Introduction
Many CME professionals are engaged in innovative CME activities worthy of recognition. These individuals and activities exemplify the best practices many are striving toward in the profession of CME. The Alliance acknowledges such excellence through its annual awards selection process. The 2009 award recipients continue to raise the bar in the field of CME.

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William Campbell Felch/Wyeth Award for Research in CME

This Award Made Possible with an Educational Grant from Wyeth Pharmaceuticals
In Honor of William Campbell Felch, MD, a Founding Member of the Alliance for CME
To Recognize the Best Completed Research Project in the Arena of Continuing Medical Education

Spaced Education: An Effective New Methodology for Online CME

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(L to R): Betsy Woodall, representing Wyeth Pharmaceuticals, grantor of the $3,000 cash award, Price Kerfoot, representing the Veterans Affairs Boston Healthcare System/Harvard Medical School, and Donna Connelly, representing the America Urological Association (recipients). Not pictured: recipient Michael Kearney of Beth Israel Deaconess Medical Center/Harvard Medical School, and Susan Tyler, Leader of the Award Selection Panel.
2009 William Campbell Felch/Wyeth Award for Research in CME

In Recognition of the Best Completed Research Project in the Arena of CME

B. Price Kerfoot, MD; Michael C. Kearney, MD; Donna Connelly, BS; Michael L. Ritchey, MD

Spaced Education: An Effective New Methodology for Online CME

Recent meta-analyses have demonstrated that educational interventions directed to providers can generate significant improvements in care delivery, even without concomitant systems-level changes.1,2 Even so, the impact of these traditional CME programs on practice patterns is often quite modest.2–5 There are several reasons why this may occur. Participation rates for CME programs are often low and those who attend may be un-engaged. The content is often delivered in a bolus manner, making it difficult for attendees to retain key concepts. Also, reinforcement of learned content is rarely, if ever, undertaken. Together, these factors result in limited retention and application of learned material.6–8

Spaced Education—A New Form of Online Education

Spaced education offers a promising solution for overcoming these barriers to effective CME. Spaced education refers to online educational programs based on the spacing effect, the psychological finding that educational encounters that are spaced and repeated over time (spaced distribution) result in more efficient learning and improved retention, compared to massed distribution at a single time-point.9–12 Over the last three years, nine large randomized trials have been published. They show that spaced education can improve knowledge acquisition,13 boost knowledge retention,14 improve clinicians’ ability to self-assess their performance,15 and change behavior.16

We recently developed and launched a system of interactive spaced education (ISE) which allows us to monitor learning in real-time. With ISE, clinicians are sent an email containing a clinical case scenario and a multiple-choice question (see Figure 1A). To answer the question, they must click on a hyperlink in the email. This opens a new web page that recognizes the clinician’s email address and asks the clinician to submit an answer to the question (see Figure 1B). Upon submitting this answer, the response is downloaded to a central server, and the clinician is immediately presented with the correct answer and learning points germane to the question (see Figure 1C). By testing the clinician on the material, ISE takes advantage of the testing effect, the psychological finding that testing of learned material does not serve merely to evaluate a learner’s performance. Rather, testing actually alters the learning process itself to significantly improve knowledge retention.17,18 With ISE, evaluation and education are inextricably linked due to the question-answer format of the material. In effect, every ISE item acts as an individual test question. In aggregate they can be used to reliably assess baseline knowledge and knowledge gains.

Our Research Study—Winner of the 2009 William Campbell Felch/Wyeth Award for Research in CME

While spaced education has been shown to be an effective and well-accepted form of online education for medical students, it is not known whether spaced education is similarly effective for graduate medical education (GME) or CME. Using clinical practice guideline (CPG) education as an experimental system, we conducted a randomized controlled trial to evaluate whether ISE is an effective and acceptable form of GME and CME. This study was supported by the American Urological Association.

We developed and validated 48 ISE items (questions and answers) on five urology CPGs (hematuria and priapism [H-P]; staghorn calculi, infertility, and antibiotic use [S-I-A]). Then 160 urologists and 320 urology residents were randomized to one of two cohorts. Physicians were sent three emails a week, each containing two questions. Content was repeated three times over 20 weeks. Cohort A physicians received the three-cycle ISE course on H-P, with 24 control items on S-I-A in Cycle 3. Cohort B physicians received the three-cycle ISE course on S-I-A, with 24 control items on H-P in Cycle 3. In total, the ISE program was completed by 71% of the urologists and 83% of the residents. Cohort A scores on H-P increased from mean 44.9% in Cycle 1 to 75.7% in Cycle 3—a 57% relative increase compared to controls (p<0.001, Cohen effect size 2.2). Similarly,
Figure 1: Example of Spaced Education

**A. Delivery of the Evaluative Component with an Embedded Hyperlink**

A spaced education item containing a clinical case scenario and a question (the evaluative component) is sent to a clinician via email. In order to submit an answer to the question, the clinician must click on a hyperlink in the email.

**B. Submission of an Answer to the Question**

By clicking on this hyperlink within the email (above), a webpage is opened which then recognizes the clinician’s identity (email address) and asks him or her to submit an answer to the question.

**C. Central Recording of That Clinician’s Answer to the Evaluative Component and Presentation of the Educational Component**

Upon submission, the answer is downloaded to a central server, and the clinician is immediately presented with a follow-up webpage (the educational component) that gives the correct answer and learning points germane to the question. Also included is a list of the frequency (count) of answers by other providers, so clinicians can see how they perform relative to peers.

**Reference:**


To view the full AUA Guidelines referenced above, please click on [http://www.auanet.org/forms/guidelines.cfm?id=12](http://www.auanet.org/forms/guidelines.cfm?id=12)
cohort B scores on S-I-A increased from 45.2% in Cycle 1 to 69.5% in Cycle 3—a 56% relative increase compared to controls (p<0.001; effect size 2.2). Of all participants, 84% requested to enroll in further ISE programs. In summary, ISE was demonstrated to be an effective and well-accepted form of GME and CME, and is a promising new methodology to improve CPG knowledge.

We were honored to receive the 2009 William Campbell Felch/Wyeth Award for Research in CME for this research. The manuscript based on these research results will be published soon in the *Annals of Surgery*.

**Implications for the CME Community**

Spaced education is a novel form of online education, founded on core principles of learning, which has the potential to revolutionize how online CME is conducted. ISE is content-neutral, so that this methodology can be harnessed in any of the CME domains across a wide range of provider types. By linking evaluation with education in a question-answer format, ISE is able to document the mastery of educational content by clinicians. Consistent with findings from our other studies, ISE tends to become addictive to many of the physicians who participate in the programs. The quick-and-easy ISE format melds well into physicians’ busy clinical schedules, and over time these small amounts of learning aggregate into substantial improvements in knowledge. We now are using an adaptive delivery system that personalizes the spacing and content of a spaced education course based on the learner’s demonstrated knowledge level. A preliminary study showed that this adaptive algorithm improves learning efficiency by more than 35%. Given its combination of high acceptability and high effectiveness, spaced education is an extremely promising new methodology for online CME.

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**Financial Disclosures**

Dr. Kerfoot owns equity in, and is a board member of, Spaced Education, Inc. There are no other potential conflicts of interest relevant to this article.

**References**


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**Podcast**

To learn more about this project, visit *Conversations in CME* and listen to a podcast with Price Kerfoot, MD, and host Floyd Pennington, PhD, at: www.ctlassoc.libsyn.com.
Award for Most Outstanding Certified Enduring Material CME Activity

This award is made possible through a grant from Medscape.
In Recognition of Excellence in the Design and Implementation of a CME Enduring Material Activity

What’s Best for My Patient: Using Evidence to Design the Right Team, the Right Treatment, at the Right Time for the Management of Colon and Rectal Cancers

Peer &bull Point Medical Education Institute, LLC
Richard H. Kennison, DPM, CCMEP
Gary Bird, PhD

(L to R): Ezra Ernst, representing Medscape LLC, grantor of the $2,000 cash award, Linda Stanley, Leader of the Award Selection Panel, and recipients Richard Kennison and Gary Bird, of Peer&bullPoint Medical Education Institute.
2009 Award for Most Outstanding Certified Enduring Material CME Activity

In Recognition of Excellence in the Design and Implementation of a CME Enduring Material Activity

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Richard Kennison, DPM, CCMEP, President and General Manager
All from the Peer•Point Medical Education Institute, LLC

What’s Best for My Patient: Using Evidence to Design the Right Team, the Right Treatment, at the Right Time for the Management of Colon and Rectal Cancers

Current trends for the management of colon and rectal cancer (CRC) involve a care team-based structure involving clinicians with surgical and medical oncology specializations as well as gastroenterologist and pathologist colleagues. Providing CME to all clinicians involved in CRC management in a live event is problematic because of difficulties in defining a common educational theme, and the differing time constraints imposed on each member of the team. However, knowledge, competency and performance gaps, which require educational intervention, are evident in this group of clinicians. With this in mind, What’s Best for My Patient sought to bring together care team members of varying specializations, using unique, highly interactive online case simulations that maximized reach and stimulated learning.

Needs Assessment for CRC Content in the Activity

In the US, CRC is the third most common cancer overall and causes approximately 10% of all cancer-related deaths per year. According to the American Cancer Society, 112,340 new cases of colon cancer and 41,420 new cases of rectal cancer occurred in the United States in 2007.1 Typically, some 15–20% of newly diagnosed patients will have metastatic disease at initial presentation, whereas 80–85% have earlier stage disease.2 Despite advances in its management, CRC was the estimated cause of death for 52,180 people in 2007.1 However, when CRC is detected at an early, localized stage, the five-year survival rate of 90% is promising. Nevertheless, 62% of all CRC cases present as either locally advanced or metastatic disease, and the associated five-year survival rate with a tumor that has spread to adjacent organs and/or lymph nodes is 66%. With distant metastases, only 9% of individuals will live five years.

Advances in the management of patients, from screening and initial detection through treatment, have continued to evolve over the last decade—with the emphasis promoted by the National Comprehensive Cancer Network (NCCN) being to shift practice habits toward a multidisciplinary, team-based approach.3,4 However, although the logic behind bringing together members with different specialties in the oncology clinical team is sound, there are inherent deficits in this approach that may adversely affect patient outcomes. These deficits center on knowledge, competency and performance issues that become apparent when all care team member efforts must be coordinated. Without adequate communication between its members, the team approach is at best an inefficient process, to the detriment of performance. This is compounded because the evidence-based NCCN guidelines for best practice CRC screening and treatment, and their specific implications for the various sub-specialties involved, are regularly updated—leaving the potential for a knowledge or competency gap both within each specialty and between the specialties. The activity therefore had fundamental requirements to:

1. Foster a mechanism for improving the dialogue between care team members
2. Enhance knowledge of the latest evidence-based guidelines
3. Provide a platform for the application of that knowledge
4. Provide some form of cross-pollination so members of the care team could better understand each others’ perspectives on best practice patient management.
Learning Objectives

The learning objectives for this CME activity were as follows:

Upon completion of this educational activity, the participant should be able to:

• Identify the various specialists who treat cancer of the colon and rectum and discriminate their role on the treatment team
• Explain the importance of lymph node harvesting, including the significance of the number of lymph nodes sampled and implications for accurate staging
• Use evidence-based guidelines to identify patients with cancer of the colon and rectum who may benefit from adjuvant treatment
• Describe the risks and benefits of implementing adjuvant chemotherapy in stage II and stage III colorectal cancer.

How This Activity Closed the Practice Gaps

It was decided that a highly interactive, but easy-to-use case simulation approach would be needed to resolve the complex issues and practice gaps facing clinicians who deal with CRC patients. Given the time-constraints placed on this group of clinicians, the activity needed to be accessible online and be available on-demand. This approach was deemed to have the greatest reach, and from the onset was designed to be a cost-effective enduring activity.

The user experience was designed to immerse the person participating in the activity with the experience of viewing a patient’s treatment from the perspective of the medical oncologist or colon and rectal surgeon. Two parallel simulations, each of 30 minute duration, were presented—one case from each clinical perspective, with both purposely utilizing an ill-structured, atypical patient history. In order to promote transference of the issues and hence understanding of a different point of view, the user was invited to complete the second simulation after completing the first. Each simulation presented a fully interactive chart showing the stage of the patient’s evaluation and treatment. The results of consultations and tests performed at various dates were shown as images or as written reports, and were added to the history, thus giving the user a view comparable to seeing the chart evolve in real time. The flexibility of the interface made it easy for participants to be quizzed at key stages, using carefully constructed multiple choice questions, to assess their knowledge on important issues and to examine their personal perceptions of the practice gaps. Different questions were used for each simulation, allowing the learning objectives to be addressed from different clinical perspectives. The strategy for closing the practice gaps involved postquestion remediation using a combination of expert opinion, with two expert faculty members [colon and rectal surgeon, Janice F. Rafferty, MD, and medical oncologist, Robert L. Cody, MD] examining best practice in a video discussion coupled with references to evidence-based practice in the form of live links to full journal articles and current NCCN guidelines.

Evaluation Outcomes

The What’s Best for My Patient simulations were certified by the Peer•Point Medical Education Institute as educational activities for one year, beginning August 1, 2007. In this time, the simulations attracted a total of 478 users, 98 of whom requested credit. Results of the evaluation to determine the effectiveness of the activity are described below.

Preactivity questions revealed a justification of the needs assessment, as 63% of participants agreed with the statement that they felt there is room for improvement with regard to their interactions with other members of the care team. In addition, 44% of participants felt that their knowledge of the NCCN guidelines was average or poor, while only 15% described their knowledge as excellent. In addition, just over a third of participants revealed that they use the guidelines in less than 50% of their patients.

Postactivity questions demonstrated the effectiveness of the activities as a vehicle for learning. When asked if the activities met the learning objectives, 98% of respondents ranked them as good or excellent. Both case simulations had greater than a 90% approval rating in answer to the question that participation in the activities will help them make better evidence-based decisions for their patients (see Figure 1). More than half of participants in both simulations believed that as a result of participating in the activities their practice patterns would be more likely to change. Similarly, greater than half of participants in both simulations believed that their interactions with colleagues would be more likely to change. When asked if their knowledge of the NCCN guidelines for the surgical/pharmacologic management of CRC was improved as a result of
participating in the simulations, greater than 85% responded in the affirmative. Finally, as justification for impressing the importance of the NCCN guidelines, most participants in both simulations recognized that improved knowledge of the NCCN guidelines would enhance the management of their patients (see Figure 2).

**Conclusion**

The What’s Best for My Patient simulations were well received, and were highly effective in meeting the learning objectives, as self-reported by the participants. This unique parallel case-simulation format (one case from each clinical perspective) provided an interactive learning environment using a convenient, flexible platform that combined maximized reach and an educational deliverable which helped to close the practice gaps.

**References**


**Podcast**

To learn more about this project, visit *Conversations in CME* and listen to a podcast with Gary Bird, PhD, and host Floyd Pennington, PhD, at: www.ctlassoc.libsyn.com.

![Figure 1: Effect of the Activity on Evidence-Based Decision Making](image1)

**Figure 1:** Effect of the Activity on Evidence-Based Decision Making

**Figure 2:** Impact of the Activity on Improving Understanding of the Importance of the Evidence-Based Guidelines

![Figure 2](image2)
Award for Most Outstanding Certified Live CME Activity

This Award is Endowed by an Educational Grant from Audio Digest Foundation

To Recognize an Organization Responsible for Innovation and Excellence in the Design, Educational Format, and Instructional Delivery of a Live CME Activity

The Role of the Breast Surgeon in the Interdisciplinary Management of Early Breast Cancer

Research to Practice
Neil Love, MD

(L to R): Diana Durham, representing Audio Digest Foundation, grantor of the $1,000 cash award, Brian Moss, representing Research To Practice (recipient), and Joyce Fried, Leader of the Award Selection Panel. Not pictured, recipient Neil Love.
2009 Award for Most Outstanding Certified Live CME Activity

In Recognition of an Organization Responsible for Innovation and Excellence in the Design, Educational Format, and Instructional Delivery of a Live CME Activity

Neil Love, MD; Brian Moss, MBA; Douglas Paley, BA; Kathryn Ault Ziel, PhD; Aviva Asnis-Alibozek, MPAS; Isabelle Tate, LPN
All from Research To Practice

The Role of the Breast Surgeon in the Interdisciplinary Management of Early Breast Cancer

Background

On Thursday, May 1, 2008, Research To Practice (RTP) hosted a live CME satellite symposium focused on the presentation and discussion of the results of a national breast cancer Patterns of Care survey completed by practicing general surgeons and surgical specialists. The rationale behind the incorporation of this type of premeeting, case-based study into the design of the live event was twofold.

1. As little was previously known about the frequency and nature of the interactions between surgeons and breast cancer patients regarding systemic therapy, or how surgical practice patterns in the community compared to the best practices of surgical oncology specialists with an expertise in breast cancer, the survey served as a means to uncover educational gaps.

2. Based on a number of theoretical models in the CME and adult learning literature that propose physicians modify their prior beliefs and practices after observing the clinical decisions of colleagues, the use of the survey results as the source of content for the meeting was intended to encourage attendees to actively compare and contrast their practice patterns with those of colleagues and experts to help them affirm and/or reassess their treatment strategies.1–5

Methods

Premeeting Survey and Content Development

In February 2008, RTP enlisted the help of the independent research firm, Haldy McIntosh, to randomly recruit 100 practicing general surgeons to complete an online questionnaire that included hypothetical case presentations focused on local and systemic therapeutic modalities for early breast cancer. A cohort (n=28) of clinical investigators with expertise in the management of breast cancer was also sought to take this survey. After completion of all surveys, the RTP clinical team analyzed the results, looking for questions for which significant heterogeneity existed, as well as those topics on which community practice patterns/knowledge levels deviated from those of the surgical experts (see Figure 1). The RTP team then developed an extensive slide set incorporating both the survey results and the relevant clinical trial data that either provided a solid foundation in support of specific treatment options or affirmed a lack of definitive answers related to each question/scenario identified.

The Live Symposium

Held as part of the 2008 American Society of Breast Surgeons Annual Meeting, and attended by more than 300 clinicians, the live meeting featured an interdisciplinary panel of four renowned clinical investigators with expertise in the surgical and systemic management of breast cancer. During the event, RTP president and medical oncologist Dr Neil Love, serving as the moderator, led the audience through the slide set and encouraged them to:

1. Review each data slide
2. Reflect on their own personal practice patterns
3. Listen to the faculty discussion
4. Reassess their own decision-making processes.
No didactic presentations were incorporated into the agenda, and the entire event essentially was a panel discussion with Dr. Love querying the faculty about the survey findings, associated trial data, and their personal treatment patterns. Each attendee received a 28-page printed workbook complete with graphic representations of the survey results so they could refer to the findings during and after the meeting.

**Enduring CME Activity**

To reach an even wider audience, RTP audio recorded the proceedings of the live meeting and conducted one-on-one interviews with the faculty members to obtain their in-depth perspectives on aspects of the survey findings not addressed during the live event. These were developed into an accredited enduring audio and print CME activity and distributed nationwide to more than 10,000 US-based general surgeons and surgical oncologists.

**Educational Outcomes Measurement**

To measure baseline knowledge, RTP developed a premeeting case-based questionnaire. The goal was to compare this information to an immediate postactivity case-based evaluation to assess changes in learner competence. RTP invited approximately 50 meeting registrants to complete the survey in advance of the activity. Eighteen attendees elected to fill out the questionnaire.

Following the event, RTP then invited the 18 attendees who participated in the premeeting educational outcomes measurement (EOM) survey to complete a follow-up questionnaire. Twelve individuals provided their responses to the case-based questions.

During this assessment, participants were also asked to provide their level of preference for the meeting’s format—with the moderator presenting the slides and the use of Patterns of Care data as a way of structuring the agenda. In addition to the case-based evaluation tool, RTP also conducted an immediate postactivity educational assessment with all meeting attendees to measure changes in knowledge, competence, and behavior (see Figure 2).

**Conclusions**

Based on the EOM and other CME evaluation metrics, RTP believes the use of a Patterns of Care study as the content platform for a live educational event is both desirable and potentially beneficial to attendees. While evaluations of additional events of this kind are necessary to further substantiate these assertions, the success of this preliminary experience necessitates that other providers give consideration to this format.

**Acknowledgement**

This activity was supported by unrestricted educational grants from Genentech BioOncology, Genomic Health, and Novartis Pharmaceuticals.

**References**


**Podcast**

To learn more about this project, visit Conversations in CME and listen to a podcast with Neil Love, MD, and host Floyd Pennington, PhD, at: www.ctlassoc.libsyn.com.
**Figure 1: Example of Premeeting Survey Question Illustrating Differences in Practice Patterns Between Experts and Community Surgeons**

Would you offer neoadjuvant chemotherapy to a 70-year-old woman with a 3-cm, ER/PR-positive, HER2-negative tumor who would have an unacceptable cosmetic outcome with standard partial mastectomy?

**Figure 2: Immediate Postmeeting Assessment**

This activity will influence how I practice.

- **Outstanding**
- **Good**
- **Satisfactory**
- **Fair/Poor**

n=213 applicants
Award for Outstanding CME Collaboration

This award is made in honor of Richard Gorlin, MD, world-renowned cardiologist, educator, clinician and researcher.

To recognize those organizations best demonstrating innovation or uniqueness in achieving effective CME collaboration.

CS2day: Collaboration and Innovation in Education

California Academy of Family Physicians
Shelly Rodrigues, CAE

Physicians’ Institute for Excellence in Medicine
Bob Addleton, EdD

CME Enterprise
Bruce Bellande, PhD, FACME

Purdue University, School of Pharmacy
Bob Bennett, RPh

Healthcare Performance Consulting, Inc.
Chris Larrison, BA

University of Virginia, School of Medicine
Jann Balmer, PhD

Iowa Foundation for Medical Care
Mike Speight, BS

University of Wisconsin, School of Medicine and Public Health
George Mejicano, MD

Interstate Postgraduate Medical Association
Mary Ales, BA

(L to R): seated, Dixie Blankenship of Interstate Postgraduate Medical Association, George Mejicano of the University of Wisconsin School of Medicine and Public Health, Mary Ales of Interstate Postgraduate Medical Association, Shelly Rodrigues of California Academy of Family Physicians, Mike Speight of the Iowa Foundation for Medical Care, Jann Balmer of the University of Virginia School of Medicine; standing, Dan Sloan and Sheila Robertson of CME Enterprise, Heidi Ness of Interstate Postgraduate Medical Association, Tom McKeithen and Chris Larrison of Healthcare Performance Consulting, Rick Thielen and Bruce Bellande of CME Enterprise, Beth Mulliken and Curtis Olson of the University of Wisconsin School of Medicine and Public Health, Simone Karp, representing CECity, grantor of the $2,000 cash award, Charles Willis, Leader of the Award Selection Panel, and Robyn Snyder of CME Enterprise. Not pictured, recipients Bob Addleton of Physicians’ Institute for Excellence in Medicine and Bob Bennett of Purdue University School of Pharmacy.
2009 Award for Outstanding CME Collaboration

In Recognition of Those Organizations Best Demonstrating Innovation or Uniqueness in Achieving Effective CME Collaboration

Shelly B. Rodrigues, CAE, MS, CCMEP
California Academy of Family Physicians

Cease Smoking Today: Collaboration and Innovation in Education (or, The Breakfast Club Revisited)

Many of us are old enough to remember the classic teen movie The Breakfast Club. A group of very diverse high schoolers find themselves thrown together in the school library for Saturday detention. They learn they have much more in common than not, and as a group write their final essay. Fast forward to Spring 2007—a group of individuals from nine diverse organizations are in a room at a hotel in Chicago and, to their delight, find they have much more in common than not. The result is an innovative educational endeavor. And like The Breakfast Club, the Cease Smoking Today (CS2day) partners, are submitting a single essay.

The nine CS2day partners are working collaboratively on one of the nation’s most pressing public health problems, one associated with the deaths of millions of people. Pfizer has entrusted us with unprecedented resources to achieve our goal to reduce the number of smokers. There is no doubt in my mind that the stakes for all 10 organizations are exceedingly high. However, I believe that the stakes are even higher for two other groups: the general public and the CME community. Indeed, there is a strong probability that this initiative will literally change the face of CME in the US. As a result, we must not fail.

All nine partners have stepped up to the plate and collectively asked to be leaders in the field. In turn, Pfizer has answered the call and expects that each of us deliver on our commitments to the very best of our abilities. I am humbled to lead this project; I feel honored to be working with such a talented and committed group of professionals; I welcome the challenges and opportunities ahead; I look forward to working with everyone associated with CS2day.

—George Mejicano, MD, CS2day Lead

The Partnership

The CS2day partnership creates a new framework for collaboration in CME/CPD. This groundbreaking initiative brings together nine partners developing 175 activities to deliver education to more than 50,000 physicians, pharmacists, and health care professionals. Never before has such a gathering of dedicated CME professionals combined forces around a single public health initiative: reducing the number of smokers in the US. Collaboration involves every organization both suspending their sense of self and giving shamelessly of their strengths for the good of many. CS2day was founded on such beliefs. Key elements involve:

1. The discovery process that defined the scope of the initiative
2. A multifaceted needs assessment
3. Shared curriculum resources, including:
   a. A common set of tools for educational planners both internal and external to this process
   b. An integrated live curriculum
   c. Patient and clinical video segments
4. A common web portal sharing educational resources, breaking news and clinical aides to smoking cessation
5. Pilot testing of key tools and concepts with external faculty
6. Independent yet integrated Performance Improvement projects that include a clinician registry tool to measure change in practice
7. Continuous quality assessment at every stage of the initiative
8. Common outcomes analyses that permit the comparison of varied delivery methods
9. Sharing knowledge and practice of core educational competencies with other CME organizations.
The Discovery Process

All partners participated in a Delphi process to agree on the project scope, target learners, focus for needs assessment, measures of success, and project core values.

Needs Assessment

The needs assessment process integrated the literature base, interviews with target learners and physician survey responses to identify real and perceived gaps in physician knowledge as well as barriers to improving care. A set of competencies was developed from this needs assessment that drives tool creation, content delivery, and outcomes measurement.

Tools

A toolkit team developed a core set of tools available to all partners via the web portal (these tools are available publicly). Toolkit contents include: slide decks with annotations and guidelines for matching slides to audience, eight case studies of patient scenarios, case vignettes for evaluation, videos (real patient and scripted), practice improvement tools (eg, group visits, team huddles, registry use), practice resources and patient education materials.

Videos

Integral to curriculum development are video segments for incorporation into both live and enduring materials. Videos from three patients document the cessation journey in short video clips. In addition, more than 25 short videos highlight face-to-face interactions with patients and clinicians. These videos can be used with slides, in conjunction with online learning, or as pre and posttest pieces. A final group of videos called triggers consists of 10–15 second clips that can be used to generate a conversation, encourage a question, or the like.

Common Website

Central to the delivery of educational activities was the need for a common website that included learning and content management systems (content is available for all educators to use at: www.ceasesmoking2day.com).

Faculty

The evidence-based content was provided by the Center for Tobacco Research and Intervention (CTRI) at the University of Wisconsin, lead developers of the Clinical Practice Guideline: Treating Tobacco Use and Dependence: 2008 Update, published by the Agency for Healthcare Research and Quality (AHRQ). While CTRI provided the scientific expertise for the content, the collaborative used target learners, including primary care physicians, nurse practitioners, pulmonologists, cardiologists and psychiatrists, to critique the needs assessment, core curriculum, and web delivery system. Using faculty in this advisory capacity allowed the collaborative to implement the Plan-Do-Study-Act cycle in content development. This process will be used repeatedly to provide the most relevant and useful curriculum possible.

Clinical Measures and Performance Improvement Projects

Central to this collaborative are four performance improvement (PI) projects, each implementing different learning delivery systems for practice change in smoking cessation. To measure improvement, the 2008 guidelines have been translated to clinical measures so clinicians can measure their current practices, make appropriate adjustments, and re-evaluate their success. The four PI projects use the same clinical measures, registry, data and timelines, and share curriculum and resources. They have very different educational structures—from an intensive Institute for Healthcare Improvement model collaborative to a web-based, self-directed learning option. Evaluation of change in patient status and practice improvement across the projects will yield Level 5 and 6 outcomes.

Outcomes Measurement

Consistent with shared needs assessment, curriculum, tools and clinical measures is the agreed-upon process for outcomes and evaluation. Each learning activity will be evaluated with consistent questions on content, faculty expertise, relevance, bias, and intent to change. Many activities have postevent evaluation processes in place, and the strongest evaluation piece will be the patient status data from the registry used by the PI projects.
In addition to educational outcomes, the partners are completing the first phase of an internal evaluation and looking at markers and lessons learned throughout the project. An outside organization has been retained to complete the evaluation, which includes a survey of all partners (and the staff for the partners, n=27), and a series of stakeholder interviews. Initial results are positive, and will be shared with the CME community. Phase 1 has provided us with new tasks for the remainder of the grant cycle as well.

Infrastructure

The CS2day collaborative is unique in its infrastructure—and perhaps in the ease with which the group formed. The CS2day organization chart illustrates the structure (see Figure 1).

Each organization has signed a participation agreement that includes roles, responsibilities, voting, reporting requirements, conflict resolution, confidentiality and funding. Each organization has designated a voting partner who has one vote. The CS2day partners have appointed an Executive Committee, and have agreed on the project and its financial management components. Unique to the project is that each activity has not only management from the provider organization, but also a liaison from the project management team. Each partner has agreed to a 10% withhold of grant payment, with payment tied to milestones. Quarterly progress reports and mini-budget reconciliations are prepared and submitted to the partners and to the grantor. The purpose of this communication to all stakeholders is to ensure that project milestones are met. Importantly, these milestones are not related to content, the selection of speakers, educational format, method of evaluation, and the like. The partners meet monthly via conference call, and the Executive Committee meets weekly.

Each partner is also committed to communication about the initiative, and the partners have agreed to a spread plan that includes presentations at the Alliance Annual Conference and other professional meetings, articles on websites and in publications, and a media strategy that ensures we are able to respond to and generate public awareness.

Conclusion

At the end of *The Breakfast Club* the teens go their separate ways, but leave the audience with a sense they have changed for the better and will remain a community. We are nowhere near the end of our saga, but the CS2day partners also believe we have been changed for the better and know we will remain a CME community. In fact, several new initiatives have been developed, with various partners and new organizations, all seeking to build upon the lessons learned by the CS2day partners.

*This has been an incredible learning experience for us as an organization, and for me personally. The opportunity to work with the smart, dedicated partners, and their teams has been tremendous. The chance to improve health care outcomes is incredible. And an unintended consequence has been the friendships developed over the work.*

—Partner anonymous response to internal evaluation survey question

Keep watching—perhaps the CS2day partnership will become a CME classic.

Podcast

To learn more about this project, visit Conversations in CME and listen to a podcast with George Mejicano, MD, and host Floyd Pennington, PhD, at: www.ctlassoc.libsyn.com.

**Figure 1: The CS2day Organization Chart**
Award for Innovation in Continuing Professional Development for the CME Professional and/or Enterprise

This award is made possible through an educational grant from The FCG Institute for Continuing Education and IME, LLC in honor of Rafael Sanchez, MD, dedicated physician, educator and CME leader.

To recognize outstanding innovation in continuing professional development for CME professionals.

CCMEP™: The Certification Program for CME Professionals

Judith Ribble, PhD, CCMEP and the NC-CME Board of Directors
Martin Cearnal Envoy Thomas, MPH
Karen Overstreet, EdD, CCMEP Pamela Mason, CCMEP
Laird Kelly, CCMEP Jon Ukopec, PhD, CCMEP
Marissa Seligman, PharmD, CCMEP Lewis Miller, CCMEP
Jack Kues, PhD, CCMEP Dennis Wentz, MD

(L to R): seated, NC-CME Board Directors Pam Mason, Karen Overstreet and Laird Kelly, NC-CME Executive Director Judy Ribble, Paul Weber, representing the Alliance, grantor of the $2,000 cash award; standing, NC-CME Board Directors Lew Miller, Jon Ukopec, Jack Kues, Marty Cearnal and Greg Thomas, and Mila Kostic, Leader of the Award Selection Panel. Not pictured, recipient Dennis Wentz.
2009 Award for Innovation in Continuing Professional Development for the CME Professional and/or Enterprise

In Recognition of Outstanding Innovation in Continuing Professional Development for CME Professionals

Laird Kelly, CCMEP, Treasurer, National Commission for Certification of CME Professionals and President, RSi/FocalSearch

Validating Competence on the Ground Floor—The Certified CME Professional Program

Much criticism has been directed toward the CME profession and CME professionals in the past few years. Some of this has come from within our ranks and some from outside. Some criticism has been based on thoughtful consideration of our field and much has come from outsiders who are half-informed, at best.

There has been confusion, even among the medical profession, of the character and intent of CME programming and the value of CME. As outlined by numerous speakers at the 2009 Alliance Annual Conference, there will be numerous scholarly reports and recommendations issued this year on the regulation or control of the production of CME programming.

Less attention is being paid, in any formal way, to a very important question—Who is actually producing the programming? Many feel that setting of standards for the flow of funds supporting content development assures relevant, well-produced programming will result. However, even major academic centers have limited staff time to personally prepare programs, so they often use outside agencies or individuals to prepare and co-ordinate the content and its presentation.

The National Commission for Certification of CME Professionals (NC-CME) was created in 2005 and has set its focus on these people on the ground floor of CME—the women and men who throughout the US are doing the work of CME: assembling the faculties, guiding the agendas, and preparing and executing the programming. These responsibilities are significant and impactful. Recognition of the commitments and abilities of the many individuals responsible for CME programming could only augment their efforts.

Professional competence in CME should be encouraged at all employment levels in the CME enterprise, regardless of whether it is a part-time practitioner in a small hospital, a full-time faculty member at an academic center, or one of a staff of fifty at a major medical education company.

NC-CME, a nonprofit organization, under the leadership of its first President and now Executive Director, Judy Ribble, PhD, CCMEP, met its goal of establishing a measurable reference credential for practitioners in the field. While previously there had been awards for work of distinction, such as the Alliance Fellows program, there was no basic credential that employers could use to distinguish an individual’s years of time in grade versus their real understanding of the important skills needed to produce quality, compliant programming.

NC-CME began its work by joining the National Organization for Competency Assurance (NOCA), a membership organization that approves the credentials of groups that offer certification exams. NC-CME is on track to become accredited itself, as it moves through the required stages of growth.

One of the principles learned through NOCA and adopted by NC-CME is that professional competence is measured in three ways: Experience, Education and Examination.

Applicants for the CCMEP™ exam submit an online application, based on a multi-level self-assessment detailing their experience and education, both formal schooling and informal through participation in continuing professional development (CPD) such as Alliance meetings, webinars, certificate programs and sessions held by others in the field. Points are given for these activities, along with additional points for participating in a leadership role. Those with an adequate number of points are approved to sit for the exam. (Typically, someone who has been in CME for two to three years, has attended one or more annual meetings and, in general, worked to stay current in the field has adequate points to proceed.)

CME is a complex profession, practiced in diverse circumstances. It was a challenge to produce an exam that fairly measures competence across a variety of work settings and assignments. The NC-CME Executive Committee solicited proposals from numerous professional testing organizations, awarding its contract to Schroeder Measurement Technologies (SMT). The value of collaborating with SMT can not be over stated. As a
A distinguished group of psychometricians with extensive experience in the creation and validation of certification exams, SMT provided the NC-CME Executive Committee with guidance and services that ensured that the nature and quality of the NC-CME examination was equivalent to that of other professional certification programs.

The first step in creating a competent exam is to determine, in detail, exactly what CME professionals do. Starting with the Alliance Competencies, a group of thirteen subject matter experts developed a list of 75 tasks or elements of information useful in the skill set of a professional.

A survey was then conducted to professionals across the work spectrum. There were 272 valid, completed surveys returned, from professionals representing all aspects of CME practice.

The 75 knowledge/skill items were ranked according to their relevance and, based on ranking, allocations were made for the domains of the exam. The following emphases were determined for the exam:

- Adult Learning Principles .................. 15%
- Educational Interventions .................. 30%
- Relationships with Stakeholders .......... 10%
- Leadership/Administration/Management .. 25%
- The CME Environment ...................... 20%

Details on the knowledge/skills set components of these domains can be found on the web at: www.nc-cme.org, under the slides section, in a presentation entitled What CME Professionals Do.

Once the domains were determined, exam questions were written by sixteen CME professionals in a three-day workshop conducted by Schroeder. Exam questions were validated, beta-tested, re-validated and set for inclusion in the exam.

Tests are now offered at more than 200 sites nationally the last two weeks of March, June, September and the entire month of December. Since its initial offering in the summer of 2008, nearly two hundred professionals have earned the CCMEP™ designation.

The Board of NC-CME was honored and gratified to receive the Award for Innovation in Continuing Professional Development from the Alliance. We look forward to continued collaboration with the Alliance and other organizations within the profession to assure that those entrusted with responsibility for CME are certified to be able to perform their duties.

We believe that everyone in this fast-moving field should periodically take time to review the rules and regulations, attend conferences and re-read important papers on topics such as adult learning and instructional design. Whether you engage in review and reflection as an individual activity or in preparation for certification or re-certification, you will always benefit through your own commitment to lifelong learning.
Member Sections Great Idea Awards

These awards are supported by the Alliance.

To recognize outstanding contributions to the field of CME within each Alliance Member Section.

Health Care Education Associations
Analyzing Changes in Learners as Part of Our Annual CE Survey
National Foundation for Infectious Diseases
Lauren Ero, MS

Hospitals Health Systems
Information Services Applications for the Physician
Spartanburg Regional Healthcare System
Delilah Goode, BS

Medical Education and Communications Companies
Evaluating and Managing Major Depression: Linking Assessment Measures and Outcomes in Light of the Black Box Warning
CME Outfitters, LLC
Richard Vanderpool
Sharon Tordoff, BS
Jan Perez, BS

Medical Schools
Accelerating Best Care in Pennsylvania
Jefferson Medical College of Thomas Jefferson University
Jeanne Cole, MS
Alexandria Skoufalos, EdD
Bettina Berman, RN
David Nash, MD
David Ballard, MD
Julie Gunderson, MM
Ziad Haydar, MD

continued next page
Medical Specialty Societies
2008 American College of Surgeons CME Primer
American College of Surgeons
Kathleen Goldsmith

Pharmaceutical Alliance for CME
Provider Education Day
Wyeth Pharmaceuticals
Betsy Woodall, PharmD
Jennifer Smith, PhD

State Medical Societies
Pilot Block Grant Project on Depression
Physicians’ Institute for Excellence in Medicine
Bob Addleton, EdD

Alliance Distinguished Member and Fellowship Awards

These awards are offered by the Alliance for CME.

Awards of distinction are offered to members through numeric points accumulated for a variety of services within the association.

The Distinguished Member Award is given in recognition of active member involvement in, and major service contribution to, the Alliance. (30 total points for service)

The Fellowship Award is given in recognition of outstanding and meritorious service, long standing membership, and active participation with the Alliance. (60 total points for service)


Alliance Fellows (L to R): Greg Thomas, George Mejicano, Carol Havens, Damon Marquis, and Bernard Marlow.
Distinguished Service Award

This Award is Supported by the Alliance for CME

In Recognition of Outstanding Leadership and Lifelong Contributions as a Physician and Educator and For His Professional Contributions to the Medical and CME Communities and Personal Passion for Physician Lifelong Learning to Ensure Quality Patient Care

_________________________________________________________________________________________

Harry Gallis
Frances M. Maitland Memorial Lecturer

This Award is Supported by the Alliance for CME in honor of Frances Maitland

In Honor of the Memory of Frances Maitland, former Alliance Executive Director, and in Recognition of Lifelong Commitment, Dedication, and Significant Contributions as a Mentor and Colleague

Memorial Lecturer: Suzanne Ziemnik
Thank you to the Alliance for selecting me for this year’s Frances Maitland Memorial Lecture and to Merck & Co., Inc. for their sponsorship of this lecture to honor Frances Maitland and continue her legacy as one of CME’s best known mentors. This lecture recognizes the importance of the role of mentoring in the CME profession, which has been proven to be successful as evidenced by the many CME professionals who have been mentored by someone like Frances Maitland. I am deeply honored to be the 10th recipient of this Alliance award.

As we mark the 10th anniversary of the Frances Maitland Memorial Lecture, I encourage you to read the manuscripts of former Maitland lecturers, as they provide tremendous guidance and advice on mentoring that you will find extremely valuable whether you are a mentor or a mentee. These are available on the Alliance website. It is an illustrious list of individuals that I am truly humbled to join. I have attempted to weave the wisdom of these individuals into this lecture. I decided to take yet a different approach to my lecture—spending less time on defining mentoring and discussing it in the more formal context. Instead, I am focusing on the relevance of mentoring for CME professionals at every level, and discussing mentoring as more of an informal activity. As Bob Raszkowski noted in 2003, this is the “established tradition of CME. It requires no contract, no long-term commitment. It is the tradition of freely sharing insights and ideas.” In her graceful manner of expression, Patricia Spencer described mentoring in 2007 as “making intentional choices about how we live and then living into those choices through all our experiences with everyone we encounter.” No wonder she was one of the most influential mentors in my life.

During my preparation for this lecture, I was reminded of Frances’ extensive CME portfolio as a 20+ year CME veteran, and the many connections we ended up sharing after we first met in 1988. I began to wonder how my decisions were in some way influenced by the path Frances chose. Frances began her CME career at the American Academy of Orthopedic Surgeons. In the early 1970s, she became the Assistant Executive Secretary for the Council of Medical Specialty Societies (CMSS), which at the time housed the Accreditation Council for Continuing Medical Education (ACCME). There she took the lead in developing a new system of accreditation of CME providers. Frances held the position of Executive Secretary of the ACCME and in 1991 assumed the position of Executive Director of the Alliance. She continued her work at the ACCME until 1993. Frances was also a member of the National Task Force on CME Provider/Industry Collaboration.

I can pinpoint the place and time when my most instrumental mentors touched my life. Many of you are sitting in this audience. Sadly, some are no longer with us. I vividly recall being at this very conference, in this very city, in 1989 when my boss at the time and later lifelong mentor, Patricia Spencer, introduced me to many of her CME colleagues. Many of us were from Illinois and quickly realized that we came 2,000 miles to share our ideas and challenges when we all lived within 50 miles of each other! It was Frances Maitland who suggested that we do something to ensure we continue this spirit of idea exchange back at home. It is in the time that ideas and experiences are exchanged that the tradition of the mentoring process is continuously renewed.

Later in 1989, Frances invited a group of us to lunch, and there the roots for the Illinois Alliance for CME began. Frances and I got to know each other better through this exchange, and it wasn’t long until she invited me to chair the Alliance Institute subcommittee. I was in my 20s and had only been in CME for three years, but she recognized my eagerness to learn and to be actively involved in the wider CME community, and she gave me that opportunity—a lesson for mentors and mentees alike. I tell you, the more experienced CME professionals, that it is your obligation to recognize the experience, skills and potential in newcomers to the field, and find a way to get them involved in our field now. Newcomer does not equal inexperienced. As Marcella Hollinger remarked in 2002, “The essence of mentoring is not only to pass along knowledge or skills to others, to not only help others problem-solve, but to influence these others to be knowledgeable enough and confident enough and caring enough to be mentors too.”

Mentors are found inside and outside the work setting. I have been one of the lucky few who can say with confidence that since entering the CME field over 20 years ago, I worked for supervisors who were instrumental in my progression from neophyte to mentor and leader. I am compelled to recognize those individuals given this unique lecture opportunity. They are Betty Warner, Jim Breeling, Patricia Spencer, Bob Perelman, Errol Alden,
and John Ball. These incredibly talented individuals did far more than mentor me in CME. Barbara Schneidman noted a similar observation about Frances Maitland in 2006. “Her methods of role modeling and mentoring were unique in that they did not involve only work-related issues. Her professional behavior was wide reaching and had a profound impact on how I handled myself in similar situations with my own interpersonal and professional skills.” This is the same gift I received from my workplace mentors. I hope that all of you are that fortunate, but if you’re not, participating in mentoring relationships in the wider CME community may give you what you’re not receiving in your own workplace. I can say that about few professions.

What defines a mentor? A mentor is someone who:

• Helps someone grow and develop
• Nurtures, cultivates, educates, trains, encourages, supports or serves others
• Fosters friendly relations and inspires with confidence
• Gives hope or courage.

As David Lichtenauer commented in 2004, “Mentors are important because they take you to the next level with their experience and wisdom.”

And what defines a mentee? Most obviously, it is someone who is being mentored or guided by a mentor. The mentor works with the mentee to strengthen competencies needed to enhance job performance, career progress and often times, personal as well as professional growth.

As chair of the Alliance Professional Development Committee, I would be remiss in not mentioning the Competencies for CME Professionals, developed by the Alliance. The competencies most related to mentoring are in Competency Area 8: Self-Assessment and Life-long Learning. I encourage both mentors and mentees to review the Competency Areas in depth. (They can be found on the Alliance website.) The list may appear to be never ending, so I would like to briefly discuss the practicalities that might help ensure a successful mentoring experience given the realities of our ever increasingly regulated CME environment and resource-challenged work environments. Feeling overwhelmed is an understatement. I can’t think of a more important time for mentors to step up to the plate and mentees to seek mentors.

Many of you may be familiar with the anonymous quote often circulated via the Internet, Are your friends here for a reason, a season, or a lifetime? Since I believe in natural mentoring through friendship, I suggest that this quote applies to mentors who come into your lives for a reason, a season or a lifetime. The mentor and mentee must both figure out which type of relationship it is and then they will know what to do for each other to ensure a successful mentoring partnership. When someone is in your life for a reason, it is usually to meet a need you have expressed. Maybe you just need to ask a colleague a specific question about the ACCME Updated Criteria. People may come into your life for a season because your turn has come to share, grow or learn. In the first Frances Maitland Memorial Lecture in 2000, Sue Ann Capizzi quoted Marsha Sinetar’s book, The Mentor’s Spirit, in which she suggests that sometimes you will find a mentor for a skill or a project. It might be that you would like to work with a colleague in a different CME environment on a CME outcomes project. Lifetime relationships teach you lifetime lessons. I suggest that this may be the more formal mentoring relationship which some of you might actually start at this Alliance Conference!

Regardless if your mentoring relationship is for a reason, season or a lifetime, it is important to set expectations for communication, so both mentor and mentee can participate in the relationship—while still getting their daily work done without feeling added pressures—and realize the gifts of the mentoring process. Discuss your preference for communication. Is it in person, on the phone, through email or texting? Discuss time constraints and, if you don’t have time when approached by the other, be clear and identify a time that works for you both. I regret the instances that I did not take the time to adequately help a newcomer either at an Alliance Conference or in another venue.

So I charge mentors and mentees to pay it forward. You may recall the 2000 movie where Haley Joel Osment comes up with a plan to do good deeds for three people who then, by way of payment, each must do good turns for three other people. These nine people also must pay it forward and so on, ad infinitum. Here are the three rules to pay it forward:

1. Something that really helps people
2. Something they can’t do by themselves
3. I do it for them; they do it for three other people.
When someone does you a big favor, don’t pay it back, pay it forward. You never know how your actions can change the world or, at least, our CME world.

Sue Ann Capizzi remarked in 2000, “Frances Maitland was a guiding light through the most innovative and sometimes perilous times in recent CME history. It was Frances who took up the charge and effectively convinced the FDA to allow the voluntary accreditation system to regulate the separation between education and promotion.” That type of guiding light is needed now more than ever, thus mentoring in the CME profession is an absolute imperative.

In closing, I say to the experienced leaders of CME professionals, don’t forget to take the time to help the less experienced and don’t forget that individuals new to the CME field bring a wealth of experiences that will enrich our CME world.

To those who may not consider themselves leaders but have been around the block in CME, help each other and help those who are new to the field. Participate in horizontal mentoring, as referenced by George Oetting in his 2005 lecture. Horizontal mentoring with your colleagues at the same operating level is a powerful force in our personal interactions with colleagues, as we teach and learn from each other.

To those who are new to the field, don’t hesitate to reach out for guidance from those more experienced, and remember that you have much to teach them based on the many different experiences and skills outside CME that you bring to the table. As Bob Orsetti remarked in his lecture last year, “Realize that you have chosen a wonderful profession, that, despite regulatory boundaries, offers profound opportunity to make a difference in the lives of many individuals.”

My hope and wish for each of you is that your lives are as enriched as mine has been by the 20-plus years of CME friends, mentors and mentees. Take seriously the opportunities to engage with one another that mentoring affords, and remember to pay it forward.
Thomas G. Pearson Memorial Award

This Award is Supported by the Alliance for CME in honor of Thomas Pearson, EdD

In Honor of the Memory of Thomas Pearson, EdD, 26th & 27th Annual Conference Chair, and in Recognition of the Contribution of the 34th Annual Conference Chair.

George Mejicano, 2009 Alliance Annual Conference Chair