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CME: Ailing from a case of systemic inflammatory response syndrome

Todd Dorman, MD

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Member, American Medical Association

Vital signs: Temperature 100.3°F; blood pressure 160/95; heart rate 105 bpm; respiratory rate 28 pm

In health care, providers value tracking a patient's vital signs. It is these signs that provide a window into the present state of the patient and a quick way to assess if something is wrong. If one were to take the vital signs on most continuing medical education (CME) providers, planners and faculty today, one would likely find that the patient is febrile, hypertensive and tachypneic—that is, the patient has signs and symptoms consistent with systemic inflammatory response syndrome (SIRS). A good clinician, suspecting something amiss and looking to dig further, would typically start by taking a history.

In this case, the patient, a CME provider, would respond that he was enjoying his usual state of good health until media, government and regulatory agencies began to question the veracity of his work and the transparency of his process. To wit, the recent investigations conducted by the Senate Finance Committee into relationships between physicians or medical researchers and pharmaceutical, medical device, and biotechnology companies have put a great deal of pressure on the entire CME community. A clinician might trace the true source of this patient's malaise to these investigations, and the negative media attention that has splashed on CME as result.

Let's take a step back and assess the reality of the situation.

The majority of the Senate Finance Committee's investigations to date have focused on *individual* physicians, and on discrepancies in which disclosed payments far exceed the monetary values received as honoraria in CME. Despite being either uninvolved or minimally involved in the Senate's actual investigations, CME has nonetheless become the focus of the media and many others. Even when a journal discovers that it has been the victim of a ghostwritten manuscript, the recommendations include the removal of all funding for CME. No wonder our patient is suffering from SIRS.

In April, the Institute of Medicine (IOM) released its recommendations in the report [Conflict of Interest in Medical Research, Education and Practice](#).¹ Before reviewing the findings, let me disclose that I had the honor of serving on the committee that produced the report. My participation as a member on the committee was designated by the IOM as "necessary but conflicted." These conflicts included serving as a consultant to an incubator company, holding stock in a technology company, and serving as an associate dean and director of a CME office that accepts funding from commercial entities, as defined by the Accreditation Council for Continuing Medical Education. It is worth noting that during the course of my service on this committee, my consultancy ended (I had not done work with that company for over a year) and a year had passed since my stock had been paid-out. This left serving as associate dean

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Director's column

By Alejandro Aparicio, MD



As I reflect on the new year's first *CPPD Report*, which includes a short reference to the 20th Annual Conference of the National Task Force on CME Provider/Industry Collaboration ([additional information](#)), it occurs to

me that this issue echoes the conference's "Learning from the Past, Planning for the Future" theme. The articles in this issue discuss a few of the important events that occurred in the world of continuing medical education (CME) in 2009 and highlight some of the work that lay ahead in 2010 and beyond.

In April 2009 the Institute of Medicine (IOM) released its report, "Conflict of Interest in Medical Research, Education, and Practice," which included important recommendations for the CME community. In this issue we are fortunate to have an article by IOM committee member Todd Dorman, MD, a recognized leader in the CME community. You will enjoy his insightful article (page 1) that discusses the vital issues of transparency, accountability, proportionality, fairness and related topics in CME. By establishing a clinical analogy between CME and an ailing patient, Dr. Dorman reminds us that the importance of CME lies in helping our learners be better physicians and, in turn, more effective in helping ailing patients.

Ideas exchanged

Other important CME conferences in 2009 included the Alliance for CME Annual Conference, the Society for Academic Continuing Medical Education (SACME)

Spring Meeting and the SACME Fall Meeting, held in association with the Association of American Medical Colleges (AAMC) Annual Meeting. The AAMC meeting is noteworthy in that it demonstrated the awareness of the importance of CME—the longest phase of a physician's education—in the academic community.

Additional important publications on CME this past year included several American Medical Association (AMA) Council on Medical Education reports, which were presented at the AMA House of Delegates (HOD) Annual and Interim meetings. These reports can be viewed in the [AMA-HOD meeting archives](#). In December, the IOM released "Redesigning Continuing Education in the Health Profession," which is another report of particular interest to the CME community and one that will likely be discussed in a future issue of the *CPPD Report*.

Another article in this issue, and one in a series of articles highlighting clinical topics of importance to physicians, was written by our AMA colleague, Patricia Sokol, RN, JD (page 5). Based on a monograph produced by the AMA patient safety unit, Ms. Sokol argues for physicians taking a more active role in medical reconciliation. Promoting clinical safety is important not only because it improves care, but also because it contributes to patient safety. [The monograph](#) is certified for *AMA PRA Category 1 Credit™* and can be accessed at no cost.

Looking ahead

For insight into one of the ways that the CME agenda is being prioritized in 2010 at the national level, we look to the words of Norman Kahn Jr., MD (page 4). Dr. Kahn, another leader in the CME and medical communities, points out that as members of the Conjoint Committee on Continuing Medical Education, many organizations,

including the AMA, are working together to address major issues facing the CME community. Dr. Kahn explores how those issues might impact the care of our patients and the public. While the goal of the conjoint committee may be ambitious, I believe the talent of the group is equal to the task, and will benefit greatly from Dr. Kahn's facilitation.

Looking forward, other initiatives include a continuation of the AMA Council on Medical Education's review of the AMA PRA credit system rules. This initiative gathered input from a large number of stakeholders in 2009 and should reach completion in 2010. The Accreditation Council on Continuing Medical Education convened a meeting of its member organizations as well as other important stakeholders in December 2009. The group had an extensive and frank discussion on topics germane to the entire CME landscape. These included decreasing or eliminating unnecessary costs or bureaucratic burdens, improving the quality of CME and increasing its impact on the performance of physicians and the health care system in 2010.

While 2009 was a very busy year—and we anticipate 2010 will be equally hectic—it is good work, important work, and work that is core to our mission of helping physicians help patients.

As Robert Frost wrote:

*My object in living is to unite
My avocation and my vocation
As my two eyes make one in sight.
Only where love and need are one,
And the work is play for mortal stakes,
Is the deed ever really done
For Heaven and the future's sakes.*

Our "work" is to help physicians help patients. Have a wonderful 2010! ■

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of a CME office as my remaining conflict. Although I agree with the IOM's decision, I must admit that when I took the job, I never envisioned an academic position could carry such a designation.

The IOM report, which includes many recommendations that are pertinent to CME and to physicians in practice, is underpinned by four principles: transparency, accountability, proportionality and fairness. I find it easiest to group these principles into two sets. Transparency and accountability comprise the first pairing, and establishes that for the CME system to be seen as ethically sound by all stakeholders, all relationships—and all policies related to relationships—

should be made ubiquitously available. The second pairing, proportionality and fairness, holds that the system and the individual health care providers be held accountable for the information disclosed, and that the management of these disclosed relationships should be equitable and proportional to the risk and the resultant harm. Thus, some relationships may need to be banned outright, while others would be acceptable. The IOM frequently utilizes the concept of the rebuttable presumption where it states that it is best to not do certain things, but then permits these activities if approved by a defined review group and the decisions are made transparent. In reflection, one could argue that my "necessary but conflicted" position was rebuttable presumption in action.

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In addition to establishing these four principles as the ethical core approaches for addressing relationships and conflicts of interest (COI), the IOM report differed from what others have promulgated to date in certain important ways. First, the IOM report addressed a diverse set of circumstances and utilized the same principles to recommend improvements that would still protect and allow the great good that comes from interaction between the health care and industry sectors.

In addition, by creating parallel recommendations for physicians and staff—no matter if they practice in an academic center or in a private practice—the report maintained a level playing field between these two vitally important sectors. Finally, it also recognized that the issues surrounding COI are so important that organizational structures *must* be modified to ensure that a COI committee exists within an organization’s management infrastructure.

For physicians, there is plenty of confusion associated with the wide variety of rules related to disclosure. In fact, given that the “what, why, who, when and how” of disclosure are different with almost every journal, CME provider, institution and national organization, the IOM recommended that a standard approach be established to include guidance on content, format and the procedures of disclosure. This type of uniformity should significantly simplify the process in the future ... and perhaps help lower the blood pressure of our patient.

The IOM report addressed guideline committee structure and composition, and laid out specific guidance on how to minimize the risk of bias within these committees. The recommendations allow for experts to remain involved, but they preclude those with conflicts from controlling the process or the final work product. These necessary but conflicted individuals can thus play a role in the same fashion as I have within the IOM committee.

Regarding CME, the report recommended that a new system of funding be created, that stakeholders should help determine what the new system will be, and that this new system be determined within 24 months and subsequently implemented. The IOM did not place restrictions on this new process other than it should be free of industry influence, enhance public trust and ensure that high-quality, evidence-based education is provided. This is a major challenge to the CME community and will require visionary leadership.

Importantly, the report also focused on the lack of education physicians receive regarding the rules and regulations surrounding relationships and conflict management in cases relating to the CME world, national organizations or ethical opinions. The IOM saw this as a major issue related to faculty development and thus suggested training for all physicians by academic centers and teaching hospitals, and that national accrediting bodies also help develop the standards for that education. The myriad rules can be confusing, and without adequate clarity and education, physicians can make mistakes in disclosure that impede transparency. Furthermore, the report recommended that incentives be created and utilized to help promote implementation.

In addition to the IOM report, several other important publications have been released in 2009. The [Cochrane Collaboration](#) published a review of continuing education meetings and workshops. This review supported the findings from a previously published [AHRQ monograph](#) on the effectiveness of CME.^{2,3} Both publications found that educational meetings are effective. Specifically, this new report found that mixed interactive and didactic education meetings were *more* effective than either didactic meetings or interactive meetings, and also that educational meetings appeared to be less effective for less serious outcomes than for more serious outcomes. Similarly, the AHRQ report stated that mixed modes of education were more effective than single modes. These two reports, when taken together, should finally put to rest the notion that CME is ineffective.

Now back to our sick CME provider patient. Now that we have a diagnosis—acute stress response—what course of treatment should we prescribe? The remedy seems simple enough: the health care industry should work to reduce the stress and confusion surrounding the CME environment and COI by embracing the concepts within the IOM report. To begin the healing process, the community outside of health care should allow time to collect data on the impact of the large number of changes that have been implemented by health care in the last two to three years regarding COI and relationships with industry. Without knowledge of the impact of the many changes already in place, wholesale cuts and broad-based sweeping regulation are simply inappropriate at a time of such change. Change for change sake is never a good idea and the unintended consequences may lead to harm, not benefit.

Specifically, one must acknowledge *education* is not only absolutely central to health care’s trifold mission—patient care, education and research—it, in fact, plays a role in all three. But it should not be carved off and treated as different and distinct; the principles behind the rules and regulations for education should be the same as those used for patient care and research. If this level of consistency is achieved, the rules and regulations surrounding education would meet the principles outlined in the IOM report. However, it should be noted that patient care and research are currently funded by a number of sources including commercial entities, yet education is poorly funded by sources other than commercial entities. Clearly an agenda that includes inquiry into CME issues on a national level, and a system to fund such an agenda, are sorely needed.

Of course, if that doesn’t work, then my best advice is to take two aspirin and call me the morning. ■

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3. Cochrane Collaboration: Continuing education meetings and workshops: effects on professional practice and health outcomes. <http://www.cochrane.org/reviews/en/ab003030.html>. Accessed October 27, 2009.

The Conjoint Committee on Continuing Medical Education: National priorities for 2010

Norman B. Kahn Jr., MD, EVP/CEO, Council of Medical Specialty Societies
Member, American Medical Association

Formed in 2002 to “re-position CME,” the Conjoint Committee on Continuing Medical Education (CCCME) brought together 16 national organizations spanning the spectrum of medical education and practice (see Table 1). Early products included a “dashboard” of goals and strategies, and a series of articles published in the *Journal of Continuing Education in the Health Professions*. In late 2008 and early 2009, the CCCME strategic planning process identified that the performance of the U.S. health system was relatively poor when measured by international benchmarks, such as those used by the World Health Organization.

In an era in which physician practices are increasingly measured against evidenced-based, nationally accepted benchmarks of performance, CCCME faced the question of who is responsible for improving the performance of the U.S. health system? Physicians spend a limited amount of time in the undifferentiated environment of medical school, and a similarly short block of time learning their specialty in residency. The bulk of a physician’s career is spent in decades of practice, during which physicians participate in ongoing continuing education. Therefore, CME has emerged as the target system in which to intervene to improve U.S. health system performance.

Table 1: 2010 members of the Conjoint Committee on Continuing Medical Education

Accreditation Council for Continuing Medical Education (ACCME)
Accreditation Council for Graduate Medical Education (ACGME)
Alliance for Continuing Medical Education (ACME)
American Academy of Family Physicians (AAFP)
American Board of Medical Specialties (ABMS)
American Hospital Association (AHA)
American Medical Association (AMA)
American Osteopathic Association (AOA)
Association for Hospital Medical Education (AHME)
Association of American Medical Colleges (AAMC)
Council of Medical Specialty Societies (CMSS)
Federation of State Medical Boards (FSMB)
The Joint Commission
Journal of Continuing Education in the Health Professions (JCEHP)
National Board of Medical Examiners (NBME)
Society for Academic Continuing Medical Education (SACME)

In order to achieve the CCCME goal “to use the CME system to improve the performance of the U.S. health system, as measured by international benchmarks,” the CCCME’s vision of an optimal system of CME is one that is practice-oriented, evidence-based, system-minded and integrated into lifelong physician education. Three strategies were selected to achieve this goal:

Strategy 1: Moving toward the integration of performance improvement into CME

This strategy includes leveraging the strength of CCCME member organizations to bring together leaders of CME and performance improvement (PI) systems to integrate PI into systems of medical practice. Integrating PI into CME operates within a framework implemented in 2005, and is based on the work of a PI CME task force convened by the American Medical Association Council on Medical Education. PI CME includes measuring physician practice performance, delivering educational interventions targeted to change practice behaviors and re-measuring physician practice performance. CCCME organizations accept this framework as the basis for a nationally standardized system of PI CME.

In March of 2009, the American Board of Medical Specialties (ABMS) approved two recommendations that support this CCCME strategy. First, all certifying boards will require CME credit for diplomates to participate in Maintenance of Certification (MOC). Second, the ABMS accepted the PI CME framework in principle for programs now eligible for approval by certifying boards for MOC Part IV, provided that all stages are complete.

Strategy 2: Moving toward a curriculum for CME that aligns across the continuum of medical education

The elements of this strategy include the use of CCCME member organizations to develop curricula based on the Accreditation Council for Graduate Medical Education (ACGME) core competencies. Curricula would be tailored to target different levels across the continuum: system, specialty and practice. For example, to improve gaps identified at the system level, an appropriate curriculum would be developed to focus on the needs found at the system level. Likewise, as medical specialties differ in their roles in the system, different curricula would also need to be developed to match the roles and needs of a given specialty. Finally, as individual physician practices differ within a specialty, curricula would also need to focus on gaps identified in an individual practice.

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Strategy 3: Leading a national conversation about financing CME that supports the CCCME vision

This strategy focuses on assuring a system of financial support for CME that is free from commercial influence. It is supported by recommendation 5.3 of the 2009 Institute of Medicine report “[Conflict of Interest in Medical Research, Education and Practice](#),” which calls for:

[A] broad-based consensus development process to propose a new system of funding accredited continuing medical education that is free of industry influence, enhances public trust in the integrity of the system, and provides high-quality education.

As a starting point, CCCME accepts the profession’s current voluntary self-regulatory standards, the “Standards for Commercial SupportSM: Standards to Ensure the Independence of CME Activities,” which were approved by the Accreditation Council for Continuing Medical Education in 2004 with additional enforcement provisions implemented in 2006 through 2009.

This strategy will likely be implemented in the spring of 2010, with a call for comment and a national meeting to explore how the profession can achieve this important goal. CCCME anticipates that the medical profession, its key stakeholders and the public will see these goals achieved by the middle of 2011. ■

The physician’s role in medication reconciliation: Issues, strategies and safety principles

Patricia Sokol, RN, JD

Clinical Quality and Patient Safety, American Medical Association

The American Medical Association (AMA) has taken action to provide physicians with information designed to raise awareness of the importance of medication reconciliation—making sense of a patient’s medications and resolving potential inconsistencies. This process is a necessary step in promoting the safe use of medications. By asking, listening and learning, the AMA and physicians play a role in improving the health of our nation.

The AMA convened a panel of experts in medicine, nursing, pharmacy and law to examine issues and develop strategies and safety principles to assist physicians and other health care professionals in managing medication reconciliation—a complex component of medication management.

The panel defined medication reconciliation as making sense of a patient’s medications and resolving conflicts between different sources of information to minimize harm and maximize therapeutic effects. Further, they described the reconciliation process as ongoing, dynamic, episodic and team-based. Medication reconciliation is identified as an integral component of the physician’s professional activities; therefore, it is ultimately the physician’s responsibility to ensure patient medication use is safe and effective. Importantly, it is emphasized that the patient, as the one constant across the continuum of care,

is the most important member of the medication management team. Patient involvement and understanding of the medication management process is thus central to its success. The AMA was the first organization to address medication reconciliation as a patient-centric activity that occurs within the context of the therapeutic process of medication management.

CME providers:
[Make this guide on medication reconciliation CME activity available to the physicians you serve!](#)

To assist physicians in this often difficult process, the panel put forth evidence-based principles to standardize medication reconciliation across all settings of care. To manage the complexity of medication reconciliation, strategies were compiled to help physicians recognize gaps or inconsistencies in their systems that impeded the reconciliation process, or that required support to facilitate the adoption of a successful process.

The monograph “[The Physician’s Role in Medication Reconciliation](#)”

We want to hear about your CME activities!

A recent survey conducted in the *CPPD Report* indicated that readers are interested in case studies about certified CME activities. To help provide this to our readers, we need to hear from you about certified CME activities you have planned. Have you completed a PI CME, or performance improvement CME, activity? Do you offer Internet point-of-care learning? Did you recently certify an enduring material that was especially challenging? If you are interested in sharing information about these or any of the other types of CME activities, [we would like to hear from you](#). ■

provides a framework for physicians to understand their role and responsibilities in the medical reconciliation process. To enhance communication and care coordination, the monograph offers general concepts and strategies, implementation steps, and case-based learning. Realizing that patient engagement is essential to safe medication management and the reconciliation process, the program also includes a guide to completing an AMA My Medications[®] patient medication card.

This monograph is available at no cost and is certified for AMA PRA Category 1 Credit[™]. ■

CME requirements for medical license renewal

CME providers should be aware of licensure requirements that affect their physician learners and should make their learners aware of the benefits of obtaining the AMA Physician's Recognition Award (PRA) to meet these requirements. A total of 62 medical licensing boards in 45 states, the District of Columbia and three territories (Guam, Puerto Rico and the Virgin Islands) will require physicians to obtain CME credits for license renewal in 2010. Although the number of credits required varies by state, 45 states and territories require a portion of a physician's CME to be AMA PRA *Category 1 Credit*[™] or equivalent American Osteopathic Association, American Academy of Family Physicians or American College of Obstetrics and Gynecology credits. Of the licensing jurisdictions that require CME, 43 will accept the AMA PRA certificate or approved PRA application as equivalent for the purpose of licensure re-registration. For an updated breakdown of requirements by state, see the AMA's newly updated 2010 edition of [State Medical Licensure Requirements and Statistics](#).

The full publication is available to [order online](#) or by calling (800) 621-8335. ■

Alliance for CME 2010 Annual Meeting

For those planning to attend the Alliance for CME Annual Conference in New Orleans, please note the following sessions that will be presented by the AMA Division of Continuing Physician Professional Development (CPPD). We hope to see you there!

AMA PRA credit system basics (Friday, Jan. 29, 10– 11 a.m.)

This presentation will give an overview of the AMA PRA credit system and its application in an accredited CME provider's CME program. This session will clarify policies that are frequently asked by providers, and is a great opportunity to get your questions answered about AMA PRA policies and procedures.

2010 AMA update and open forum (Friday, Jan. 29, 2:45–3:45 p.m.)

This session will provide updates on current AMA initiatives and policies related to CME/CPPD, and will provide participants with an opportunity to share ideas related to how the AMA PRA credit system can be of increased value to physicians.

[Learn more about the conference!](#) ■

Archived webinars available on PI CME and the AMA PRA credit system

Several AMA webinars are available to help CME providers implement PI CME, or performance improvement CME, and to understand the AMA PRA credit system.

These archived webinars are available to view at a time and location convenient to you, and registration includes access to view the presentation two times. This provides a great opportunity to share the information with your CME and quality improvement committees!

[View more information or register today.](#) ■

Presentations from the National Task Force on CME Provider/Industry Collaboration conference available online

More than 500 participants gathered for the 20th Annual Conference of the National Task Force on CME Provider/Industry Collaboration, held Oct. 14–16, 2009, in Baltimore, Md. The theme for this year's conference was "Learning from the past; Planning for the future." The conference offered exciting interactive plenary and breakout sessions. Presentations from the conference are [available online](#). ■

Updates from the 2009 Interim Meeting of the AMA House of Delegates

At the 2009 Interim Meeting in November, two reports relevant to the CME community were presented to the AMA House of Delegates (HOD). The reports discussed below are available in their entirety online in the [AMA-HOD meeting archives](#).

Council on Medical Education Report 5—Opposition to Increased CME Provider Fees

This report was for information only, and was filed.

Council on Ethical and Judicial Affairs Report 1—Financial Relationships with Industry in Continuing Medical Education

This report was referred back to the AMA Council on Ethical and Judicial Affairs. ■

AMA PRA FAQs

Q: Can an accredited provider designate a prepared course (i.e., ACLS, PALS, etc.) for *AMA PRA Category 1 Credit*™?

Advanced Cardiac Life Support (ACLS) and similar forms of training that are of a depth and scope suitable for a physician audience may be certified for *AMA PRA Category 1 Credit*™. Providers are still required to document that all of the [core requirements](#) for certifying an activity for *AMA PRA Category 1 Credit*™ have been met.

Q: Can a physician claim credit for participating in the same educational activity more than once?

A physician should not claim credit for participating in the same activity more than once unless there has been a substantial change in the content.

Contact the [AMA Division of Continuing Physician Professional Development](#) with additional questions about credit, or view a list of [frequently asked questions](#). ■

Calendar of events

Jan. 27–30	Alliance for CME 35th Annual Meeting New Orleans
April 15–18	The Society for Academic Continuing Medical Education 2010 Spring Meeting Miami
April 26–28	2nd International Conference on Virtual Patients and MedBiquitous Annual Conference London
April 28	ACCME “CME as a Bridge to Quality™” Accreditation Workshop Chicago
June 6–10	Global Alliance for Medical Education Montreal
Oct. 13–15	21st Annual Conference of the National Task Force on CME Provider/Industry Collaboration Baltimore

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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/pr

Resources for accredited CME providers

www.ama-assn.org/go/cmeprovider

Read the AMA PRA booklet

www.ama-assn.org/go/prabooklet

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