

Results of 2009 survey of accredited intrastate CME providers

At its 2009 Annual Meeting of the House of Delegates (HOD), the American Medical Association (AMA) heard concerns, as articulated in Resolution 302 (A-09), that the number of state-accredited continuing medical education (CME) providers may be declining due to the burden and costs to maintain accreditation as a result of changes in accreditation requirements and fee increases by the Accreditation Council for Continuing Medical Education (ACCME). In response to this resolution, the AMA conducted a survey in July 2009 to better understand intrastate accredited CME providers' views on proposed ACCME fee increases and to determine whether proposed changes to the ACCME accreditation criteria and rules would affect CME providers' willingness or ability to continue being accredited. The [survey results](#) were summarized as part of a comprehensive report, [CME Report 14 \(A-10\)](#), that was presented to the AMA-HOD at its 2010 Annual Meeting. This article excerpts the survey summary from CME Report 14 and fulfills our promise to share with the CME community the results of the CME provider survey.

To begin, a few comments are in order about the survey itself and the findings that follow. Of the 1,323 individuals designated as contacts from the intrastate providers who received the survey, 549 responded, for a response rate of 41 percent. All 46 states that had ACCME recognized accreditation programs at that time provided feedback. A response rate of 41 percent from the CME providers is quite respectable given the complexity of the topic and the questions that were posed, as well as the length of this survey. A few CME provider attributes were examined as part of this analysis, such as size of the CME program, years in operation and type of CME organization. None of these variables had an impact on the response patterns. Thus, the survey respondents can be viewed as a homogeneous group when examining their responses to specific survey items. The final observation has to do with the survey items themselves. While each issue (staff resources, fee increases, fluctuations in enrollment, scope of course offerings, etc.) can be viewed uniquely, it is clear that these items are intertwined and have an impact on each other. As for the ACCME criteria, it is not that any given requirement is perceived as either "easy or difficult," but, rather, it is the collective weight of these criteria that provides a context in which this information should be viewed and considered. It is the total package of requirements/obligations that has synergistic consequences beyond any one requirement.

Survey results

The majority of responses were received from hospital and health care systems (75 percent) and state specialty societies (9 percent). The providers that responded to the survey report that they serve audiences of physicians ranging in size from 12 to 50,000, with an average of about 1,000 physicians. In 2008, these providers produced, on average, 45 activities for 348 hours of instruction.

The overwhelming majority (86 percent) of respondents indicated that it was "very important" to their organization to be able to provide *AMA PRA Category 1 Credit™*

Inside ...

Director's column

Page 2

Performance measures in PI CME activities

Page 2

Updates from the 2010 Annual Meeting of the AMA House of Delegates

Page 3

Preparing physicians to respond to disasters and public health emergencies—new journal CME offering

Page 4

21st Annual Conference of the National Task Force on CME Provider/Industry Collaboration

Page 4

Calendar of Events

Page 4

Changes to the AMA PRA credit system announced

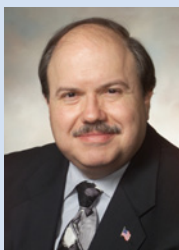
Page 4

"Get the Facts!" campaign: New fact sheets available

Page 6

Director's column

By Alejandro Aparicio, MD, FACP



By the time you read this issue of the *CPPD Report*, summer will have ended. All of us in CPPD hope that you had the opportunity to take some time off this summer and enjoy other passions besides work.

In this issue, you will find an article detailing the results of a survey conducted in 2009 by the AMA Council on Medical Education. The council conducted the survey to gather the necessary background information needed to write Report 14. This report was approved by the AMA House of Delegates (HOD) at its Annual Meeting in June. We want to express our appreciation to the state-accredited providers that took the time to complete the survey and to the state medical societies that not only encouraged their accredited providers to complete the surveys, but completed their own surveys as well. The council report, as well as the survey results (which do not contain information that could identify responses of individual providers), have been shared with the ACCME's board of directors and staff in the spirit of transparency and collaboration and so that it may inform further actions by the ACCME.

In another article, Keri Christensen, MS, an AMA senior policy analyst, Performance Improvement, discusses performance measures in PI CME. Not only can PI CME activities positively impact patient care and improve physician performance, they may also count toward Maintenance of Certification requirements (when approved by the individual specialty boards) and provide CME credit that can be used to meet licensing and other CME requirements. As more providers develop PI CME activities, we have received more questions about evidence-based performance measures, including those developed by the AMA-convened Physician Consortium for Performance Improvement (PCPI). Keri is eminently qualified to write on this topic and has been a frequent co-presenter with CPPD staff in webinars dealing with PI CME issues and opportunities.

Also in this issue is a list of reports and resolutions approved by the AMA-HOD at its Annual Meeting. We included only those items of particular interest to the CME community. Besides the implications for AMA actions or policy, the reports themselves frequently contain information and references that may help you when exploring these topics.

We are also highlighting the most recent fact sheet produced by the National Task Force on CME Provider/Industry Collaboration. The new fact sheet, like its three

predecessors, provides concise information and references on important topics related to CME. The upcoming conference of the National Task Force in October is listed among the other meetings of interest happening in the next few months. Visit www.ama-assn.org/go/cmetaskforce for more information.

Finally, we are pleased to announce that the 2010 revision of "The Physician's Recognition Award and Credit System: Information for Accredited Providers and Physicians" booklet—also approved by the AMA Council on Medical Education—has been released. The booklet has been published in PDF form; visit www.ama-assn.org/go/pri to download a copy. We attempted, based on your feedback over the years, to clarify any unclear language or concepts. You'll find a summary of the revisions on the second page of the PDF. Your feedback was very helpful in this endeavor, and we are grateful for it. As our partners in helping doctors help patients, you are of critical importance to physicians, to patients and to the public. By providing certified CME activities that help "maintain, develop or increase the knowledge, skills and professional performance and relationships that a physician uses" in their every day practice, you have the opportunity to make a difference. It is also a great reason to come to work every day, even after a wonderful summer vacation. ■

Performance measures in PI CME activities

By Keri Christensen, MS
Senior policy analyst, AMA Performance Improvement

The Performance Improvement CME (PI CME) learning model—as defined by the American Medical Association (AMA)—is a certified CME activity for physicians, structured as a long-term, three-stage process, and it must be based on one or more evidence-based performance measures. Implementing a PI CME activity, then, requires that the CME provider know what a performance measure is and how to select appropriate measures to use in the design of a PI CME activity. The purpose of this article is to define what measures are and are not appropriate and, in doing so, help CME providers find evidence-based measures.

First, let's consider what a performance measure is. A performance measure is a mechanism that enables the user to quantify the quality of a selected aspect of care by comparing it to a criterion.

"If you can't measure it, you can't improve it."
—Anonymous

The components of a performance measure include: (1) a numerator statement, (2) a denominator statement, and (3) denominator exceptions. A measure's numerator includes the number of patients meeting the numerator criteria. A measure's denominator includes the number of patients meeting the denominator criteria. Patients may be excluded from the denominator of an individual measure for medical reasons (e.g., the care process is contraindicated), patient reasons (e.g., the patient declined the care process) and system reasons (e.g., resources to perform the services are not available). These exceptions are identified based on the clinical judgment of the clinician.

The method of calculation for **performance** follows these steps:

1. Identify the patients who meet the eligibility criteria for the denominator
2. Identify which of those patients meet the numerator criteria

(Continued on page 5)

AMA House of Delegates actions

The following are recommendations from reports and resolutions that may be of interest to the CME community, adopted at the 2010 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD). All reports and resolutions discussed below are available in their entirety online in the [AMA-HOD meeting archives](#)

Council on Medical Education Report 3— Specialty Board Certification and Recertification and Maintenance of Licensure

1. That our AMA continue to support the AMA Principles of Maintenance of Certification (MOC);
2. That our AMA reaffirm AMA Policies H-275.978 and H-275.923 that support the ongoing evaluation of Licensure; and
3. That our AMA monitor Maintenance of Licensure (MOL) as being led by the Federation of State Medical Boards (FSMB) and work with FSMB and other stakeholders to develop a coherent set of principles for MOL.

Council on Medical Education Report 6— Telemedicine and Medical Licensure

1. That our AMA reaffirm Policy H-480.969, “The Promotion of Quality Telemedicine.”
2. That our AMA rescind Policy D-275.967, “Telemedicine and Medical Licensure.”

Council on Medical Education Report 7— Continuing Medical Education in Disaster Medicine and Public Health Preparedness

1. That our AMA reaffirm Policy H-130.949, “Organized Medicine’s Role in the National Response to Terrorism.”
2. That our AMA reaffirm Policy H-295.868, “Education in Disaster Medicine and Public Health Preparedness During Medical School Residency Training,” which recommends that formal education and training in disaster medicine and public health preparedness be incorporated into the curriculum at all medical schools and residency programs and supports the AMA’s National Disaster Life Support (NDLS) program office’s work to revise and enhance the NDLS courses and supporting course materials in both didactic and electronic formats for use in medical schools and residency programs. It also supports continued involvement of the National Disaster Life Support Education Consortium in the newly created Federal Education and Training Interagency Group (FETIG).
3. That our AMA continue to work with other specialties and stakeholders to coordinate and encourage provision of disaster preparedness education and training in medical schools and in graduate and continuing medical education.
4. That Policy D-295.932 be rescinded.

Council on Medical Education Report 12—Regu- lation of Continuing Medical Education Content

1. That our AMA reaffirm Policy H-300.953, “Content Specific CME Mandated for Licensure.”
2. That our AMA reaffirm Policy H-300.994, “Support for Voluntary Continuing Medical Education.”
3. That our AMA recommend that organizations with responsibilities for patient care and patient safety request physicians to engage in content-specific educational activities only when there is a reasonable expectation that the CME intervention will be appropriate for the physician and effective in improving patient care or increasing patient safety in the context of the physician’s practice.

CME Report 13—Expectations for Lifelong Learning

This informational report was filed. No new AMA policy resulted.

Council on Medical Education Report 14— Opposition to Increased CME Provider Fees

1. That our AMA communicate its appreciation to the Accreditation Council for Continuing Medical Education (ACCME) Board of Directors for their responsiveness to AMA’s requests this past year.
2. That our AMA continue to work with the ACCME to: (a) reduce the financial burden of institutional accreditation and state recognition; (b) reduce bureaucracy in these processes; (c) improve continuing medical education, and (d) encourage the ACCME to show that the updated accreditation criteria improves patient care.
3. That our AMA continue to work with the ACCME to: (a) mandate meaningful involvement of state medical societies in the policies that affect recognition, and (b) reconsider the fee increases to be paid by the state-accredited providers to ACCME.
4. That the Council on Medical Education monitors the results of the aforementioned recommendations with a report back to the House of Delegates at the 2011 Annual Meeting.

Resolution 301: Ensuring Physician Competence in the Care of Older Adults

That our AMA recognize the critical need to ensure that all physicians who care for older adults, across all specialties, are educated and trained in geriatric care and encourage all appropriate specialty societies to identify and implement the most expedient and effective means to ensure adequate education in geriatrics at the medical school, graduate and continuing medical education levels for all relevant specialties.

(Continued on page 6)

Preparing physicians to respond to disasters and public health emergencies—new journal CME offering

Ruth Anne Steinbrecher, MPH
Director, AMA National Disaster Life Support

Disaster Medicine and Public Health Preparedness (DMPHP) is the American Medical Association's (AMA) first comprehensive and authoritative journal emphasizing public health preparedness and disaster response for physicians and other health care and public health professionals. This peer-reviewed journal seeks to translate science into practice and integrate medical and public health perspectives. The events of September 11, the subsequent anthrax attacks, the tsunami in Indonesia, Hurricane Katrina, SARS, the H1N1 influenza pandemic and the recent earthquake in Haiti all demonstrate that physicians must be prepared to respond to large-scale health emergencies.

To support the journal's ongoing commitment to public health preparedness in the medical and public health communities, beginning with the June 2010 issue, DMPHP physicians can access a CME-designated article. Physicians may earn AMA PRA Category 1 Credit™ by reading the CME-designated article in the online issue of DMPHP and taking a quiz online. To complete the CME quiz online, a physician must be a paid subscriber to DMPHP. The June CME-designated article, "Otolgic Considerations of Blast Injury" by D. Spencer Darley, MD and Robert M. Kellman, MD (*Disaster Med Public Health Preparedness*. 2010;4:145-152) provides an overview of blast mechanics and injuries, then outlines blast-related injuries to the ear and assessment and management of blast ear injury. ■

CME providers:

Share this [journal CME activity](#) with the physicians you serve!

21st Annual Conference of the National Task Force on CME Provider/Industry Collaboration

"Moving forward in an age of uncertainty: Creating innovative, practical, educational solutions"

Mark your calendars now to attend the 21st Annual Conference of the National Task Force on CME Provider/Industry Collaboration, scheduled for October 13–15 in Baltimore. The full conference agenda, list of speakers and registration are available [online](#). ■

Calendar of events

Oct. 13–15	21st Annual Conference of the National Task Force on CME Provider/Industry Collaboration Baltimore
Nov. 5–8	The Society for Academic Continuing Medical Education 2009 Fall Meeting Boston
Nov. 5–10	Association of American Medical Colleges Annual Meeting Washington, D.C.
Nov. 12–13	2009 Council of Medical Specialty Societies Annual Meeting Rosemont, Ill.

Changes to the AMA PRA credit system announced

Changes to the American Medical Association (AMA) PRA credit system have been announced. Information is now [available online](#). The new rules will go into effect for all accredited CME providers starting July 1, 2011. To learn more about the changes and how this will impact certified CME activities, consider participating in a webinar presentation on one of the following dates:

- Tuesday, October 26, 1–2:30 p.m. CDT
- Thursday, November 4, 2–3:30 p.m. CDT

Each presentation will include Q/A with faculty members from the AMA. [Register online today](#).

Information will also be presented at the following meetings:

- **Medical Association of the State of Alabama**, Montgomery, Ala. (October 27, 2010)
- **Massachusetts Medical Society**, Waltham, Mass. (November 5, 2010)

- **South Carolina Medical Association**, Columbia, S.C. (November 11, 2010)
- **Alliance for CME Annual Conference**, San Francisco (January 26–29, 2011)
- **Association for Hospital Medical Education Educational Institute**, Denver (April 15, 2011)

AMA staff are available to present information at State Medical Society/CME provider meetings over the coming months. If you are interested in arranging for a presentation, please contact us at (312) 464-4677.

The next issue of the CPPD Report will highlight changes to the AMA PRA credit system. Watch for this in January.

Be sure others in your organization are part of the AMA CPPD Information Network and receive e-mail announcements about changes to the AMA PRA credit system. [Sign up online](#).

(Continued from page 2)

3. For those patients who do not meet the numerator criteria, determine whether an appropriate exception applies and subtract those patients from the denominator

$$\text{Performance} = \frac{\text{Patients who meet the measure}}{\text{Patients who qualify for the measure—patients who have valid exceptions}}$$

Selecting an appropriate performance measure

Ideally, a CME provider that is considering implementing a PI CME activity will work with colleagues who have skills in quality/performance improvement to identify a quality issue to be addressed. Once the quality issue has been identified, then appropriate evidence-based measures can be selected.

When determining what measure(s) to select for a PI CME activity, two initial questions to ask are:

1. What process do we want to improve and why?
2. How will we know if a change results in improvement?

“What gets measured gets done.”
—Unknown

Measures can be specified at different reporting levels, including physician, patient, system, hospital, physician group and payer. Additionally, different types of measures help measure different things.

- **Structural measures:** A measurement of some quality of the physical or organizational aspect of the organization. Structural measures can signify whether basic organizational constructs are in place. Example: Adoption of medication e-prescribing
- **Process measures:** A measurement of compliance with a specific procedure. Process measures can supply actionable feedback by illuminating if the prescribed procedure is being followed consistently. Example: % of patients with an A1c value tested
- **Intermediate outcome measures:** Example: % of patients with an A1c value < 7
- **Outcome measures:** A measurement of product quality based on the specifications. Outcome measures indicate whether or not the process is successful in reaching its goal. Example: % of patients who were re-admitted within 30 days of discharge for heart failure

Again, working with quality improvement colleagues will be essential in determining the type of measure that is most suited to the performance gap the PI CME activity is trying to address. Generally, process measures are quite suitable for initial performance improvement efforts, as they are specific and actionable. It is easier to understand how you might increase the percentage of patients with an A1c value tested than it is to understand how to decrease your readmission rate for heart failure or patient satisfaction score. As part of a PI CME activity, physicians should review data about their own patients in order to understand more

about their individual practice patterns. Data may be available from several sources depending on where the physician provides care; physician practice records and hospital medical records are two typical sources of data.

Evidence-based performance measures have already been developed by several organizations and are available for use. One such organization, the AMA-convened [Physician Consortium for Performance Improvement \(PCPI\)](#) has developed 266 measures and worksheets for 43 clinical conditions. Royalty-free permission is available to CME providers to use Consortium measures. Performance measures are also available from the [National Committee for Quality Assurance](#), [National Quality Measures Clearinghouse](#), [Physician Quality Reporting Initiative](#) and the [Joint Commission](#).

The PCPI develops evidence-based performance measures using a consensus-based process that starts with the selection of a topic, typically a specific disease condition or clinical area. Next, a 10–20 person workgroup is convened with diverse membership, representing all specialties and clinical groups that are involved in the care of patients with this condition. Multiple meetings take place over several months to review existing clinical guidelines and evidence and propose draft measures. These draft measures are then specified by staff trained in medical coding. Once approved by the workgroup, the measures are published on the internet for public comment. All public comments are reviewed and addressed, and the measures may be updated based on these comments. Once finalized, the measures are voted on for approval by PCPI membership. Pilot testing of the measures may be conducted during this timeframe.

“Without a yardstick, there is no measurement; without measurement, there is no control.”
—Anonymous

The PCPI submits approved measures to the National Quality Forum (NQF) in response to a call for measures. The NQF rigorously reviews the measures and makes a preliminary recommendation regarding endorsement, which is then put out for public comment. Based on these comments, the review committee approves appropriate measures, which are then voted on by the NQF membership. The NQF review committee then makes a final decision on whether or not to accept the measure and endorse it. This rigorous process ensures that there is general approval for these measures and that they have been reviewed and approved by diverse organizations.

Once the measures are approved by the NQF, the measure developers' work does not end. Measures must be tested for feasibility, reliability and clarity. Developers must monitor for unintended consequences. The measure specifications must be updated as new codes come out and new drugs and procedures are developed. In addition, all measures are fully reviewed every two to three years to ensure they still include the most up-to-date evidence.

(Continued on next page)

Performance measures—what they *are not*

Performance measures are often confused with clinical guidelines. A clinical guideline is a document meant to guide decisions regarding the diagnosis, management and/or treatment of a specific disease. Guidelines are typically based on an examination of current clinical evidence and may include summarized consensus statements. Guidelines are intended to serve as a reference to prospectively guide and influence clinical behavior.

Performance measures, on the other hand, are intended to evaluate that behavior. For the purposes of a PI CME activity, performance measures must be evidence-based, building on data from clinical trials and informed by clinical guidelines. The output of a performance measure is a performance rate, which is typically expressed as a percentage. Additionally, measures are typically calculated retrospectively using data recorded in a medical record or claim; whereas a guideline is typically utilized while care is being provided.

Example: Clinical guideline and related performance measure

Guideline statement: CD4 and CD8 T Cell Lymphocytes and Percentages

- A CD4 cell count with percentage should be obtained upon initiation of care.
- It is important that the provider and patient be aware of the substantial variation in CD4 cell counts, especially during acute illness. Some experts recommend obtaining two baseline measurements before decisions are made to initiate therapy.

Measure statement:

- Percentage of patients aged 6 months and older with a diagnosis of HIV/AIDS for whom a CD4+ cell count or CD4+ cell percentage was performed at least once every 6 months.

Performance measurement, used correctly, can serve as a valuable tool to evaluate the quality of care provided by a physician, clinic, hospital or other health care institution. Careful evaluation of accurate data can provide meaningful insight to guide performance improvement activities. Continued assessment will allow progress to be tracked and achievements highlighted, ultimately showing how better care is being provided to patients. ■

Additional resources:

www.physicianconsortium.org

www.ama-assn.org/go/webinarscppd

“Get the Facts!” campaign: New fact sheets available

The “Get the Facts!” campaign is a national effort to disseminate information on issues important to the Continuing Medical Education (CME) community. The National Task Force on CME Provider/Industry Collaboration initiated this campaign in 2009 to address and prevent misinformation and misunderstandings about independent CME by providing accurate, objective information about certified CME to those inside and outside the CME community.

A new fact sheet was recently released on the topic of on-label and off-label usage of prescription medicines and devices. Topics covered in other fact sheets include: providing valid, independent evidence for clinical decisions; addressing conflicts of interests; and pharmaceutical/biotechnology support of CME. All four fact sheets are [available online](#).

Get involved! Distribute the campaign’s fact sheets to your colleagues, members of your organization, meeting attendees and others. You may also consider posting them on your company’s website. The CME community has a responsibility to make sure that CME information used by stakeholders in the health care arena is accurate and appropriately reflects the current process, standards and regulations.

Please contact: ntf.factsheets@ama-assn.org for more information about these fact sheets or the “Get the Facts!” campaign. ■

(Continued from page 3)

Resolution 310: Suggested Revision in ACCME Evaluations

That our AMA strongly encourage the Accreditation Council for Continuing Medical Education to recognize the value of gaining knowledge outside a physician’s specialty and change the activity evaluation to reflect this. ■

(Continued from page 1)

to the physicians they serve. Another 14 percent indicated that this was somewhat important. Only one CME provider (less than 1 percent) answered that providing AMA PRA credit was not important.

When asked about the overall impact of the new ACCME criteria, almost 60 percent of respondents indicated that the criteria would make it more difficult to provide quality CME activities. Only 17 percent indicated that the new criteria would help their institution provide quality CME. Of the 15 percent that answered “other” to this question, several comments indicated the new ACCME criteria would lead to a decrease in the number of activities the provider would be able to produce.

Providers were asked to indicate the degree of ease or difficulty their organization might have in documenting compliance with each of the 22 ACCME criteria. While the majority of providers rated six criteria as being “very easy” or “somewhat easy” to document, 15 criteria were rated as being “somewhat difficult” to document, and one criterion was evaluated by the majority as being “very difficult” to document.

Providers were asked to indicate which factors might cause their organization to consider not being accredited in the future. Responses were as follows:

	Very likely	Somewhat likely	Not very likely
Too much time involved (N=434)	177 (40.8%)	171 (39.4%)	86 (19.8%)
Lack of staff (N=434)	156 (35.9%)	171 (39.4%)	107 (24.7%)
Lack of physician support/involvement (N=434)	135 (31.1%)	179 (41.2%)	120 (27.6%)
Accreditation fee increase (N=436)	78 (17.9%)	179 (41.1%)	179 (41.1%)
Demonstrating compliance with 2006 ACCME accreditation criteria (N=437)	63 (14.4%)	179 (41.0%)	195 (44.6%)
Competition from other types of CME providers (N=428)	58 (13.6%)	115 (26.9%)	255 (59.6%)
Lack of commercial support (N=432)	72 (16.7%)	101 (23.4%)	259 (60.0%)

Another survey question asked providers to suggest what else the AMA should take into consideration in preparing this report for the AMA-HOD. Of the 269 responses to this question, 128 indicated that the financial and staff resources necessary for the entire accreditation process are a concern. Another 73 indicated that documenting compliance with the new criteria is a challenge.

Perhaps the most significant finding from this survey is that 34 percent of these intrastate providers report that their organizations are currently “discussing whether or not to maintain CME accreditation.” The data indicate that, while there may be multiple factors impacting intrastate accredited providers, the ACCME criteria and fees are considered problematic by more than 55 percent of providers. The results of this survey suggest that if these issues are left unresolved, there likely will be a further reduction in the number of intrastate CME providers and in the number of CME activities certified for AMA PRA credit to serve physicians at the local level.

AMA-HOD action

After reviewing this data and the other information that was included in [CME Report 14 \(A-10\)](#), the AMA-HOD directed the AMA to work with the ACCME to: reduce the financial burden of institutional accreditation and state recognition; reduce bureaucracy in the accreditation and recognition processes; improve CME; show that the updated criteria improve patient care; mandate meaningful involvement of state medical societies in policies that affect state recognition; and reconsider the fee increases for intrastate accredited CME providers. The complete text of the official actions of the AMA-HOD may be found [online](#). ■

CPPD staff contacts

Alejandro Aparicio, MD, FACP

Division director, Continuing Physician Professional Development

(312) 464-5531

alejandro.aparicio@ama-assn.org

Sue Ann Capizzi, MBA

Associate division director, Continuing Physician Professional Development

(312) 464-4230

sue.ann.capizzi@ama-assn.org

Jeanette Harmon, MBA

Director, AMA PRA Standards and Policy, Continuing Physician Professional Development

(312) 464-4677

jeanette.harmon@ama-assn.org

Kevin Heffernan, MA

Director, AMA Accreditation and CPPD Educational Activities, Continuing Physician Professional Development

(312) 464-4637

kevin.heffernan@ama-assn.org

CPPD on the Web

AMA CME resources

www.ama-assn.org/go/cme

Physician's Recognition Award information for physicians and CME providers

www.ama-assn.org/go/pra

Resources for accredited CME providers

www.ama-assn.org/go/cmeprovider

Read the AMA PRA booklet

www.ama-assn.org/go/prabooklet

The *CPPD Report* is published three times annually. The AMA Division of CPPD welcomes your suggestions and comments. To subscribe or unsubscribe, and for all other correspondence, contact:

Mindi Daiga, MBA

Managing editor, *CPPD Report*

mindy.daiga@ama-assn.org

Kevin Heffernan, MA

Editor, *CPPD Report*

kevin.heffernan@ama-assn.org

Past editions of the *CPPD Report* can be viewed in PDF format at:

www.ama-assn.org/go/cmecppd