can be set as a baseline to monitor change in practice patterns and effect, Schutt emphasized. Likewise, standards, norms, or practice guidelines (more data!) can be used as treatment goals. Referring again to diabetes, the American Diabetes Association's Clinical Practice Recommendations include a set guideline for the frequency of HbA1c testing, as well as a target goal for the value, which can be used as a goal for all physicians to reach with their patients.

In this example, data were used to identify a problem, further refine the issue (and design a program to meet the need), and monitor the impact of the change. CME providers can use data in a similar way in their needs assessment, objectives development, activity design, and evaluation processes, in order to achieve data-driven programs that demonstrate outcomes.

What are your questions about using data to effect change in CME? E-mail us at spreisler@pwcg.com, “Attn: YSmall” in subject line. Responses will appear in a future issue. ~

# A Cut Above “Compliant” in Evaluation Techniques

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

Continuing our review of CME planning and implementation areas, *CME Briefing* spoke with three who have demonstrated “exemplary compliance” in Essential Element 2.4. Readers may find it useful to read how CME managers at a commercial provider, a medical school, and a hospital managed to accomplish this in ways that truly make them stand out from the crowd.

## The Pragmatism of a Commercial Provider

The Institute for Continuing Healthcare Education (ICHE) is a multi-accredited division of CoMed Communications, Inc., a full-service commercial communications company in Philadelphia. Asked what ICHE did differently to win top honors in Essential 2.4, Executive Director Eric Peterson started with the fact that CME providers face several hurdles in accurately measuring and evaluating the results of their activities.

“I think this essential scares many providers, who think they must ‘prove’ that a group of participants in a given activity—even a 1-hour lecture—learned cutting-edge science unavailable anywhere else, prompting them to immediately start changing their practice of medicine,” he explained. Many providers get frightened, feeling the bar is too

high or they don’t have the resources required to prove this through evaluations.

Peterson downplayed such fears, stating that individual CME activities ought better be viewed as part of a cumulative mix of medical messages reaching physicians and health professionals on a variety of fronts, such as medical journals, conversations with colleagues, hospital courses, local CME activities, and international symposia led by national thought leaders. In his view, the provider’s role is to *facilitate* participant absorption of knowledge in given areas, a process repeated via multiple channels and media. Once educators become more realistic about how CME changes physician practice, they can better appreciate the value of Essential 2.4 in using prior performance to guide future activity planning.

## Improving Evaluation Tactics

Peterson spoke of ICHE’s plan to switch evaluation instruments from traditional postactivity evaluation forms distributed and collected on-site to shorter, follow-up electronic surveys sent 3 months after an activity.

“Through on-line evaluations, we hope to make it faster, easier, and more convenient for busy professionals to respond,” said Peterson.

E-evaluations should encourage more thoughtful responses and comments from participants, who will have had time to determine if they are really applying recently learned information. On-line evaluations will also help streamline data collection and analysis.

ICHE is also trying to uncover the role that the activity may have played in any decision to make changes in practice. Peterson noted, “We are quite happy when we learn that our activity confirmed information that participants learned through other sources or reinforced a decision to make changes in practice.”

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***E-evaluations should encourage more thoughtful responses and comments from participants, who will have had time to determine if they are really applying recently learned information.***

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ICHE also wants to direct most evaluation work towards activities with greatest potential for meaningful impact, such as the ability to alter behavioral attitudes ingrained from early medical training. A good example is the group’s recent heart failure management course, which is based on impressive new data regarding use of beta-blocker drugs in the treatment paradigm. This program, which directly reverses what physicians have studied and practiced for years, can be easily evaluated to uncover residual attitudinal barriers—information that can help spur development of more effective education.

## Taking a Broader, Longer-term Look

The School of Medicine and Biomedical Sciences at Buffalo, part of the State University of New York, is a medical school without its own teaching hospital but one with close

### Essential Element 2.4: The provider must evaluate the effectiveness of its CME activities in meeting identified educational needs.

Rating	Criteria
<b>Noncompliance</b>	Educational activities are not evaluated.
<b>Partial compliance</b>	Educational activities are evaluated inconsistently and/or documentation is inconsistent.
<b>Compliance</b>	Educational activities are evaluated consistently for effectiveness in meeting identified educational needs, as measured by satisfaction, knowledge, or skills.
<b>Exemplary compliance</b>	<b>Educational activities are evaluated consistently for effectiveness in meeting identified educational needs, as measured by practice application and/or health status improvement.</b>

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

ties to local clinical institutions, including two health systems, a county hospital, and a major cancer research institute.

In talking with Assistant Dean and CME Director Barbara Mierzwa, two things stand out. First, the medical school takes a proactive, two-pronged approach to the evaluations, assessing individual activities as well as their overall CME program and mission. Second, they've shown it's possible to improve the evaluation process with input from others and by measuring CME activity within the context of an entire treatment paradigm.

At Buffalo, individual CME lectures are rated on how well they add to participant knowledge in relation to their core graduate medical education curriculum. Mierzwa also conducts annual long-term departmental reviews at the beginning and end of each academic year. This is a time when the entire CME department takes stock, assessing programs and questioning the group's overall ability to deliver medical education to students and affiliated practitioners in the formats and technologies they prefer.

#### **Quality Assurance as Part of the Evaluation Process**

One reason for Buffalo's high rating in Essential 2.4 can be attributed to its innovative partnering with other school departments.

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***“This is true CME in action—hands-on teaching and reminder communications, followed by measurement, reveals whether or not the education has paid off.”***

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“Our ‘Ottawa knee rules’ activity is a good example of how a simple CME in-service demonstration of knee assessment guidelines, reinforced by pocket card reminders

and clinical assessment forms, has been able to change emergency room (ER) procedures and x-ray protocols used in treating pediatric knee injuries,” explained Mierzwa.

This program, which integrates a brief, hands-on demonstration for ER physicians, supported by forms and checklists, will be assessed in the spring at a meeting of ER physicians, who will compare the x-ray use before and after the 1-year trial period. The comparison will gauge the actual impact of their learning on ER practice. “This is true CME in action,” Mierzwa added, “whereby hands-on teaching and reminder communications, followed by measurement, reveals whether or not the education has paid off.”

#### **Team Evaluation Efforts Make a Difference**

Swedish Medical Center in Seattle operates three hospitals in the region. Their CME office is part of the Department of Medical Education, which has system-wide educational responsibility, ranging from residency programs to library, community health education, medical photography, and related services.

Swedish's Medical Education and CME Director Sandy Norris acknowledged that in matching an evaluation technique to any specific program, the department has access to methods, internal experts, and resource tools perhaps not available to other providers. CME planners, for example, work closely with the hospital's Quality Integration and Improvement Department, which has projects designed to statistically track the impact of education on clinical practice before and after learning—for example, the timely administration of aspirin to cardiac patients arriving in the Emergency Department.

Working with other hospital departments on quality-related projects, rather than planning and evaluating educational activities in isolation, increases the punch of their programs, according to Norris. “By working closely with hospital departments such as Quality, Risk Manage-

ment, and Pharmacy, all of which share our passion for improving patient care and services, a small department like ours can have a major impact in effectuating clinical changes,” she said.

#### **Tips From the Top:**

##### **Take the Long View, Keep It Simple**

Asked for evaluation improvement ideas, Norris echoed earlier themes raised by high-ranking colleagues, particularly the need for longer evaluation cycles.

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***“By working closely with hospital departments such as Quality, Risk Management, and Pharmacy, a small department like ours can have a major impact in effectuating clinical changes.”***

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“We find 3 months is the best time to go back to activity participants for feedback on changes they've made as a result of learning,” explained Norris. “We've had excellent response. In 6 months, recall of specific course information is not as fresh in the learner's mind, or learning has been so internalized that identification of the specific time and location of learning is impossible. We also find such feedback is more meaningful than the rushed, scribbled evaluations at the end of an activity.”

Norris also stressed the importance of keeping it simple: “I think we tend to get overwhelmed fairly quickly when we think about the ‘best ways’ to gauge performance. By focusing on one or two specific changes in knowledge, behavior, or skills, we can evaluate program effectiveness without the need for follow-up studies that are so complex in design that we get lost in the details.” ~

# Healthcare Delivery

Continued from page 1

process or the way I deliver care that will give a better outcome every time?

With these questions answered, a clinician is ready to engage in the steps, Plan-Do-Study-Act. Completing these four steps constitutes a PDSA cycle. Each cycle consists of a plan of action, measurement or testing, evaluation, and a change in process that will lead to a desired improvement. Cycles are then sequentially repeated every 2 to 12 weeks to achieve continuous clinical practice improvement. Staker applied PDSA and RCT in his practice to improve the care of his patients with diabetes mellitus. The details of how it was done are outlined in two articles found under *Additional Reading*.

## Daily Changes Expected? Daily Feedback Needed!

"In the care of my patients with diabetes," recalled Staker, "I expected them to change their diet or exercise every day in response to their self-monitored blood glucose. Daily change required daily feedback." He taught patients to measure and to plot or graph fasting blood sugar (FBS) results on a daily basis, and in doing so, increased the frequency of feedback they needed to help them see the impact of their daily decisions on their diabetes. This process took into account the individual's physiologic and social situations, so that each individual patient was able to modify his or her daily decisions to achieve the ultimate goal of glucose control.

One hundred patients with diabetes were instructed on: (1) the technique of self-monitoring of blood glucose; (2) the use of a diabetes specification chart—a simple, inexpensive, graphic measurement tool—that enabled the patient to measure, plot, and track glucose levels over time; and 3) basic elements of good diabetes care. Using these tools, patients spent about 5 minutes each day measuring, plotting, and receiving self-generated feedback on

their glucose levels—a much greater amount of time in total than would be provided through a periodic doctor's visit. Through this, patients became recipients, as well as providers, of their own care.

Some of the steps that CME providers go through were also taken in the implementation of Staker's project. He identified a need, linked the need with a measurable goal (FBS of 110 mg/dL), notified expected learners of objectives (study participants took part in a prestudy training session), and evaluated outcomes (assessed patients' diabetes specification charts at each follow-up visit).

Speaking to these similarities and others, Staker noted, "What works, works! Improvement in clinical care is based on the use of the Plan-Do-Study-Act cycle. In planning CME, we use the same method, but have developed different labels for the steps. Both involve setting clear goals, deciding how to measure the results, studying the measured results, and then changing what we do so that it is better next time, or so that we get the outcomes we want."

## Study Outcomes

The study, which began in August 1994, collected data on the same population of patients over a 4-year period through December 1998. In that time, average FBS levels decreased from 187 to 110 mg/dL, and HbA1c (glycosylated hemoglobin) decreased from 10.5% to 7.2%. Patients were followed for 3 years beyond the study date, though Staker is careful to note that demonstration of a reduction in the incidence of diabetes complications overall would have been difficult to see from an individual physician's practice (which, according to Staker, explains the need for aggregation of data by a health plan or integrated healthcare system from a group of physicians practicing in a similar manner). But clinical practice improvement by individual physicians is of great value, nonetheless, and Staker plans to communicate this as he transitions to a new phase of his career as Medical Director for a large health plan.

"While I was in practice," Staker recalled, "I used the same methods

in a number of other patient populations with similar results." These population groups included those with hyperlipidemia, hypertension, asthma, and weight control or other lifestyle modification issues. He continued, "Part of the reason I left practice and went to health plan administration was I felt the latter would be a better sphere of influence for spreading these ideas."

## CQI/CME: An Important Connection

In Staker's view, there is a need to improve the chain of events that starts with CME and ends with better patient care. Staker noted, "A marriage of the tools and disciplines of CQI and CME seems natural and could be mutually beneficial, especially if the end results were to connect CME to the measurement of improvement, behavior change, better work process, better clinical outcomes, and a clear perception of the economic effect of better health care."

## Applying Practice-Based Learning Questions to the Practice of CME

Staker has good reason to remind us of the quote from Ralph Waldo Emerson, "Truly speaking, 'tis not education that I receive from any man, but provocation." Staker emphasized, "The role of CME is really provocation!"

When planning CME activities, consider four questions (slightly modified) that are the heart and soul of healthcare delivery improvement:

- What is my CME goal?
- What can I measure to be sure this CME activity was successful?
- Will this CME activity allow physicians to make a change in the way they deliver care that may provide a better patient outcome?
- What change can I make in the way I deliver CME that will make the next CME activity better? ~

## Additional Reading

Staker LV. Changing clinical practice by improving systems: the pursuit of clinical excellence through practice-based measurement for learning and improvement. *Qual Manag Health Care*. 2000;9:1-13.

Staker LV. Practice-based learning for improvement: the pursuit of clinical excellence. *Tex Med*. 2000;96:53-60.

# NAAMECC Hosts First Meeting to Define Needs, Expectations, and Priorities

**T**he time is right for NAAMECC," declared Jacqueline Parochka, EdD, FACME, and founding President of the newly established North American Association of Medical Education and Communication Companies (NAAMECC) at its inaugural meeting in October 2001.

NAAMECC was formed to provide support and advocacy to companies that meet NAAMECC's definition of a medical education and communication company (MECC) — a for-profit or not-for-profit entity whose *primary business* is the dissemination of the most current information on disease states, therapies, medical products and devices, and other pertinent medical practice topics to physicians and other healthcare professionals.

The first order of the day was a review of preliminary details set by the group's founding Board of Directors, including Parochka; Karen Overstreet, EdD, RPh, Vice President; Mark Schaffer, EdM, Secretary; and Richard Tischler, Jr, PhD, Treasurer. In laying the groundwork for NAAMECC, the founders seek to "put the face of commercially funded education" on the map by promoting the value of education activities based on adherence to standards set by the Accreditation Council for Continuing Med-

ical Education (ACCME), the American Medical Association, and other established bodies.

## Strengthening NAAMECC by Getting Involved

In the few short months since NAAMECC was conceived, a basic agenda has been set that includes the committee structure and rules for charter membership. The first five committees will address the most urgent needs, such as organizational bylaws, policies, and procedures; election of officers; media relations; communications; and a NAAMECC Annual Meeting. Once these functions are in place, other committees will work on member benefits, research activities, outreach, and awards for best practices.

"The future of NAAMECC depends on you. We're happy to ask you to roll up your sleeves, and get involved," said Overstreet, eager to see key committee slots quickly filled. Echoing her enthusiasm, Tischler told the audience, "We welcome your time and financial support and hope you not only join NAAMECC but also work hard to spread the word."

## Ideas Are Brewing Already

The open forum that followed the meeting agenda revealed enthusiasm for the NAAMECC mission, ideas on further shaping of the association, and questions on some organizational aspects, such as how voting rights may differ between large and small MECCs that join the association. Parochka reacted to the questions and ideas, reiterating the benefit of early involvement by companies: "You have the chance to make NAAMECC *your* voice."

Much discussion centered on the need for more research and data on MECC program results, hard evidence that can be used to counter misperceptions and inaccuracies about MECCs. Tischler agreed with the call for backup and support.

"Numbers create credibility," he said. "The only way NAAMECC can respond to unsubstantiated criticisms from outsiders is to provide documented proof of our program quality, followed by publication of positive results."

For Schaffer, a critical NAAMECC objective is to strengthen links between MECCs and academia in promoting a more uniform understanding of ACCME standards. "There is a lot we can do, not only to become better providers but also to publicize our performance," he advised. "Given the scrutiny our groups face, we're forced to work hard to play by the rules. He concluded, "By sharing our experience with ACCME standards, we can dispel myths about our operations and promote the use of 'best practices' throughout the CME world."

NAAMECC will hold its next meeting in Orlando at the January 2002 Annual Conference of the Alliance for CME. ~

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