Carver College of Medicine Self-Study Report
submitted to the Accreditation Council for Continuing Medical Education

I. Introduction

A. Demographic Information Form (Pages 1-2)

B. Self Study Report Prologue

Brief History of the CME Program. The Iowa State Board of Medical Examiners was formed by action of the 60th General Assembly in 1963. The Board is responsible for administering and enforcing state laws and administrative rules governing licensure for the practice of medicine in Iowa and determines requirements for continuing medical education.

In April of 1969, The University of Iowa established an Office of Continuing Medical Education (CME) as an administrative unit within the College of Medicine. As the sole public medical school in Iowa, the only Iowa medical school conferring the Doctor of Medicine degree, and the only nationally accredited CME provider in the state, the University of Iowa Carver College of Medicine has a long tradition of providing continuing medical education for physicians.

Richard M. Caplan, M.D. served as the director and associate dean for CME until his retirement in June of 1991. On July 1, 1991, Richard P. Nelson, M.D. was appointed associate dean of the College with CME as an area of responsibility. In October of 1996, CME became a Division within the College’s Office of Statewide Clinical Education Program (OSCEP) under the Direction of Assistant Dean, Roger Tracy. At that time, senior program associate, Louis G. Crist, MA, was appointed administrative director of CME.

Current Leadership and Structure. In the spring of 1998, the CME Division was placed under the overall direction of Michael G. Kienzle, MD, Special Assistant to the Dean and Professor of Internal Medicine. On July 1, 2003, Mr. Crist stepped down as administrative director of CME to begin phased retirement and Ms. Susan Zollo was appointed director. The organizational structure of the CME Division may be found in the Attachment on Page 9. The CME Division is also supported by a CME Faculty Committee and a Conflict of Interest Advisory Group described in detail under “Program Strengths.”

Self Study Structure and Process. The ACCME self study is approached as an ongoing, dynamic process that strives to incorporate adult learning principles, outcomes measurements, ACCME essential elements, and AMA requirements into day-to-day operations. Specifically, the self study process provides an operational framework from which to develop and review policies, refine procedures, build on successes, and identify areas for improvement. For this re-accreditation period, the process began with a review of our previous self study report to determine whether goals delineated for the current re-accreditation period were met. The Attachment on page 10 shows planned improvements from our 2004 self study and whether they were met fully, partially, or not at all.
Following this self assessment and approximately six months prior to submission, the Chair of the CME Advisory Committee, the medical and administrative directors of CME, and CME staff began conferring about the overall strategy and approaches to developing and writing the narrative. The first draft of this self study was developed by the Administrative Director with input from CME staff, CME Committee membership, the Conflict of Interest Advisory Group, and the CME Medical Director, Michael G. Kienzle, MD.

The CME Advisory Committee functions as the primary task force for reviewing and approving the self-study. Sections of the initial draft were sent to the membership of the Committee along with relevant ACCME criteria in early October, 2007. Suggestions, comments, and recommendations from the Committee were then incorporated into later drafts and the report was then forwarded to the Executive Dean of the College for his review and comments.

The ACCME self study reports that have been completed to date serve as documentation of the program’s history and provide a reference point for our overall program evaluation. CME staff are expected to contribute to and become familiar with the most current self study report which is also required reading for employees new to the CME Division.

Program Strengths

Commitment of Faculty Without question, one of the major strengths of our CME program is the involvement of our faculty in planning and delivering CME programs. With close to 100 Regularly Scheduled Conference Series and 130-160 external CME activities offered every year, CCOM faculty continue to demonstrate their strong commitment to providing continuing medical education opportunities to colleagues both internal and external to the institution. Despite the amount of time required to meet the College’s tripartite mission of clinical care, medical education, and research, our faculty continue to show their dedication to developing CME programs that meet the educational needs of their constituents throughout the state and beyond.

Organizational Support. The CME Division is supported by a faculty Advisory Committee whose members are appointed through the Dean’s Office. The Committee is comprised of physicians from several clinical departments within the College, one resident in training, one or two medical students, and at least one community physician external to the institution. The Committee meets every other month over the noon hour to discuss agendas developed collaboratively by the CME Administrative Director and the physician serving as Committee Chair. Faculty members are invited to contribute to agendas and CME staff also attend and contribute to these meetings. The membership term for faculty carries the expectation of a three-year commitment. (Attachments, pages 11-13.)

In 2004, A Conflict of Interest (COI) Advisory Group was formed by the College to adjudicate in complex conflict of interest reviews and decisions relating to CME. Faculty physicians from several clinical departments are represented on this Committee which also includes the UI’s Director of the Clinical Trials Office. This Group meets every other month to provide COI decision-making support and guidance to CME professional staff. (Attachment, page 14.)
The current Chair of the CME Advisory Committee for the CCOM (Joel Gordon, MD) is also the Clinical Curriculum Director for all junior and senior medical student clinical rotations. The Chair of the Conflict of Interest Advisory Group (Mark Wilson, MD) serves as the Director of Graduate Medical Education (GME) for The University of Iowa Hospitals and Clinics. With UME and GME directors playing significant leadership roles in CME, continuing medical education maintains a prominent position within the medical education continuum at this institution. (Attachment Page 14A)

Institutional Partnerships and Communication. A number of informal partnerships and synergies within UI Health Care have been initiated by the CME Division within the current re-accreditation period. The goals of these new partnerships have been to share mutually beneficial data and information on statewide and national health concerns; raise the visibility of our overall CME program; and avoid duplication and gaps in service delivery.

One example of such institutional collaboration within the clinical enterprise involves University of Iowa Health Care Clinical Outreach Services. For more than 60 years, outreach clinics staffed by University of Iowa physicians and nurses have supported the community-based health care system in Iowa by providing specialty services in towns and cities throughout the state. One-hour “Learning at Lunch” CME programs on topics requested by community physicians are now being integrated into this clinical outreach service.

Staff from the University of Iowa Office of Clinical Quality, Safety, and Performance Improvement have shared with the CME Division a number of internal documents relating to UIHC quality improvement efforts. Also provided by this Office are data showing how the UIHC ranks and compares with CMS quality indicators on state and national levels. These data have provided important planning and needs assessment tools for our internal Regularly Scheduled Conference Series (RSC)s as well as some of our external CME activities.

In 2005, we began strengthening our working relationship with the College’s Office of Consultation and Research in Medical Education by inviting a member of their professional staff to join the CME Committee and by requesting their expertise in writing items and analyzing data for our statewide physician CME surveys.

In 2004, the Executive Dean of the College, Peter Densen, MD, brought together several College departments and centers (including the CME Division) to participate in collaborative meetings and activities where goals and strategies for improvement could be shared. This ongoing effort has resulted in enhanced communication and planning along the continuum of medical education.

CME Division staff also participate in planning meetings with UIHC’s Office of Strategic Relations to enhance and strengthen outreach relationships with Iowa’s community physicians. While the primary mission of the CME Division is to develop and deliver needs-based continuing education programs, we try to align our outreach efforts with those of other groups and individuals within the clinical enterprise as appropriate.
**External Relationships.** In addition to the internal organizational structure described above, the College’s CME Division has developed a number of external relationships in support of its mission to provide quality educational opportunities for physicians. The College typically provides joint sponsorship for over 30-40 activities a year in collaboration with (non-accredited) hospitals and professional medical societies around the state and region. Professional staff from the CME Division have served as reviewers of providers accredited by the Iowa Medical Society (IMS) and have assisted the IMS in interpreting and implementing ACCME expectations for re-accreditation. The CME Division jointly sponsors a number of programs annually with the Iowa Department of Public Health and the University of Iowa College of Public Health. The administrative director of CME is a member of the Society for Academic Continuing Medical Education (SACME) and the Alliance for Continuing Medical Education (ACME). Staff from the CME Division attend annual meetings of these groups and participate in Webinars sponsored by the AMA and ACME.

**CME Outreach and Distance Education.** Nearly 60% of respondents to our most recent statewide physician survey indicated that outreach to rural communities and counties would be the best way to improve our overall CME program. Despite this figure, only a minority of respondents (19%) stated on the survey that web-based offerings are the optimal alternative to meetings that allow real-time interactivity with instructors and colleagues. Because UI’s Carver College of Medicine is the only nationally accredited provider in a state with 99 counties and because of our location in the southeastern third of the state, attendance at our programs represents significant time and travel constraints for many rural physicians who might have to drive 4+ hours each way to attend our educational offerings. As a result, we recently developed a formal outreach program (“CME-To-Go”) and have delivered eight all-day CME programs to date in local communities around the state. The target audience for the programs includes primary care physicians who make up the largest segment of the state’s physician provider base. The content of the programs to date has been multidisciplinary. (i.e. a range of common health concerns typically encountered in the primary care practice setting.) The College has supported this CME initiative by allocating 10% of a salary for a faculty physician outreach director position and 100% of a new professional outreach coordinator position in the CME office. It is anticipated that this very popular initiative will continue to expand with increased demands from our constituents and continued support from the College.

Iowa is also fortunate in having one of the only state-owned, (and state-supported) interactive video conferencing networks in the U.S. [http://www.icn.state.ia.us/](http://www.icn.state.ia.us/) Using DS3 and T-1 technologies, the Iowa Communications Network (ICN) supports distance education and telemedicine programs such as CyberProfs®, an interactive CME program developed by the College to deliver medical education programs around the state. Because several telemedicine grants were received by Iowa hospitals in the 1990s, many of the smallest and most rural hospitals in Iowa now have the necessary telecommunications infrastructure and equipment to receive telehealth programs over the state run backbone. ([Attachments pages 15-16](#)) The use of this interactive video program has increased the number of physicians and health professionals who participate in our CME offerings. This delivery mechanism is of particular benefit to physicians residing in rural and remote areas for whom travel represents significant time away from patient care. During the current re-accreditation period, 636 health professionals attended
our video conferencing programs. We plan to identify additional sources of funding in coming years to increase the number of attendees at these distance education programs.

Communication. The degree to which our programs have been successful in meeting our mission may be traced in part to effective levels of communication among staff of the CME Division, faculty course directors, and the physicians who attend our programs or request our joint sponsorship. This communication has been optimized in a number of ways including the introduction of CME Update Workshops for faculty and staff (Attachment, page 17); regular statewide physician needs assessments; community based physician focus groups; a CME listserv for faculty and administrative staff; and a number of outreach efforts aimed at primary care providers in communities around the state.

CME staff have given a number of presentations at a variety of Deans’ leadership meetings regarding important conflict of interest issues and the procedures that have been implemented to prevent COI in CME activities. As a result, the Carver College of Medicine is now forming a College-wide task force to address broader conflict of interest issues for all faculty and staff whether CME is involved or not. (Attachment, pages 18-21.)

Staffing. An increase in staffing of the CME Division over the past year has strengthened our program considerably. A benchmarking study using data from the 2005 ACCME annual report was developed and utilized to make the case to the College’s HR Department that the CME Division was relatively understaffed with respect to the number of programs we sponsor. (Attachment, pages 22-24.) As a result, we were able to replace two part-time personnel who recently retired with three full-time positions, including an Outreach Coordinator, RSC Manager, and Contracts & Compliance Officer. We feel that the size and qualifications of our current staff are excellent indicators that we will be able to meet the responsibilities and duties required of our office.

Database Management/Forms and Documents. The transition from a minimally functional (off-the-shelf) database management system to a robust, customized system has required long and arduous efforts on the part of CME staff. Within the past year, two Health Care Information Systems (HCIS) staff were assigned to the CME Division and our database management system is close to being completed. Enhanced components of this system will include online registration and self-service credit transcripts for physicians who attend our programs. Additionally, we will be able to mine several sources of demographic data currently unavailable to us in order to better determine whether we are reaching our target audiences.

All CME forms, templates, and instructions have now been made available electronically on our web site to facilitate the process of requesting Category 1 Credit. (Attachment, pages 25-27) The CME Division recently completed a web-based self-disclosure and disclosure lookup system (using an Oracle database on the back end) which is available to University of Iowa CME course directors, faculty, and administrative staff. (Attachment, pages 28-30.)

Exemplary Compliance. In reviewing the ACCME’s decision-making criteria, we believe we have successfully achieved full compliance in all Essential Areas and Elements. Exemplary Compliance Criteria are somewhat more difficult to self-assess objectively. We therefore offer
the following possibilities with the understanding that the ultimate determination of all compliance levels will be left to the discretion of reviewers. For Element 1.2, please note that we met exemplary compliance for mention of CME in our parent organization’s mission statement; support for financial, facility, and human resources, and a CME mission statement reviewed regularly by the College’s governing body, the Medical Council. In reviewing the ACCME exemplary compliance criteria, Element 3.1 might be considered for possible inclusion in the Exemplary category. For Element 3.3, we have used a number of strategies to comply with ACCME’s policies for disclosure and commercial support, although it is somewhat difficult for us to make the case that our practices in this area are more ‘innovative’ or ‘creative’ than those of other providers.
II. Element 1.1 Mission

We take the position that the quality of care available to patients is bound largely to the continued maintenance and enhancement of practice skills by the physicians who provide that care. A physician’s ability to practice contemporary medicine effectively – ultimately to solve problems often involving vital and deeply significant outcomes – can be accomplished only if he or she is committed to life-long learning. Continuing education activities offered by the Carver College of Medicine are planned with these convictions in mind.

The CME mission statement is reviewed and updated at regular intervals by the Administrative Director, Medical Director, and members of the CME Advisory Committee. Following updates or revisions to this document, a draft is presented to the College’s governing body – the Medical Council – for review and approval or approval with changes. The current version of the CME Mission statement was approved unanimously by the Medical Council on May 10, 2007.

(Attachment, pages 32-34.)
III. Element 1.2 Parent Organization

A. Relationship of CME Division to Parent Organization. The CME program operates administratively within the Dean’s Office of the University of Iowa Carver College of Medicine. The Carver College of Medicine is one of 11 Colleges within the University of Iowa which is governed by the Iowa State Board of Regents. The current Dean of the College of Medicine, Jean Robillard, MD, also serves as The University of Iowa Vice President for Medical Affairs and Chair of the Faculty Practice Plan Board. In these roles he reports to the University of Iowa President and fulfills the mission of both the College and its affiliated hospital, The University of Iowa Hospitals and Clinics. (Attachment, pages 36-37.) Facilities, personnel, and financial assistance are provided to the CME Division by the University of Iowa Carver College of Medicine. A Human Resources Office within the College, in tandem with the University’s Human Resources Department, guides and directs matters related to employee and labor relations, compensation and classification, benefits, and employee services. Although the CME Division is expected to cost recover to the extent possible, the College provides office space for CME staff and assists with salaries, supplies, office equipment, and professional memberships. The amount of this support is based on fiscal conditions and economic variables faced by the Iowa legislature, the University of Iowa, and the Carver College of Medicine. The CME Division offices are located in the College of Medicine Administration Building which also houses the Dean’s Offices and related personnel.

B. Evidence of support from Parent Organization.

B1 Parent organization’s mission statement. (Attachment, pages 38-41.)

B2 Support for financial, facility and human resources. (Attachment, pages 42-55.)

B3 CME Mission Statement Review. As stated in the previous section (Element 1.1 Mission), the CME mission is updated every three years and is reviewed and approved by the CME Advisory Committee and Medical Council following each update. The current version of the CME Mission Statement was approved as follows:

Continuing Medical Education (Advisory) Committee  
University of Iowa Carver College of Medicine  
Approved CME Mission Statement With Changes - April 6, 2007

Medical Council  
University of Iowa Carver College of Medicine  
Approved unanimously (no changes) - May 10, 2007
IV. Element 2.1 – Planning Process(es)

A. Planning Process by Type. Examples of activities offered by the College include those that are:

1. Directly sponsored
2. Jointly sponsored
3. Regularly-scheduled series (RSCs)
4. Self-study, employing enduring material available in a variety of formats
5. Tailored toward a physician’s individual needs (customized traineeships)

The planning process for all of our educational activities begins with a meeting that includes the course director, members of the department’s planning committee, and one or more members of the CME Division’s professional staff. CME staff review the educational principles involved in conducting a continuing medical educational activity, discuss forms and requirements with the course director, and describe safeguards to ensure that all content will be free of commercial bias. (Attachment, page 58.) Course directors and planning committee members are provided with a copy of the College’s CME Content Validation Guidelines (Attachment, page 59) which were developed to ensure understanding of the commercial support, disclosure, and conflict of interest review process. For programs that take place annually, CME staff update course directors and planners on new guidelines, standards, procedures, and documentation required by the AMA, ACCME, and our CME Division.

With the exception of individualized traineeships, the next step for all CME activities sponsored by the College is completion of an Application for Category 1 Credit for an Educational Activity. (Attachment, page 60-64H.) On the application, Directors/Coordinators of proposed CME activities are required to provide the following documentation and information:

a) Intended audience;
b) Needs assessment process;
c) Purpose and educational objectives;
d) Teaching methodologies;
e) Means of evaluating the activity;
f) Method of recording attendance;
g) Process for disclosures to the provider including identifying and resolving conflicts of interest;
h) Procedures for honoraria payments;
i) Documentation of the commercial support process, including Written Agreements for Commercial Support;
j) The audience disclosure process.

For directly and jointly sponsored programs (including live, interactive video programs), a Check List (Attachment, pages 65-66) and several templates are provided to course directors to ensure their understanding of CME certification requirements. All forms and templates are available electronically, linked to our web site, and updated regularly.
http://www.medicine.uiowa.edu/cme/planning/basic.htm
Announcements. Notification of upcoming CME activities are distributed to physicians and other targeted audiences in a variety of formats including formal brochures and announcements, letters of invitation, newsletter advertisements, press and media releases, our CME web site, and email distribution lists. Responding to comments on our statewide CME survey about our announcements going out too late, we developed a list serv of Iowa physicians for “Save the Date” email announcements that go out well in advance of formal brochures. The list serv does not incur any extra costs, is an effective way for community providers to add upcoming CME activities to their calendars, and has increased attendance at our programs by about five percent. In addition, participants who have attended a recurring program within the past three years now receive a personal letter acknowledging their past participation and keeping them informed of upcoming programs which might be of interest to them. We encourage course directors to bring extra copies of their announcements to regional and national conferences they attend. Finally, we have a CME information table at all our conferences where we display brochures of our upcoming conferences and collect comments and suggestions from attendees relative to future programs.

Link Between Educational Needs and Desired Results. In planning meetings, CME professional staff emphasize to course directors the importance of developing course objectives that address identified educational needs and can be evaluated for desired results. If the activity is recurring, the committee often begins by reviewing the program’s previous evaluation summary to assist in the determination of content and selection of speakers. Needs assessment data are reviewed to select topics, ensure that educational objectives are appropriately delineated, and determine the agenda, target audience, and scope of the upcoming educational activity. (See Element 2.2 for a detailed Needs Assessment review.) Once the topics and educational objectives for the activity have been agreed upon, potential instructors and faculty are identified, asked to disclose relevant financial relationships, and reviewed for conflict of interest. Anyone who does not disclose or whose conflicts cannot be resolved are precluded from participating in a CME activity.

All approved CME programs at this institution require an evaluation process whereby attendees report whether educational objectives for the activity were met. An evaluation tool recently revised by our office seeks to elicit more detailed attendee comments regarding the degree to which educational objectives were met and what changes and improvements in the care of patients might result from having attended the program. (Attachment, pages 67-68E). Examples of the evaluation process are described more fully in Element 2.4.

Planning Process for RSCs. Applications for RSCs are due every year on July 1 and the requirements are essentially the same as those for external programs. A detailed review of the planning and certification process for RSCs may be found in Section XII.

B. Planning Process for a Specific Activity (Attachments, page 69-83.)
A. Describe how needs assessment data are used in planning CME Activities.

Course directors are required by our CME Division to show evidence of an objective needs assessment process as the first step in planning an educational activity. This information is required on the Application for Category 1 Credit (Attachment, pages 61-62.) for all activities with the exception of individualized traineeships. In the latter case, the statement of need is identified and submitted by the individual participant requesting a traineeship experience. In addition to specifying what techniques were used to complete their needs assessment, documentation and attachments are required along with the completed application.

To determine the educational needs of our learners, a number of resources are utilized, consulted, or recommended to the course director depending upon the target audience (e.g. internal vs. external programs, physician-only attendees vs. inclusion of other health care providers). A listing of needs assessment strategies is available on our web site, with password protected links to specific resources as appropriate. Examples of such strategies and resources include, (but are not limited to):

- Evaluation summaries from previous activities;
- Results of statewide CME physician surveys (Attachment, pages 86-89); and surveys conducted through other departments and offices within the College and Hospital;
- Health care data from The Office of Clinical Quality, Safety and Performance Improvement (internal and confidential); See organizational chart, page 90.
- Health care data from other local and regional resources (e.g. the Iowa Department of Public Health, the University of Iowa College of Public Health, and professional medical societies); Visit http://www.public-health.uiowa.edu/FACTBOOK/ as an example of health data published by the UI College of Public Health. (Attachment, page 91);
- Health care data from national resources (e.g. NIH, DHHS, NCI, etc.)
- Notes from focus group interactions and other communications between our faculty and community physicians;
- Links on our web site to information on evidence based studies in medicine available through our medical library, the Hardin Library for the Health Sciences (http://www.lib.uiowa.edu/hardin/eb.html);
- Data from The Iowa Healthcare Collaborative (IHC), a provider-led organization dedicated to promoting an Iowa health care culture of continuous improvement in quality, patient safety, and value; (Attachment, page 92);
- Periodic reviews of the Center for Medicare/Medicaid Services (CMS) Core Measures for the state of Iowa (Attachment, pages 93-95);
- Copies of search requests from our CME web site (using a Visual Sciences Search account); the CME brochure questionnaire (See front pocket of this document); and “Request-A-Topic” forms we include in attendee syllabi (Attachment, pages 98-100);
- Input from local, regional, and national thought leaders and other colleagues with whom our faculty interact on a regular basis.
- Reviews of the current peer-reviewed literature.
Informal comments or requests that are recorded by CME personnel who staff the CME information table at our conferences.

When identifying educational needs, activity directors also consider a number of educational variables in addition to the subject focus of the activity. For example, the composition of the target audience (physicians only vs. a variety of health professionals); the practice type that will be targeted (academic, specialty, family medicine or a combination); the scope and depth of the overall program (broad overview or very in-depth and focused); the type of data that will be presented (research or clinical); and the format of the presentations (e.g. lecture, seminar, panel discussion, case presentations, hands-on workshops.)

Plans for Enhancing the Needs Assessment Process. Our newly hired outreach coordinator plans to conduct patient surveys across the state to assess what information gaps they feel their providers have. (Results will be tabulated only in the aggregate by county – individual physicians will not be identified.) We are hoping this strategy will prove to be an innovative approach in helping us determine areas of unmet need for Iowa’s primary care providers beyond self-reporting of physicians themselves. Any such surveys will be reviewed first for HIPAA and Human Subjects compliance.


Needs Assessment Data – Pages 101-127
Data Translated into Educational Objectives – Page 130
VI. Elements 2.3 – Purpose and Objectives

A. Conveying Purpose and Objectives to Attendees

Educational objectives for each activity are developed after relevant needs assessment data have been reviewed. All announcements for programs carrying AMA PRA Category 1 Credit™ must be pre-approved by professional staff from the CME Division before they are sent out or posted on the Web – this process ensures the development and inclusion of appropriate educational objectives in all announcements. After the announcement is approved by the CME office, it may be distributed to potential attendees included in the target audience. Educational objectives are also included in attendee syllabi and in evaluation tools to assess attendee reports as to whether the program was successful in meeting the stated objectives. This is the process for directly and jointly sponsored programs, regularly scheduled conference series (RSCs), and enduring materials.

B. Representative Promotional Material. (Attachment, page 138-144. Page 139 has the Purpose and Objectives.)
VII.  Element 2.4 – Activity Evaluation

A. Describe how your CME activities are evaluated in terms of meeting the identified educational need.

A number of strategies are used to evaluate the effectiveness of individual educational activities. These include, among others: self-reports from attendees on program evaluations as to whether (and to what degree) they felt the educational objectives were met; pre-and post testing of attendees prior to and following delivery of the activity; and longitudinal outcomes testing to determine the impact of the activity on their professional practice and care of their patients.

Questionnaires. Responses to all evaluation questionnaires are summarized and include written comments and suggestions in addition to rankings, ratings, and tabulated data. Directors of activities sponsored by the College receive these summaries and pay close attention to the ratings and comments provided by attendees. Responses play an essential role in helping course directors and faculty develop subsequent offerings, determine future topic areas and speakers, evaluate attendee satisfaction with educational methodologies used, identify components deemed most valuable by participants, and assess how future offerings might be improved. Our questionnaires (which use a combination of Likert scales, multiple choice responses, and free text comments), were designed to measure (among other variables):

- The educational objective(s) that motivated the participant to attend;
- The degree to which attendees report each educational objective was met;
- The relevance of each presentation or session to the individual’s practice and the care of their patients;
- Anticipated changes to the physician’s practice and the care of patients that might result after participating in the educational activity.

Pre- and Post-Testing. Some of our course directors are now requiring instructors and speakers to submit questions relevant to their presentation in advance of the program. Multiple choice questions are incorporated into a PowerPoint slide show presented to attendees at the outset of the meeting. Using audience response devices, members of the audience answer the questions and their responses are recorded using Classroom Performance System (CPS) software. At the end of the program, attendees are again tested over the content and asked to answer the same questions. Thus far, the learning curve that is documented from this practice points to both successes as well as areas for future focus. (Attachment, page 147).

Longitudinal Testing. Plans are underway in some CME courses to contact attendees at 6, 12, and 18 months past the educational activity to determine whether physicians have applied what they learned to the care of the patients and whether physicians report that patient outcomes have improved as a result. This effort has been somewhat impeded by the logistics involved in ‘recruiting’ physician attendees to participate in such longitudinal studies. (For example, involvement of the Human Subjects Office and what type of renumeration, if any, would be appropriate to encourage participation involving longer term followup.) Recent communication with the AMA in this regard has resulted in our possible involvement of UI’s Carver College of
Medicine as a beta site for involving physicians in long term follow-up of CME activities. (Attachments, page 148-149.)

Script Concordance. The Chair of our CME Committee and one of our most active course directors, Joel Gordon, MD, recently started using script concordance testing in some of the CME outreach programs he coordinates. Script concordance testing is an innovative form of testing that research has been shown to reflect more accurately how physicians think and act when presented first with a patient’s history, physical exam, and initial laboratory data and then with additional data designed to modify their thinking (Attachment, pages 150-154). Script concordance testing uses a single illness “script” as the clinical vignette, then introduces new information which can either be pertinent or completely irrelevant. The learner is then asked whether the new information is more helpful, less helpful, (or neither), when making a diagnosis or deciding on a particular therapy. Responses are graded on a 5-point Likert scale. Answers are usually determined by a consensus of 2 or 3 experts in the field who decide what the optimal responses should be. The tests are scored by how close (or how far) the individual’s response is from the experts’ consensus response. In CME programs where this was used, learner performance improved (there was more concordance with the experts) after the educational material was presented.

B. Evaluation Tool and Summarized Data Set. (Includes both Script Concordance and Traditional Evaluation.) (Attachments, page 155-168.)
VIII. Element 2.5 – Program Evaluation

A. Describe how your organization evaluates the effectiveness of its overall CME program.

Evaluating our program’s overall effectiveness is an ongoing process. The following strategies describe some of the ways we evaluate the impact of our overall program on our constituents; assess whether our mission is being fulfilled; and ensure that we are addressing the practice gaps of our learners.

Statewide Physician Survey. Every three years, a CME survey is developed and distributed to Iowa’s 5,000 or so physicians. The survey is vetted to the CME committee and to the College’s Office for Consultation and Research in Medical Education for comments and suggestions before it is mailed out to physicians external to our institution. Some of the goals of the survey are to:

- Assess areas of unmet need (content, topics, specialties, instructors);
- Determine physician preferences for CME delivery formats;
- Evaluate overall physician satisfaction with Carver College of Medicine (CCOM) CME programs and identify areas where improvement is needed;
- Analyze the impact of our CME programs on physician practice and the care of patients;
- Examine awareness of and interest in ACGME competencies among practicing physicians;
- Make improvements in our CME programs that will translate into improved patient outcomes.

Results of the survey are presented via an Executive Summary to the CME Committee, (Attachments, pages 173-178), forwarded to our course director email distribution list, and posted on our web site.

CME Annual Report (Internal). In addition to the Annual Report required by the ACCME and the biennial report submitted to SACME, the CME Division completes an extensive annual report that is distributed to Clinical Department Heads, Course Directors, Deans, and other CME partners within the Carver College of Medicine. The purpose of this internal report is to review accomplishments and challenges from the preceding year, set expectations for the upcoming year, determine whether previous goals were met, and elicit comments and feedback from those individuals to whom the Report is distributed. In the interest of space, the Annual Report is not included here as an attachment, but may be found by visiting our web site at http://www.medicine.uiowa.edu/cme/ and clicking on Annual Report.

Benchmarking. Reviewing data from ACCME and SACME surveys allowed us to compare our overall CME program with those of other academic medical centers. As stated previously in this Report, (Page 22-24) these benchmarking data provided justification for increasing our staff size.

Other benchmarking efforts that have contributed to our program evaluation and review process include: attending ACME, SACME, ACCME meetings; participating in annual Big Ten CME workshops; visiting other Midwestern CME programs (e.g. U Nebraska); and attending internal UI events that focus on adult education and process improvement. When CME staff attend such
activities, they are asked to bring back answers to the question, “What can we do better?” Findings and suggestions are then presented at our bi-monthly CME staff meetings and utilized for program improvement as appropriate. *(Attachment, page 179-181)*

**Electronic Communication.** The Internet provides a mechanism for both receiving and disseminating information used to improve our overall CME program. For example, the CME Director subscribes to *Health News*, an online information service that notifies recipients of recent developments in the Carver College of Medicine and our affiliated tertiary care center, the University of Iowa Hospital and Clinics. Such notices typically include new research initiatives and grant funding, recent discoveries and advancements in health care services and delivery, and aggregate patient outcomes data. This information allows the CME Director to contact the lead physician or investigator to see if there is an opportunity to disseminate results to Iowa and regional physicians via a community-based or other type of CME activity. ("Translating new knowledge of effective interventions into practice is important, and continuing medical education – CME – has an opportunity to help improve value and health outcomes as part of the new paradigm.” - SACME INTERCOM, Feb, 2007)

Another online mechanism for program evaluation is our web site which not only announces our programs, but also produces a monthly report of searches that were conducted on our site. This information is then tabulated and, when appropriate, distributed to course directors as part of the needs assessment process for selecting content areas. Our CME electronic list serv includes course directors and administrative staff involved in developing and managing both internal and external CME activities. The list serv is utilized not only to ‘push’ updates and information from the CME office, but also to elicit feedback on our overall CME program. We also have an electronic list serv of physicians in Iowa, to whom we periodically pose the questions, “How are we doing?” and “What can we do to improve our program?"

**Reviews of Mission Statement, CME Policies, and Previous Self-Studies.** Clearly, the ongoing review of our internal policies and procedures encourages the College to evaluate its overall CME program on a regular basis. This review process ensures that the CME mission statement meets ACCME requirements for re-accreditation, is congruent with the educational mission of our parent organization, and reflects the best practices that we strive to achieve and implement. Updating our mission statement allows us to identify areas where we have not reached our goals and objectives in the past or may need to direct additional resources in the future. Other CME policies (commercial support, conflict of interest, honoraria, enduring materials) are also reviewed and updated periodically to ensure they are in line with national and institutional requirements and expectations.

**Internal Process Improvement: CME Division Workshops for Faculty/ CME Committee Meetings/CME Staff meetings.** For each CME workshop offered to (internal) faculty and staff, we developed an attendee evaluation to elicit comments on our overall CME program and processes. The workshops allow for both verbal and written feedback about our program from course directors and administrative staff.

Faculty on the CME Advisory Committee and the CME Conflict of Interest Advisory Group provide the CME Division with invaluable suggestions and recommendations in a number of
relevant areas such as: specialty board requirements and procedures for demonstrating process improvement (PI) and quality improvement (QI); the potential role for ACGME core competencies in CME activities; and current research results, best practices, and areas of excellence in a variety of specialty areas within the institution.

CME staff are encouraged to bring suggestions and recommendations to internal staff meetings. Some of the best internal process improvement strategies have come from these meetings and discussions.

B. Mechanisms for Program Evaluation and Improvements.

Several changes (some procedural, some more far-reaching) have resulted from our ongoing program evaluations:

- Enhanced outreach efforts that resulted from responses on our survey requesting that more CME programs be delivered to local communities throughout the state;
- A needs-based increase in staffing that better reflects the changing landscape of physician education and outcomes-based learning;
- A shift in content that emphasizes research-into-practice to ensure relevance to Iowa physicians and their patients and to dispel the ‘ivory tower’ perception of academic vs. practice-based CME programs;
- A physician list serv that serves as a save-the-date mechanism created in response to comments that our announcements do not go out in time for primary care providers to clear their schedules (improving notification without adding to costs);
- The use of pre-and post-testing mechanisms to determine whether and to what extent content delivery has resulted in measurable increases in learning curves;
- The creation of a College-wide Conflict of Interest Advisory Task Force based on the model created by the CME COI Advisory Group.
- A major and significant shift in management of RSCs from departments to the CME Division. (Please refer to section XII for a complete and detailed description of process improvement relating to RSCs.)

Examples of programmatic changes resulting from our most recent statewide survey include: addition of content areas and topics previously not covered (e.g. “Health Consequences of Global Warming”, September, 2007; “Ethical Issues in the Care and Treatment of Muslim Women” April, 2007; “The Examined Life: Writing and the Art of Medicine”, April, 2007; “Post Traumatic Stress Syndrome,” November, 2007); an increase in the number of hands-on workshops offered; utilization of more interactive formats that include case presentations, panel discussions, and more time for Q and A; inclusion of ACGME competency material in selected programs; and development of a formal CME outreach program to make our programs more accessible to community physicians.

Future Plans for Program Evaluation.

All-Program Evaluations. Each program we certify for AMA PRA Category 1 credit is evaluated individually via summaries of attendee responses. Therefore, we currently do not have the means
to review aggregate data, responses, and recommendations for improvement across all our CME activities. We are in the process of adding an evaluation component to the customized database we are building so that we can generate summaries of attendee rankings and comments across all our programs. We anticipate (but currently cannot verify) that such a summary report will identify certain commonalities in attendee responses that will allow us to set goals for improvement in our overall CME program.

*Process and Quality Improvement Measures*. Although we have not yet tried to link improved physician competence and patient outcomes data in Iowa to our specific CME program or activities, one of our goals in the upcoming years will be to determine possible ways that might be accomplished. We are hoping to complete at least one study that uses a CMS-identified gap in health delivery in Iowa as a basis for enhancing physician education and eventually improving patient outcomes.
Examples of programmatic changes resulting from our most recent statewide survey include:
addition of content areas and topics previously not covered (e.g. “Health Consequences of
Global Warming”, September, 2007; “Ethical Issues in the Care and Treatment of Muslim
Women” April, 2007; “The Examined Life: Writing and the Art of Medicine”, April, 2007;
“Post Traumatic Stress Syndrome,” November, 2007); an increase in the number of hands-on
workshops offered; utilization of more interactive formats that include case presentations, panel
discussions, and more time for Q and A; inclusion of ACGME competency material in selected
programs; and development of a formal CME outreach program to make our programs more
accessible to community physicians.
Element 3.1: Organizational Framework

A. Organizational Structure Processes, and Systems. University of Iowa Health Care represents the partnership between The Carver College of Medicine and the UI’s affiliated hospital, The University of Iowa Hospitals and Clinics (UIHC). This partnership is committed to providing the best possible patient-centered health care, advanced biomedical research, and training for future and practicing health care professionals.

To ensure continuity and collaboration between the College and the Hospital, Jean E. Robillard, M.D., Dean of the College of Medicine was recently appointed University of Iowa Vice President for Medical Affairs by the Iowa State Board of Regents. This newly expanded leadership structure represents a major step in merging UI Health Care’s research, academic strengths, and patient care capabilities into a flexible organization that provides an integrated continuum of care and promotes partnerships across all departments and disciplines. Within this partnership, Continuing Medical Education is viewed by the College as an important component of the medical education continuum that includes undergraduate medical education (UME) and graduate medical education (GME). On the Hospital side, the CME Division provides input into Strategic Relations planning and community outreach efforts, and offers educational programs to residents and fellows in ACGME-accredited programs.

The University of Iowa Roy J. and Lucille A. Carver College of Medicine is comprised of a number of clinical, administrative, and educational departments. (Attachment, page 186). The Dean of the College reports to the President of the UI through the University Provost. The CME Division is a part of, and is supported by, several administrative units within the College’s Medicine Administration Department. (Attachment, page 187). Guidance from the CME Advisory Committee, the Conflict of Interest Advisory Group, and the Medical Council all combine to strengthen our CME program, activities, and future goals and plans.

The CME Division manages, coordinates, and ensures ACCME and AMA compliance for all continuing education activities directly and jointly sponsored by the College. Staff of the Division provide a wide variety of services to College faculty as well as to non-CME accredited groups who wish to plan and conduct category 1 CME activities. The scope of our programs include those that are internal to the institution as well as many external programs that target local, statewide, regional, national, and international audiences.

Historically, the CME Division has operated in a somewhat de-centralized environment, investing its departments and course directors with responsibility for developing content, fulfilling ACCME requirements, and selecting faculty for CME activities. Due to a number of emerging variables, including the Updated ACCME Standards and evolving re-accreditation criteria, the CME Division is gradually moving toward a more centralized approach to managing and providing oversight of CME activities on behalf of the College.

As stated in the section “Program Strengths,” the CME Division has strong support from the CME Advisory Committee and the Conflict of Interest Advisory Group. Faculty who participate in these groups are either course directors themselves or have other professional interests relevant to continuing medical education.
The Carver College of Medicine’s governing body, the Medical Council, reviews policies developed by the CME Division and approved by the CME Advisory Committee. Within the current re-accreditation period for the College, the Council reviewed and approved a number of CME policies including:

1. *Conflict of Interest Policy for Program Planners, Speakers and Authors of Continuing Medical Education (CME) Activities*;
2. *Policy Governing Honoraria and Reimbursement of Out-of-Pocket Expenses for Planners, Teachers and Authors of AMA Category 1 Educational Programs*; and

**Examples of Responsibilities and Processes within the CME Division:**

1. Educational needs assessments
2. Consultation assistance with the planning process for CME activities (emphasizing the link between needs assessment and outcomes);
3. Evaluating outcomes of CME programs;
4. Management of 90+ RSCs and monitoring for compliance (see Section XII);
5. Creation and maintenance of database management systems for CME recording and transcripts;
6. Activity budgeting, financial management and financial summaries of CME activities;
7. Complete event planning services;
8. Reports of CME activity in response to requirements or requests from the ACCME, SACME, the Carver College of Medicine, the UI and UI Hospitals and Clinics, the Iowa Medical Society, the Iowa State Board of Regents, and other entities and groups that have an interest in Continuing Medical Education;
9. Development and updating of all CME policies, procedures, and the CME mission statement;
10. Participation in College- and Hospital-based outreach efforts;
11. Staffing of CME advisory groups (CME Committee, Conflict of Interest Advisory Group)
12. Consultation with the College’s DEOs and Deans on broader matters regarding physician relationships to industry;
13. Conducting faculty workshops on CME procedures and new requirements;
14. Consulting on matters relevant to commercial support, disclosure, conflict of interest, and other important issues in CME;
15. Providing electronic and web-based access to CME forms, databases, standards, and requirements;
16. Providing post-program follow-up and assistance, including processing and awarding of continuing education credit, compiling evaluation summaries, and preparing financial statements of account.

Additional services, particularly of interest to community physicians and physician groups, include:
a) Serving as a joint sponsor of CME activities with non-accredited entities
b) Arranging individualized traineeships for community physicians
c) Providing opportunities distance-learning and videoconferencing
d) Assisting in the creation of online and other innovative approaches to CME

**Staffing.** The CME Division of the Carver College of Medicine is currently staffed by:

**Medical Director.** Michael G. Kienzle, M.D. serves as medical and faculty advisor to the CME Division. Dr. Kienzle, whose clinical specialty is cardiology, is a Professor in the Department of Internal Medicine. He is also a member of the Board of Trustees, and Chair of the Digital Products Management Board of the American College of Cardiology. Dr. Kienzle is nationally recognized for his work in telecommunications and telemedicine and contributes to the College’s efforts in computer-assisted learning and other distance-learning technologies. He is the course director for the Iowa Chapter of the American College of Cardiology meetings.

**Administrative Director.** Susan Zollo serves as the College’s administrative director of CME. Following completion of her MA degree in 1987, she received a nationally competitive, one-year fellowship to the National Library of Medicine in Bethesda, MD. Ms. Zollo was Director of UI’s National Laboratory for the Study of Rural Telemedicine from 1994 – 2001. In December, 2001 she was appointed Program Associate in the CME Division and became Administrative Director on July 1, 2003, following the announcement of Louis Crist’s phased retirement.

**Program Coordinator/Event Planner.** Lori Bailey has worked for the CME Division since June, 2005. Ms. Bailey is the event coordinator for about 30 of our major regional and national activities annually. She coordinates the meetings from start to finish including certifying programs for *AMA PRA Category 1™* approval; processing applications for other types of continuing education credit; reviewing faculty disclosures and identifying and resolving conflicts of interest; communicating with the course director; and coordinating all meeting logistics.

**Grants and compliance officer.** Teresa Thomann has been with the CME Division since 2001. She began as an Account Clerk and now serves as the Division’s Grants and Compliance Officer. Ms. Thomann is in the process of centralizing the commercial support process for all College sponsored and jointly sponsored programs so that our office can better monitor and report on CME-related expenses and revenues.

**Professional Department Assistant.** Kathleen Coleman has been with the CME department since March of 2007. Ms. Coleman holds a Bachelor of Science degree in Business with a major in management. She has 25 years experience in financial management and computer consulting in healthcare institutions. She supervises clerical staff and the student worker; coordinates all aspects of the daily office activity; manages our Regularly Scheduled Conference Series and the online CLIA (Clinical Laboratory
Improvement Act) Web-based course; and assists with technical support of the CME Division.

Secretary. Christine Land has worked for the Department since September, 1995. Ms. Land processes registrations and confirmation letters, works at conferences; organizes post-conference documentation and attendance records, and generates CME credit letters.

Secretary. Peggy Bush. Ms. Bush began with the CME Division in October of 1978. In her current position, she is responsible for mailing lists, speaker letters, email distribution lists for announcements, working at conference registrations, and a variety of additional clerical tasks.

Financial support of the CME Division. Cost recovery efforts are derived primarily from the administrative and credit-processing fees the Division charges for certifying CME activities for Category 1 credit. Support is also provided through the Dean’s Office of the College via State of Iowa appropriations. Half of one of the secretary’s salary is paid by University Hospitals in return for the College’s Category 1 certification of regularly scheduled departmental conferences and awarding of CME credit to the physicians who attend. Examination and evaluation of the CME Division’s fiscal circumstances results in occasional increases in charges for sponsoring and jointly sponsoring educational activities.

B. Organizational Charts. (Attachments, pages 188-190)

C. Annual, Audited Financial Statements. Statements of Account from the UI Business Office are included in the Attachments on pages 191-199. Please note that the operations budget of the CME Division is referred to in these documents as “Postgraduate Conferences in Medicine.”

D. (Not Applicable)

E. Example of Income and Expense Statement for a specific CME Activity. (Attachment pages 200-201).
X. Element 3.2 – Business and Management Practices

A. Attestation of Compliance with UI Business Management Policies. The University of Iowa is governed by state and federal law, administrative regulations, and policies of the Board of Regents, State of Iowa, which provide broad direction on University affairs. The University of Iowa Operations Manual contains University administrative, financial, and community policies, as well as certain University-level implementing procedures. These policies and procedures have been developed to supplement and clarify Regent policy and to incorporate specific requirements of federal, state, and administrative rules and regulations.

A University policy may include governing principles, it may either mandate or constrain action, it may ensure compliance with laws, or it may mitigate the University's risk. A policy is a set of rules or guidelines that has been officially sanctioned by the President of the University and that has University-wide application. Some University policies, though carrying institutional force and effect, are not included in the Operations Manual. Divisional, collegiate, or departmental procedures and guidelines, although useful and important, do not meet these criteria, and therefore are not published in the Operations Manual. Such procedures and guidelines shall not conflict, or have the potential to conflict, with University policies. Although not University policies, some of these procedures and guidelines are referenced in related Operations Manual sections, as appropriate, and/or linked to the Operations Manual site. Noncompliance with a University policy and/or related implementing procedure, or with other divisional, collegiate, or departmental procedure, may result in discipline.

As recognized entities within The University of Iowa, UI’s Carver College of Medicine and the CME Division comply with all business and management policies of The University of Iowa.

B. Organizations located in California. Not Applicable.

C. Table of Contents – UI Human Resources and Financial Policies & Procedures. (Attachment, page 203-216.)
XI. Element 3.3. Standards to Ensure Independence in CME Activities.

A. Planning Decisions Free of Commercial Bias. A number of strategies are utilized during the planning process to ensure that our CME programs will be free of commercial bias.

- During the initial planning process, formal correspondence is forwarded to the proposed program director citing CME requirements for commercially unbiased content. (Attachment, pages 224-225)

- Our CME Application contains specific wording regarding requirements for content that is free of the influence of commercial interests. (See, page 63, previously referenced.)

- Content Validation Guidelines were developed for all directly and jointly College-sponsored CME activities. These guidelines include the ACCME’s content validation statements, and additional attestations required by our CME office for all speakers, authors, instructors, and planners of CME activities that we sponsor. (Page 225)

- The ACCME Standards for Commercial Support are linked to the forms and documents section of our web site. http://www.medicine.uiowa.edu/cme/planning/basic.htm

- CME planners and course directors are required in the CME application (pages 61-62, previously referenced) to show evidence that a needs assessment was completed and that data from the needs assessment process were used to develop educational objectives for the activity.

- Our evaluation form (Attachment, page 226, Q # 11) requests attendee comments regarding possible evidence of commercial bias in program content. Any reports from attendees about possible commercial bias are forwarded to the course director and presented to our Conflict of Interest Advisory Group. Although this occurs rarely, we have had to follow up with course directors on a few occasions within the current re-accreditation period. (Attachment, pages 227-228.)

- All CME workshops offered to our faculty and staff and all presentations to clinical departments have a component that focuses on developing unbiased and evidence-based educational content.

B. Disclosure Process. Disclosures of all individuals with control of CME content are required by the College’s Conflict of Interest Policy for CME. (Attachment, page 229-234.) Internal financial disclosures are recorded annually in an Oracle database with a password protected web front end. (Attachment, page 235-236.) Faculty and staff are required to disclose annually or more frequently if there are changes and updates to their disclosure information. Speakers outside the institution disclose on a form developed for this purpose (Attachment, page 237-238). Appended to the hard copy disclosure form and linked to the web form are the Content Validation Guidelines developed by the CME office and requiring attestation of compliance by all CME planners and instructors. In several of our documents we explain the disclosure process.
and confirm that anyone who has not disclosed and been reviewed for potential conflict of interest cannot participate in a CME activity.

C. Identifying Conflicts of Interest. Prior to any activity, financial disclosures of the course director are reviewed by the CME office. (Attachment, page 239.) If and when the course director is found to be free of conflicts or when his/her conflicts have been resolved, disclosures of the planning committee and potential speakers and instructors are reviewed. In some cases, the review takes place by the faculty person directing the activity, in other cases, disclosures are reviewed by CME professional staff with assistance from the Conflict of Interest Advisory Group. A conflict is said to exist if the person who has the potential to influence content of the activity is vested in a commercial company relevant to the topic or subject focus of the activity or presentations. Conflicts are also said to exist if planners or speakers are vested in a company providing commercial support for the activity.

D. Resolving Conflicts of Interest. Despite CME workshops, one-on-one training sessions, information on our web site, and departmental presentations to faculty, there is no question that conflict of interest resolution has been one of the most difficult concepts to convey to those involved in planning and delivering CME activities. The following preventive and interventional strategies were therefore developed by the CME Division to facilitate the Conflict of interest resolution process:

*Prevention.* As stated previously, a copy of our *Content Validations Guidelines* is appended to every disclosure (hard copy or electronic version) and we require attestation of compliance with these *Guidelines* prior to the activity taking place. This technique for resolving conflicts is considered to be a pre-emptive intervention to ensure that speakers and planners understand and agree to the principles of commercially unbiased content prior to the planning and delivery of the activity. While our *Content Validation Guidelines* are not the only mechanism to prevent conflicts, they do serve as an important element of educational reference for anyone involved in planning and delivering a CME program.

Another preventive strategy is a web page on our CME site for Standards and Ethics in physician interactions with industry. This page contains links to a number of relevant documents including the University of Iowa’s Conflict of Interest Policy; the ACCME Updated Standards for Commercial Support, the AMA Council on Ethical and Judicial Affairs (CEJA) Opinions - Gifts to Physicians from Industry; the PharMA Code; the OIG Anti-Kickback Law and many others. When course directors and planning committees visit our site to download CME applications and other required forms, we guide them to standards for avoiding, managing, and resolving COIs. For a complete listing of the links we created on our site related to conflicts of interest, please visit: http://www.medicine.uiowa.edu/cme/planning/standards.htm

*Planners and Speakers:* Conflicts of interest may be resolved by requesting that the (non-conflicted) course director select another speaker or planning committee member or requiring that the speaker present on a topic in which he/she is not conflicted.
Presentations are previewed for CME activities only when the potential risks for COI are deemed to be high (some jointly sponsored programs, course director new to CME, etc.). Due to a number of variables including the volume of CME courses sponsored in relation to staff size; difficulties obtaining presentations in a timely fashion; and the number of jointly sponsored programs for which we are responsible, we currently do not have the time or staff to preview the educational content presented by every instructor and speaker at all our activities. However, if concerns are raised about relevance of disclosures to content, or if a program is considered to be at high risk, CME staff will request presentation materials and preview them for evidence of commercial bias. If such bias appears to be evident and cannot be resolved, the speaker is not approved to speak at the event.

**Evaluations.** For every CME activity, the course director is required to ask this question of attendees:

> As an ACCME-accredited provider of CME, The UI Carver College of Medicine must ensure balance, independence, objectivity, and scientific rigor in all continuing education activities it sponsors. Were the presentations associated with this activity balanced and free of commercial bias?
> □ Yes  □ No
> (If 'NO' please identify the presentation(s) and product(s) or companies where you felt commercial bias may have been evident.)

Although we understand that all conflicts must be resolved prior to the delivery of the activity, and we have very few reports from attendees of commercial bias in our programs, this mechanism has allowed us to continue to educate faculty on the goal of zero tolerance for conflict of interest in CME presentations.

In the minority of cases where responsibility for resolving conflicts of interest for an activity is vested in the department but CME staff have concerns because of past reports of bias, our office reserves the option of not approving CME credit for an upcoming activity.

Finally, it is not the policy of this Provider to request divesture of commercial interests from CME planners and speakers as a mechanism for resolving conflicts, although these individuals may be precluded from participating in the activity if their conflicts cannot be resolved.

**E. Management of Commercial Support.** All commercial support for CME activities must be documented in a completed, signed Written Letter of Agreement PRIOR to the activity taking place. The Agreement includes restricted and unrestricted educational grants as well as in-kind support. ([Attachment, page 240-241.](#)) All commercial support funds must be received and deposited into a provider account (i.e. departmental or CME account) and then disbursed for expenses deemed appropriate to the delivery of the program. No commercial funds are allowed to flow directly to speakers or other individuals associated with the activity. A commercial supporters’s Agreement may be used in lieu of our Provider Agreement, but only if the
company’s document has been reviewed by the CME office and found to be in compliance with ACCME requirements for commercial support. Exhibit fees are processed separately from commercial support for all CME activities.

F. Full Knowledge and Approval of Commercial Support. To verify that all commercial support goes into a CME provider account (or that of a provider-approved designee) and is processed with the full knowledge and approval of the CME office, a new position was created in our CME office to ensure compliance with this process. (Attachment, page 242-244) This position provides management oversight of all commercial support of CME activities and was developed for a number of reasons specific to our organization: 1) the large number of jointly sponsored programs and external programs we sponsor as the only nationally accredited provider in the state; 2) the fact that some of our programs prefer to manage their own event planning, thereby minimizing oversight by the CME Division; and 3) the fact that we are endeavoring to centralize management of commercial support and conflict of interest resolution in our office rather than vesting this responsibility with departments. For any departments whose CME accounts do not reside in the CME office, we require that their monthly Statements of Accounts (SOAs) from the University Business Office are made available to our CME Compliance Officer. In this way, we are able to ensure that there is a Letter of Agreement for every educational grant coming into the institution from commercial supporters of CME activities.

G. Commercial Support and Non-Teacher Participants. Our Honoraria Policy explicitly states that “Funds from commercial support may be used to cover appropriate expenses for the course director, speakers and other ‘bona fide’ employees of the educational activity.” Commercial supporters are not allowed to pay expenses of selected attendees for registrations, travel, or any other expense associated with attending a CME activity. (Attachment, page 245-246.)

H. Honoraria Payments. Honoraria must be received and disbursed in compliance with our Policy Governing Honoraria and Reimbursement of Out-of-Pocket Expenses for Planners, Teachers and Authors of AMA Category 1 Educational Programs Sponsored/Jointly Sponsored by The University of Iowa Roy J. and Lucille A. Carver College of Medicine. This policy was approved by the College’s Governing body in 2005 and specifies the following:

An acceptable honorarium for category 1 (CME-approved) events Sponsored by the Carver College of Medicine will include amounts up to $1500 per presentation. In rare cases where this amount restricts participation by a highly regarded specialist, the course director may initiate an Honorarium Appeal and submit it to the CME Division. The appeal will be reviewed in a timely fashion (within one week) by the CME faculty committee (or Peer Review Committee) and the course director will be notified immediately of the Committee’s decision.

Funds from commercial support may be used to cover appropriate expenses for the course director, speakers and other ‘bona fide’ employees of the educational activity, but those funds must come through the College’s CME Division and not flow directly from the commercial supporter to the individual.
Out-of-pocket, per diem, airfare, ground transportation, and other travel expenses for planners, teachers, speakers, instructors, and authors will be paid in compliance with University of Iowa policies governing travel reimbursement. Our Honoraria Policy is reviewed every two years (from the original approval date) and submitted to the College’s Governing body (Medical Council) for approval.

I. Managing Commercial Promotion. Commercial exhibits are not allowed in areas where educational instruction takes place. Company logos and advertising are not allowed on the same page or screen as educational content for any type of CME-related media (print, electronic, web-based, audio/video). Product identification is not allowed anywhere except in approved exhibit areas. A Written Letter of Agreement based on the template provided by the ACCME is required for all educational grants and in-kind contributions. (Pages 260-261) In the Agreement, it states explicitly that all content decisions will vest with the CME provider; product promotion material of any type is prohibited in or during the CME activity; the juxtaposition of editorial and advertising material on the same products or subjects is not allowed; and the accredited provider will ensure that the source of support from the commercial interest will be disclosed to the participants, in program announcements and/or during delivery of the program. Signatures on this document are required from an authorized company representative, the CME provider, and (when applicable) the joint sponsor or educational partner. The following attestation appears on all announcements for our CME activities:

_Determination of the educational content of this activity and the selection of speakers are responsibilities of the planning committee and director. Firms providing financial support did not have input into these areas._

In addition to the required Written Letter of Agreement for Commercial Support and the conflict of interest and honoraria policies approved by the Medical Council, the CME Division developed a commercial support policy that is used to guide planning responsibilities for all directly and jointly sponsored CME programs whether delivered ‘live’ or via enduring materials. (Attachment, page 247-249.)

J. Distribution of Enduring Materials. Enduring CME materials at this institution are infrequent and typically not supported by commercial companies. For example, during the current four-year self study period, we have had only two web-based educational programs; one print journal educational activity; and one instructional CD-ROM. The CD-ROM and one web based activity received partial commercial support and were subject to the same requirements and attestation for unbiased content and disclosure as all our other CME activities. Materials related to these activities were distributed to learners only by the CME provider, never by the commercial interest. While acknowledgment of commercial support appeared on the web site and CD-ROM, no product logos or advertising are allowed on any of our announcements, including enduring materials. Our policy on Enduring Materials guides the planning of all such activities. (Attachment, pages 250-254.)

K. Mechanisms to Ensure Content is Intended to Improve Quality in Health Care. Several of the documents requiring attestation from course directors, faculty, and planning committee members state specifically that the purpose of any educational activity sponsored by the College
is to improve the health and well being of patients. Due to the volume of programs we sponsor, we currently preview specific content only in high risk situations where infractions have occurred in the past or there are other concerns relative to disclosures and potential for commercial bias.

Examples of our documents requiring attestation that content is intended to improve the quality of health care include:

- Application for Category 1 Credit (pages 60-64)
- Speaker Letter (pages 255-256)
- Disclosure Form (pages 237-238)
- Content Validation Guidelines appended to disclosure form and requiring attestation of compliance (page 59)
- Disclosure Review and Verification Form – requiring attestations of course director with signature. (page 257)
- Honoraria Policy (pages 245-247)
- Conflict of Interest Policy (pages 229-234)

L. Ensuring that Content Provides a Balanced View of Therapeutic Options. As with the attachments referenced in section K, requirements relative to providing a balanced view of therapeutic options are included in documents requesting approval for AMA PRA Category 1 Credit and in faculty attestations of patient-centered, commercially unbiased content.

M. Disclosures to Learners. Financial disclosures of everyone in a position to influence the content of the activity are ensured using a number of strategies.

- Speaker letter. It is stated clearly in our speaker letter that all faculty must disclose to the audience. (Attachment, pages 255-256)

- Audience Disclosure Template. A template is provided to all planners and faculty via our web site and other distribution mechanisms to ensure that everyone understands the disclosure process. Audience disclosure may take place verbally (by the presenter or moderator), in a slide at the beginning of the presentation, or in a handout included in the syllabus. (Attachment, page 258)

- Disclosure Review and Verification. The course director must sign off within 2 weeks of the activity, attesting that relevant financial disclosures took place to the provider and attendees. (Attachment, page 257)

- Disclosure handout. To ensure that ALL disclosures are made to the audience, (including those of planners and course directors as well as speakers and instructors), a report is generated from our disclosure database and included in the attendee syllabus. (Attachment, page 259) Since CME staff do not attend CME programs to monitor the disclosure process, these handouts ensure that audience members will be informed of all disclosure information. In addition to the planner/speaker disclosure handout, we also
include in the program syllabus a list of commercial support provided to the program.  
(Attachment, page 259A)

In most cases, more than one disclosure mechanism takes place for each activity.

**N. Disclosure form.** The disclosure form we currently use has undergone a number of revisions to ensure an optimal process for both capturing and reviewing disclosure information. Most importantly, our disclosure requires attestation that our *Content Validation Guidelines* will be followed in the development of all content for College-sponsored CME activities. The *Guidelines* are one of the most critical components in our disclosure process and help to educate faculty on the importance of high quality, commercially unbiased content.

**O. Written Agreement for Commercial Support.** The document we use was downloaded from a template on the ACCME web site and is required whenever there is commercial support in the form of a grant or in-kind contribution to CME activities. In the case of jointly sponsored programs, we require signatures from the company representative, the provider, and the joint sponsor (educational partner).  (Attachment, page 260)

**P. Honoraria Policy.** Our Honoraria Policy was developed in 2005 and approved by the Medical Council, the governing body of the Carver College of Medicine. (Attachment, page 245-247)

**Q. Verification of Disclosures to Learners.** As stated previously in this Report, the Course Director (or a designee who attended the activity) must sign off that audience disclosures took place prior to the content being delivered. (Attachment, page 257)

**R. Disclosure of Commercial Support to Learners.** At a minimum, disclosures relative to commercial support for the activity are made to learners using a handout included in the Syllabus. (Attachment, page 259) Many course directors also announce commercial support from the podium during their welcome and introduction. Attestation that these disclosures were made is required from course directors on our Disclosure Review and Verification Form.
A. Planning Process for RSCs. The Carver College of Medicine’s CME Division provides oversight of about 100 Regularly Scheduled Conference (RSC) Series annually. Our RSCs are managed on a day-to-day basis (at the session level) by faculty course directors but are monitored annually (at the series level) by CME Division staff. All course directors are required to provide documentation of their planning and needs assessment process for the upcoming fiscal year (July 1 – June 30) and show evidence of their compliance with requirements relating to ACCME essential areas and elements from the previous year. Any series director who cannot produce requested documentation from the previous year is not approved for the upcoming year.

B. Information Management System. Applications for RSCs are based on a fiscal year: July 1 – June 30th. RSC attendance data are maintained by the clinical Departments within the College and requested by mid-July of each year for entry into the CME Division’s database management system. Faculty and other attendees who attend our RSCs receive credit letters for the preceding fiscal year in early August. Attendance data are kept in the database for at least six years as required by the ACCME.

C. Monitoring RSCs for Compliance. As a result of a number of converging variables including the Updated Standards and new RSC monitoring requirements from the ACCME, the AMA’s 2006 Revision of its PRA Manual, and general concern about RSC management and compliance issues, the Carver College of Medicine decided in 2005-2006 to begin monitoring all 106 approved RSCs for all ACCME Essential Areas and Elements to determine baseline compliance levels for each component. An anticipated benefit was that by identifying major areas of non-compliance across all series, we were able to identify which areas to sample in upcoming years.

To announce and explain the more extensive compliance review process, the CME Division delivered five 1-hour RSC workshops for UI faculty and staff throughout 2005 and 2006. The purpose of the workshops was to explain Category 1 approval requirements, with a particular emphasis on commercial support and conflict of interest issues, and to answer questions and clear up any confusion on the part of course directors and their support staff. These workshops were offered over the noon hour on May 16, June 15, and June 29 of 2005; and March 14 and March 30 of 2006. A total of 154 faculty and staff attended the workshops and a notebook of forms, procedures, and requirements was provided to each attendee. Time was built into the presentation for a Question and Answer (Q & A) period at the end of each presentation. To supplement the workshops and syllabi, links to all RSC requirements and the ACCME Updated Standards were posted on our CME web site for electronic review and/or downloading: (http://www.medicine.uiowa.edu/cme/planning/regschedconf.htm).

Non-Renewal of RSCs. Following the announcement and explanation of the new monitoring procedures to course directors via our RSC email list serv, seventeen course directors (16%) responded that they did not wish to renew their conference series as a Category 1 CME activity. Data on decisions not to renew were collected from the series course directors and may be found in the Attachment on page 267A. Some RSCs were subsumed into other ongoing series within
the department, others chose to continue their series without AMA PRA Category 1 Credit™; still others reported that increasing requests for documentation had become too burdensome.

**Survey Instrument.** A 1-page audit form was developed for the remaining 86 faculty course directors requesting documentation of compliance with ACCME Essential Areas, Elements and Standards. *(Attachment, page 268)* In addition to specific requests for documentation of compliance for the 2005-06 fiscal year, questions were specifically developed to measure the respondent’s understanding of the intent of the Updated Standards. The audit form was distributed via the CME Division’s RSC list serv on February 28, 2006 with a requested completion date of April 15th. Two professional staff from the CME Division coded results individually, and then collaborated on reaching a final designation for each variable from every series: Fully Compliant (C); Partially Compliant (P); Non Compliant (N); Not Applicable (NA); and in a very small minority of cases Undetermined (U). (U=illegible responses requiring some follow-up.)

**Audit Reviews.** Each of the remaining course directors were contacted individually in writing with the outcome of their audit. If any areas were coded partially- or non-compliant, the individual was informed as to what they needed to do to attain full compliance. This was an important educational process for course directors, but a very time consuming and labor intensive process for CME staff. Audit results generated several phone calls and emails requesting clarification and deadline extensions. Missing and corrected items received from RSC course directors were then reviewed for completeness, requiring in some cases further communication about missing data. Final results were logged into the compliance record during the last week in June.

**D. MONITORING RESULTS PRIOR TO INTERVENTION AND CORRECTIONS.**

**Data Sets Prior to Intervention and Corrections.** *(Attachment, pages 269-275.)*

*Environment.* As with many academic medical centers, the problem of faculty and staff turnover has had a tendency to confound compliance with RSC requirements, both old and new. Exacerbating this problem further, a small CME staff relative to the number of programs sponsored by the College previously prevented the Division from centralizing day-to-day management of its many RSCs.

*Planning and Needs Assessment Process.** *(100% Full compliance.)* Documentation of a planning and needs assessment process for 2005-2006 showed full compliance because Category 1 credit is not approved by our office for upcoming RSCs without that documentation.

*Communication of Purpose or Learner Objectives to Audience.** *(72% Full Compliance: 6% Partial Compliance 22% Non-Compliance.)* All RSCs identified educational objectives in their applications for the upcoming year. However, many did not include these objectives in their session-level announcements. The primary reason for this appears to be that email schedules (vs. formal announcements or flyers) have now become the primary, and in some cases, only mechanism for announcing upcoming series to the College’s faculty, fellows, and residents. Course directors indicated that they thought the elements required for a more formal
announcement would not apply to the more informal email schedules, even if the schedules were
the only notification of these sessions.

Evaluation Mechanism: (43% Full Compliance: 52% Partial Compliance: 5% Non
Compliance). Ninety-five per cent of respondents forwarded us their evaluation form. However,
we requested a summary of their evaluations to show that results were being used to plan
upcoming programs. Partial compliance was awarded to those who sent copies of their
evaluations tools, rather than a summary of evaluations as requested.

ACCME accreditation statement. (74% Full Compliance:13% Partial Compliance: 13%
Non-Compliance). Again, as with the communication of purpose or objectives, course directors
thought they didn’t have to include the ACCME accreditation statement if their primary
announcements took the form of an email schedule forwarded to internal faculty, staff, residents,
and fellows. Most course directors were also unaware of the newly revised credit designation
statement from the AMA.

Commercial Bias. (71% Full Compliance: 9% Partial Compliance: 6% Non Compliance:
14% NA). This question was asked to ensure that course directors were previewing presentations
or sitting in on sessions to make sure that no product promotion takes place. NA refers to RSCs
consisting only of presentation of patient cases.

Disclosures of Relevant Financial Relationships. (70% Full Compliance; 16% Partial
Compliance: 14% Non-Compliance;.) To our surprise (and relief), only 14% of course
directors surveyed were non-compliant with new disclosure procedures and forms instituted
over the past year. We requested ALL disclosures for the past annual approval period, and 16%
provided only a sampling of their disclosures.

Conflicts of Interest (60% Full Compliance; 14% Partial compliance: 12% non Compliant;
13% NA; 1% Unintelligible). Clearly, the item asking respondents “How were conflicts of
interest identified and resolved?” was the most confusing to respondents. It became apparent that
several respondents did not understand the distinction between disclosing relevant financial
relationships and resolving conflicts of interest – they assumed once they had obtained
disclosures and announced them to the audience, the process was complete. Although all the
RSC workshops held by the CME Division devoted significant time to this issue, and there is
substantial information on our web site about resolving COIs, this area continues to be the most
confusing to RSC course directors.

Honoraria. (27% Full Compliance; 6% Partial Compliance; 2% Non Compliant; 64% NA.)
In 2005, the Carver College of Medicine approved the “Policy Governing Honoraria and
Reimbursement of Out-of-Pocket Expenses for Planners, Teachers and Authors of AMA
Category 1 Educational Programs” which was emailed to all course directors and posted on our
web site. The majority of our RSCs do not provide honoraria (64%) and only one or two Course
Directors were found to be non-compliant reporting that they had taken over responsibility for an
RSC after the original course director left and were not aware that such a policy existed. These
individuals were coded non-compliant because they were not able to cite the main points of the
policy, not because they necessarily violated it.
Audience Disclosure. (67% Full Compliance; 13% Partial Compliance; 20% Non Compliance) The 14% non-compliant respondents indicated they were unaware of audience disclosure requirements; the partially compliant respondents indicated they disclosed only when they had a guest (non-UI) speaker.

Letters of Agreement. (10% Full Compliance; 6% Partial Compliance 1% Non Compliance; 81% NA.) The majority of our RSCs (81%) do not request or receive commercial support, the 6% partial compliance was due to completing most (but not all) of the Written Agreement for Commercial Support or sending us an agreement with a missing signature. Only one person did not know they were supposed be requiring such Agreements and that course director had only two sessions for which he received commercial support. (‘Staff turnover’ was cited by the respondent for the reason he was not up to speed with this requirement.)

Total Compliance. Following the initial audit (i.e. prior to review and corrections), 13 out of 89 (15% of our RSCs) were found to be in total compliance – that is, fully compliant in all essential areas, elements, standards, and policies

D. Monitoring Results - Following Interventions and Corrections. (Please refer to data sets on pages 276-281.)

As stated previously, CME staff reviewed the results of the initial audit and wrote to each course director individually with instructions about what was needed to come into full compliance. Over a period of a few months prior to July 1, 2006, corrected items, missing data, and other materials documenting compliance were collected by the CME Division and logged the final compliance record. (Note: three more RSCs were dropped by course directors during the audit process bringing the total from 89 to 86.

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<tr>
<th>Final overall compliance in all areas</th>
<th>96.45%</th>
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<tr>
<td>Planning Process</td>
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<td>Needs Assessment</td>
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<td>Educat. Objectives</td>
<td>85</td>
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<td>Evaluation Summary</td>
<td>84</td>
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<td>Accred. Statement</td>
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<td>Prevent Comm Bias</td>
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<td>Disclosures</td>
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<td>COI Reviews</td>
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<td>Honoraria Policy</td>
<td>25</td>
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<td>Audience Disclosures</td>
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<td>LOAs</td>
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<td><strong>Total</strong></td>
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*NA Responses excluded from final compliance percentages
** ? Reviewers not totally convinced the criterion was met.
E. Data Analysis. The number of RSCs in the Carver College of Medicine declined from 106 to 86 in 2006 due to a number of variables including increased requirements for documentation and closer scrutiny of compliance by CME Division staff. (The initial audit following cancellations had 89 RSCs but during the audit, three more RSCs canceled their series, bringing the total down to 86.) Despite ongoing efforts to explain requirements for Category 1 credit for RSCs via a variety of strategies (workshops, handouts & syllabi, face to face meetings, correspondence, email list servs, CME web site), many ACCME and AMA requirements have been inadequately understood and managed at the departmental level. Some of the causes (i.e. faculty and staff turnover; increased requirements for documentation in the overall practice of medicine) are endemic to the institutional environment and remain outside the scope of the CME Division to influence. The results of the institutional RSC review described in this report point to the need for stronger centralization of this process by the CME Division. Any thought of going to an every-two-year-review of RSCs (the hoped-for outcome) appears unlikely at this time.

In the current environment, it may be unrealistic to expect that faculty course directors, whose commitment to the College often exceeds 60 hours a week, can assume total responsibility for all the documentation required for their RSCs. As a result, support and administrative staff in this institution play a significant role in collecting and organizing RSC data. This can be somewhat problematic in that coordination of RSCs tends not to be listed as a major responsibility of most merit position descriptions and the rate of support staff turnover tends to be even higher than that of faculty. Because the review process was undertaken at about the same time that the departments were compiling attendance records for the previous year’s RSCs, (and also submitting annual budgets and preparing for July 1 residency training programs), many of the people contacted clearly felt overwhelmed by this process.

The amount of time spent by CME staff communicating with course directors as well as carrying out, coding, and analyzing the RSC survey (pre- and post-review) was considerable. The entire process lasted approximately four months, with one individual working almost exclusively on this project and another working about 10% time. Compliance monitoring by the CME Division includes processing and sending several hundred credit letters to faculty at the close of each fiscal year, establishing and following through on audit procedures in order to ensure that ACCME and AMA requirements are being met, providing guidance to course directors and their staffs as needed, and answering numerous questions and inquiries that are routinely phoned in or e-mailed to the CME Division throughout the year.

F. Improvements and Action Plan. The improvement rate of compliance FOLLOWING intervention and corrections may be seen in the Figure on Page 265 of this Report. All programs now show 80% or higher compliance in all essential areas and elements as required by the ACCME. Overall, we feel that the more rigorous monitoring system for RSCs has been successful in that this process: 1) provided baseline data about the most significant compliance problems (e.g. conflict of interest resolution); 2) created (via the training syllabus) a step-by-step process whereby RSC departmental staff could bring their programs into compliance; 3) revealed some problem areas we will need to sample in the future; and 4) raised the issue of greater centralization and closer scrutiny of RSCs.
Our action plan for 2007-08 includes the following: 1) before new RSC applications can be presented to the CME Committee for approval, the faculty course director must first have a face-to-face meeting with a CME professional staff person who will explain procedures and requirements with particular emphasis on disclosures, the conflict of interest review process, and management of commercial support; and 2) we will monitor the RSC process more frequently than once a year to ensure that course directors understand and are completing all required documentation and forms for AMA PRA credit. To that end, we proposed the creation of a new CME position, (RSC Coordinator) which was approved by the College’s Human Resources Department in January, 2007. This position was filled on March 26, 2007 by Katie Coleman who has extensive management experience working in the health care field.
XIII. ACCME Policies.

A. Verifying Physician Participation. At ‘live’ CME activities, attendance is documented during the registration process by CME (or designated departmental) staff. Anyone who does not participate in the entire program is required to fill out a ‘Change Form’ with the actual hours of attendance. (Attachment, page 283).

For web-based CME programs, tests on content are typically required in addition to evaluations of the activity. For content-based tests, results are scored via an automated proprietary scoring program and emailed to our office. (Attachment, page 284.) For web content, a score of 70% or above is required to receive credit.

Designated departmental staff are responsible for taking attendance at RSCs and attendance data are forwarded to the CME Division at the end of each fiscal year (June 30th). These data are kept for six years.

Attendees participating in any type of CME activity are entered into our CME database system and credit letters are generated from the database within two weeks of the activity date. (Attachment, page 285). A participant in any CME activity may request a transcript of their past attendance at CCOM programs at any time. (Attachment, pages 286-287.) A Class List of all attendees is also generated from the database for all CME programs. (Attachment, pages 288-290.)

B. Complying with ACCME’s Definition of CME and Eligibility CME activities proposed for Carver College of Medicine sponsorship or joint sponsorship are required to comply with the ACCME’s definition of CME as stated in the Policy section on the ACCME web site. http://www.accme.org/index.cfm/fa/Policy.policy/Policy_id/16f1c694-d03b-4241-bd1a-44b2d072dc5e.cfm (Attachment, page 291) Although not always clinical in nature, our activities address topics that fall well within the ACCME and AMA definitions of CME. http://www.ama-assn.org/ama1/pub/upload/mm/455/pra2006.pdf#page=4 (Attachment, page 292) The link to the ACCME and AMA definitions of CME are forwarded to course directors if they are uncertain as to whether their content qualifies as a CME activity. If the CME office has unresolved concerns about the appropriateness of proposed content, the ACCME office (Dennis Lott) or the AMA office (Jeanette Harmon) are contacted via email for clarification.

C. Content Validity The ACCME’s Content Validation Guidelines serve as the preamble to our internally developed Content Validation Guidelines with which all planners and speakers must comply and which we have been using since 2004. In addition, content validation statements and guidelines are included in many of our required documents including our Application for Category 1 credit; our Disclosure form, our Written Agreement for Commercial Support, and our Disclosure Review and Verification form (All these forms have appeared in various attachments throughout this Report). In cases where programs or individual presentations are deemed to be at high risk, instructional materials (e.g. Powerpoint slides) are previewed for content. Finally, answers to the question on our evaluation form regarding commercial bias are reviewed and discussed with course directors as appropriate.
XIV. Program Summary (Self Assessment and Improvement Plans.)

A. Planned Improvements.

Outcomes-Based CME Evaluation Models. To better fulfill our mission, we plan to implement an outcomes-based model for our CME program evaluation similar to the one in the Attachment on page 295. Although we are currently able to confirm attainment of Levels 1-4 by examining such variables as attendance data and physician self-reports of improvements in their practice, we still have a long way to go to achieve levels 5 and 6. We will use a variety of strategies to attain these goals such as reviewing improvements in CMS data for Iowa (external programs) and examining improvements in medical error rates (internal programs). Being able to link such changes to specific CME programs will be very difficult, given the number of other interventions and variables likely to impact such change.

Information Retrieval System. Our current outdated and somewhat inflexible information retrieval system for registrations and generating credit is being replaced by a customized database created for us by the College’s Information Technology (IT) staff in SQL Server. With the new system, we will be able to accept online registrations and faculty will be able to search our database via a password-protected web front end to generate their own CME credit transcripts. Once the new system is complete, we will be able to generate reports and queries that contribute to a more in-depth assessment process, particularly with respect to attendance and demographics. This project is estimated to be completed in the Spring of 2008.

Management of Commercial Support. With the recent creation of a new grants and contracts position in the CME Division, we plan to increase control, management, and reporting of commercial support data. The person in this position will also provide a more detailed review of and control over contractual agreements relative to commercial support, particularly in areas of joint sponsorship where management has been less than optimal in the past.

B. Future Directions.

Much of our time in the current re-accreditation period has been devoted to developing strategies to ensure compliance with the updated ACCME Standards and Essential Areas. The conflict of interest review process has required several training sessions to keep our faculty informed of these changes and to orient them to a number of new forms to ensure compliance. Closer monitoring and sampling of our many RSCs has required a similar investment in CME staff time and effort. Both of these areas have led to the need for additional staff resources – a need which was met in the past year with the filling of three new professional CME positions.

As with the profession of Medicine in general, we intend to investigate ways in which we can move our CME program toward more outcomes-based results. There are several health indicators that will be used to determine improvements in patient outcomes, although it may be difficult to identify and isolate the specific role and impact of CME in this process.
As noted in our mission statement, we plan to integrate the ACGME competencies into the content of some of our programs. This will be accomplished by determining baseline knowledge of the Competencies within our target audiences and developing content that addresses identified gaps in knowledge.

We plan to improve our overall needs assessment process by exploring more innovative strategies for determining areas of unmet educational need among physicians. For example, one methodology will involve querying patients and the general public about topics they would like their health providers to know more about. (Human Subjects approval for this project is pending.)

Continuing to develop partnerships with a number of stakeholders at our institution is another important long-term goal for the CME Division. The Clinical Enterprise views CME as an important outreach presence across the state and we intend to build and strengthen constituent relationships with other groups involved in physician professional development and continuing medical education.

Requests for the College to jointly sponsor CME programs have increased significantly over the past two years. These programs are very time- and labor intensive and consequently they have become very difficult for us to manage appropriately. We plan to develop a policy for accepting joint sponsorship which balances the reality of compliance issues with our intent to maintain positive outreach relationships with entities and groups throughout the state.

Finally, we are about to launch a point-of-care CME project that has been in the pipeline for over two years. Since there are currently not many point-of-care models to serve as examples, we spent considerable time on the front end ensuring that our program meets ACCME and AMA requirements for this new format. The project has an expected launch date of December, 2007 and we anticipate having considerable data to report on in our next Self-Study.