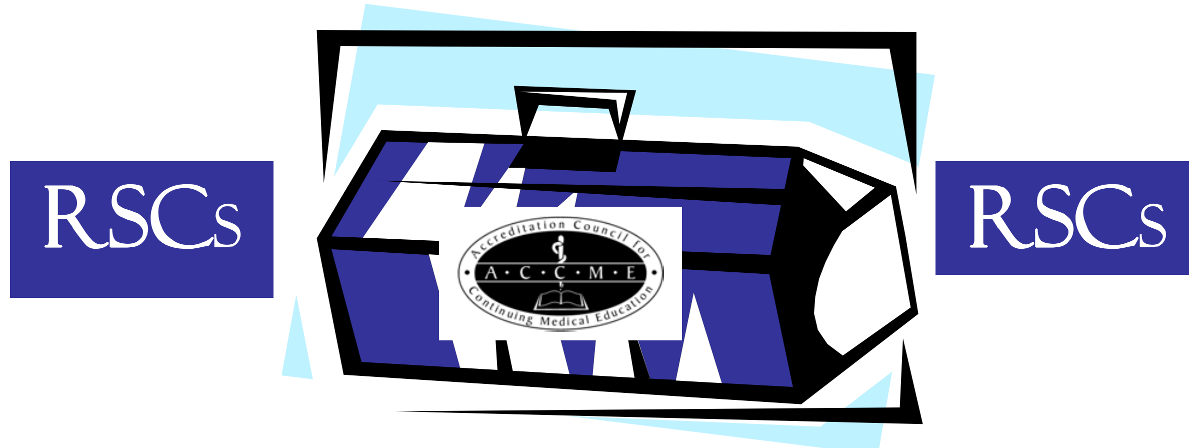

TOOLS TO SUPPORT IMPLEMENTATION OF A MONITORING SYSTEM FOR REGULARLY SCHEDULED CONFERENCES[1]

DEVELOPED BY
THE ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION
DECEMBER 2005

[1] In Support of ACCME's RSC Policy, adopted November 2003

DATE: December, 2005

TO: Colleagues in Continuing Medical Education

FROM: Murray Kopelow, MD, MSC, FRCPC
ACCME Chief Executive

RE: Tools to Help Providers Implement Monitoring Systems for Regularly Scheduled Conferences (RSCs)

In 2003, ACCME adopted a new approach to the accreditation of providers offering Regularly Scheduled Conferences (RSCs). Both providers and ACCME have implemented the policy into organizational procedures. The ACCME is pleased to offer the enclosed tools to support providers in better understanding and further implementing monitoring systems for RSCs.

This RSC toolkit contains the following materials:

Reflection and Self-assessment Tools

- **Reflecting on the Planning and Implementation of RSCs**
  This tool is designed to help providers reflect on the preparation and delivery of RSCs.

- **ACCME's Review of Monitoring System and Compliance Data for RSCs**
  This tool is designed for ACCME surveyors' to record findings on a provider's monitoring system and compliance with ACCME's Elements. Providers can use the form to assess their performance and their monitoring system's ability to produce the data and information needed in the ACCME's review process.

Requirements for RSC Monitoring Systems and Reports on Monitoring Systems

- **ACCME's Expectations of Providers RSC Monitoring Systems and Reports on Monitoring Systems**
  This document specifies parameters for monitoring systems, including expectations for data collection and reporting.

Educational tools[1]

There are four sample monitoring system reports presented as illustrations of what a provider might submit in a self study report for accreditation.

The ACCME is hopeful that these tools will meet the CME community's needs. The ACCME welcomes your suggestions for additional needed materials. As always, the ACCME appreciates your commitment to quality continuing medical education for physicians.

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[1] The ACCME is offering these implementation tools not as finite interpretations of its policies, but as examples that providers have requested to give them ideas and foundations with which work can continue. Organizations should feel free to adapt these tools to their specific CME programs.

ACCME
Tools to Support Implementation of a Monitoring System for Regularly Scheduled Conferences

TABLE OF CONTENTS

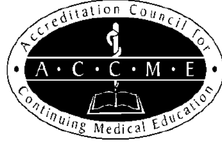
PAGE

Reflecting on the Planning and Implementation of RSCs 4

ACCME's Expectations of Systems to Monitor for Compliance in RSCs 5

ACCME Review of Monitoring System and Compliance Data for RSCs (surveyor form) 7

Examples of Reports of Monitoring Systems 8-21
- Example #1: City Hospital 8-11
- Example #2: ABC Medical School 12-15
- Example #3: Good Health System 16-19
- Example #4: East Medical School 20-21



Reflecting on the Planning and Implementation of Regularly Scheduled Conferences

A Regularly Scheduled Conference (RSC) is defined as an activity that is planned to have 1) a series with multiple sessions that 2) occur on an ongoing basis (offered weekly, monthly, or quarterly) and 3) are primarily planned by and presented to the accredited organization's professional staff. Examples of activities that are planned and presented as a regularly scheduled conference are Grand Rounds, Tumor Boards, and M&M Conferences. Hospitals, health systems, and medical schools are the types of CME providers that typically offer RSCs because each of these organization types has in-house professional staff. RSCs are offered as directly sponsored and jointly sponsored activities.

In 2003, ACCME adopted a policy for RSCs that allows CME providers that offer RSCs to monitor their own compliance with ACCME's Elements and Policies. Materials released in May 2003 and November 2005 offer examples of how providers might develop monitoring systems for their Regularly Scheduled Conferences. These examples are available at www.accme.org. The ACCME expects that a CME provider will plan and implement its regularly scheduled conference activities according to its own policies and procedures but in a manner that is in compliance with ACCME's Essential Areas, Elements, and Policies.

Each CME provider that offers RSCs is faced with making decisions about how RSCs will be planned, implemented, and evaluated. The questions below offer a perspective for providers to consider when reflecting on the planning and implementation of RSC activities:

1. **How do you organize your RSCs?**
   - Is each session one activity?
   - Is each series an activity?
   - Are all RSCs together one activity with many components?
2. **What procedures do you use to plan your RSCs?**
   - Do you have a yearly planning meeting for all RSCs where needs are identified?
   - Do you have applications that RSC planners must complete?
   - Do you have meetings with each group/individual with responsibilities for an RSC activity?
3. **How do you implement your RSCs?**
   - Who are the individuals responsible for the implementation of the RSCs?
   - Do you have expectations of these individuals? If so, what are they?
   - Do you have guides or templates that are used for implementation?
   - Are there different procedures for different series?

ACCME's Expectations of Systems to Monitor for Compliance in Regularly Scheduled Conferences

ACCME accredited providers that produce Regularly Scheduled Conferences (RSCs) should be aware of ACCME's expectations of systems that monitor for compliance in RSC activities. In addition to ACCME's expectations of monitoring systems, the ACCME has articulated in its Accreditation Process Materials the manner in which providers that produce RSCs must present its monitoring system descriptions, data, and information. These instructions can be found in the *ACCME's Accreditation Process Materials* posted on www.accme.org.

The ACCME expects that providers will:

1. **Describe and verify it has a system in place to monitor its compliance with the ACCME Elements and Policies, including the Standards for Commercial Support. (RSC-A)**
2. **Verify its system to monitor for compliance is based on actual performance data and information derived from RSCs that describe compliance (in support of ACCME Elements 2.1-2.5 and 3.1-3.3). (RSC-B)**

At accreditation the provider must :

- **Identify** the accreditation requirements monitored (e.g. ACCME Elements)

  Performance data and information must be collected:

  a) on all ACCME Elements and Policies; and

  b) from all series for each year of the accreditation term[1]; and

  c) from at least 10% to 25% of sessions within each series.
- **Show** the sampling and monitoring methods used
- **Provide** a description and analysis of data collected
- **Present** its **conclusions*** regarding compliance

*Conclusions by a provider on whether the RSCs meet ACCME's expectations must be based on: (1) ACCME's Criteria for Compliance for each Element; and (2) the ACCME's standards for determining whether a provider has fulfilled the criterion for compliance with each Element. The ACCME's standards are:

		Meeting ACCME's Expectation
Compliance	=	≥ 80% of the time
Partial Compliance	=	51 - 79% of the time
Non Compliance	=	≤ 50% of the time

There is no partial compliance finding for ACCME's Element 3.3 (SCS). If a provider does not meet ACCME's expectation ≥ 80% of the time in the SCS, the finding is noncompliance.

3. **Verify its system to monitor for compliance results in improvements when called for by these compliance data (in support of ACCME Elements 2.4, 2.5 and 3.1). (RSC-C)**

   At accreditation the provider must:

   - **Describe** an action plan for, or actual improvements made

   The provider must be able to produce follow-up data that demonstrates compliance when its monitoring system has uncovered the need for improvements. If timing between monitoring system results and ACCME's accreditation process does not permit the production of follow-up data, the provider should develop an action plan for making improvements.

[1] The ACCME does not mean that data on all Elements and Policies must be collected from every series. For example, a CME provider may collect data on Element 2.1 (planning process) from Series A and data on Element 2.2 (use of needs data) from Series B. The ACCME does not mean that the Provider must collect data from each session. ACCME expects data from at least 10 to 25% of sessions within any one series.

4. **Verify its system to monitor for compliance ensures that appropriate ACCME Letters of Agreement are in place whenever funds are contributed in support of CME (in support of ACCME Element 3.3) (RSC-D)**

   In order to monitor for appropriate letters of agreement, the provider must have data descriptive of the commercial support contributed to all RSC activities. These data include the RSCs that received commercial support, the commercial supporters, and amount of support.

5. **Make available and accessible to the learners some form of an information management system (examples include paper-, web-, or LAN-based systems) through which data and information on a learner's participation can be recorded and retrieved. The critical data and information elements include: learner identifier, name/topic of activity, date of activity, hours of credit designated or actually claimed. (Note: The ACCME limits the provider's responsibility in this regard to "access, availability and retrieval." Learners are free to choose not to use this available and accessible system.)** (RSC-E)

   The provider must ensure that use of its information management system results in an ability to retrieve the critical data and information elements.

ACCME Review of Monitoring System and Compliance Data for Regularly Scheduled Conferences

Provider Name			
Provider Number		Date of Survey	
ACCME Surveyor*			
Title of Activity	Program of Regularly Scheduled Conferences		

RSC-A ....**The provider has a system in place to monitor its program of RSCs for compliance.** Yes ☐ No ☐

ACCME Element		The system to monitor for compliance is based on actual performance data and information (RSC-B)	For each element listed, the provider's monitoring data demonstrates that the program of RSCs is in compliance. EC	Yes	Some-times	No	If *Sometimes* or *No*, improvements were made and data demonstrates change (RSC-C and 2.5)
2.1	A planning process was used that linked the identified needs with desired results.	☐	☐	☐	☐	☐	☐
2.2	Needs assessment data were used to plan the RSCs.	☐	☐	☐	☐	☐	☐
2.3	The purpose/objectives of the RSCs were communicated to the learners prior to the RSCs.	☐	☐	☐	☐	☐	☐
2.4	The RSCs were evaluated in terms of the effectiveness in meeting the identified needs.	☐	☐	☐	☐	☐	☐
	The ACCME accreditation statement is correct.	☐		☐	☐	☐	☐
3.3	RSCs developed independently of commercial interests. (SCS 1 / 3.3b)	☐	☐	☐	☐	☐	☐
	All individuals in a position to control content disclosed relevant financial relationships to provider. (SCS 2)	☐	☐	☐	☐	☐	☐
	Individuals who refused to disclose relevant financial relationships were disqualified (if applicable). (SCS 2)	☐	☐	☐	☐	☐	☐
	There is evidence of the implementation of a mechanism to identify COI. (SCS2)	☐	☐	☐	☐	☐	☐
	There is evidence of the implementation of a mechanism to resolve COI. (SCS 2)	☐	☐	☐	☐	☐	☐
	Honoraria and expense reimbursements were paid in compliance with provider's policies and procedures. (SCS 3)	☐	☐	☐	☐	☐	☐
	No product-promotion or product-specific advertisements are juxtaposed with educational materials. (SCS 4 / 3.3c)	☐	☐	☐	☐	☐	☐
	Relevant (or no) financial relationships of those in a position to control the content were disclosed to the participants prior to the RSCs. (SCS 6 / 3.3a)	☐	☐	☐	☐	☐	☐
	☐ **There is no commercial support received for RSCs. Do not answer the next two questions. Proceed to next section (RSC-E).**						
	Signed written agreements between provider and commercial supporter are present. (SCS 3 / RSC-D / 3.3 d)	☐	☐	☐	☐	☐	☐
	Disclosure to the learners of the source of commercial support is made prior to the start of the RSCs. (SCS 6 / 3.3a)	☐	☐	☐	☐	☐	☐

RSC-E
....**Learner participation can be recorded and retrieved.** ☐
The critical data and information elements are included (i.e., learner, name of RSC, date, units of credit). ☐

Comments: Describe the data, timing, and nature of any monitoring data that indicates the provider's program of RSC is not in compliance, sometimes in compliance, or exceeds compliance. Also describe the nature and timing of improvements that were made.

EXAMPLE #1
City Hospital's Monitoring System Report

City Hospital decided to reinstitute RSCs into its CME program 18 months ago. RSCs had been excluded from the CME program for a few years due to problems with demonstrating compliance, insufficient staff support, and lack of physician attendance. Two years ago, the hospital engaged in strategic planning and decided to make education an organizational imperative. This led to a re-organization of the CME department, a revitalization of the CME committee, and greater organizational resources for RSCs.

ACCME's RSC policy came at a great time for City Hospital because we were able to take a different approach to ensuring compliance with ACCME requirements. We actually implemented the monitoring system as we rolled out our RSC activities. We decided that we would monitor our RSCs on an annual basis to start and then make adjustments to monitor some or all series more frequently, if necessary.

As a first step, the CME department held training sessions for all personnel who would be involved in RSCs. We distributed a CME manual, demonstrated how to use the on-line CME application, and set dates for follow-up meetings with each department.

At the end of our academic year, we started analyzing the data we collected. CME staff and two members of our CME committee comprised our RSC task force which analyzed data, drew conclusions, and formulated recommendations to the full CME committee for programmatic changes. The table in the following pages represents the findings, conclusions and improvements made or planned as a result of the implementation of the monitoring system after one year of City Hospital's use of our RSC monitoring system.

City Hospital currently has five regularly scheduled conferences: Pediatric Grand Rounds, Internal Medicine Grand Rounds, Surgery Grand Rounds, OB-GYN Grand Rounds and Tumor Board. Each series meets 10 times per year so there are 10 sessions in each series.

All series were monitored. At least 10% of sessions within each series were monitored.
All ACCME Elements were monitored.

City Hospital utilized the following methods to collect data on its RSCs compliance with ACCME Elements and Policies:

- review of planning worksheets and materials (i.e., meeting minutes)
- review of evidence of use of needs data
- review of promotional pieces and review of activity materials (i.e., slide copies, handouts)
- review of evaluation forms
- review of budgets, income and expense statements, and written agreements along with list of commercial supporters (list is attached)

When we reviewed these materials, we referred to ACCME's Criteria for Compliance with the Essential Areas and Elements to determine our level of compliance. Our compliance conclusions are based on the assumption that at least 80% of our sample for an Element needed to demonstrate compliance in order to render a finding of "compliance."

LEARNER PARTICIPATION:

Verification of physician participation is maintained electronically. When a physician arrives at the RSC session, he/she signs in with the registrar of the meeting. The registrar enters the physician into the Access Database the hospital has developed to track attendance. A CME attendance record can be generated for any physician who asks the CME department for a list of the CME activities in which he/she participated.

LIST OF COMMERCIAL SUPPORTERS FOR CITY HOSPITAL'S RSCs

Pediatric Grand Rounds
ABC Pharmaceuticals
National Drug Company

Internal Medicine Grand Rounds
XYZ Pharmaceutical Company

Surgery Grand Rounds
Best Devices, Inc.
Universal Instrument Company
New Tomorrow Catheter Company

OB-GYN Grand Rounds
ABC Pharmaceuticals
National Drug Company

Tumor Board
No commercial supporters

1 What is monitored	2 The Provider's monitoring and sampling method	3 The Provider's description and analysis of the data collected	4 The Providers conclusions	5 The Provider's action plan and/or improvements implemented
Element 2.1	Review of planning worksheets from two of five Series (Internal Medicine and Surgery)	Completed planning worksheets from 2 of the 10 sessions in the Internal Medicine Grand Rounds and 3 of the 10 sessions in the Surgery Grand Rounds were reviewed. All worksheets show that the planner linked the identified need to the expected result by choosing an appropriate methodology. Attachments to the worksheets verify that needs data were used to plan each series and that those data were linked to methodology and expected results for each session.	COMPLIANCE; but can improve	We thought the Departments may be interested in being more creative from an educational methodology perspective. We brought them together to discuss their options. A copy of the minutes from this meeting is included in our self study report under Element 2.5. We will sample from these series next year to see what changes have been made.
Element 2.2	Review of evidence submitted for needs data from 4 sessions of OB-GYN series	Needs 'data sets' from four sessions were collected. Data for all four sessions were the same, as the planners of the OB-GYN series relied upon frequency distributions of cases seen in the last year to provide a general plan for the year. The five most frequently seen conditions were chosen as content to be covered. In addition, the OB-GYN planners linked those data to research presented in journal articles and expert opinion to drive the content for two specific sessions.	EXEMPLARY COMPLIANCE because multiple data sources were used	We will insist on all series using multiple data sources for all series that include our own outcomes, when available.
Element 2.3	Review of activity promotional pieces from Tumor Board	We reviewed written objectives from Tumor Board by collecting the flyers and printing the monthly extranet announcements. We used the flyers collected to also check for the correct accreditation statement.	Although our sample demonstrates COMPLIANCE, we want to verify that sampling Tumor Board alone provided a true representation of all RSC activities.	We went back and got more data from a few of the sessions from other series. The results were the same: compliance. We now feel comfortable monitoring Tumor Board to represent our practice and performance in all series.

1 **What is monitored**	2 **The Provider's monitoring and sampling method**	3 **The Provider's description and analysis of the data collected**	4 **The Providers conclusions**	5 **The Provider's action plan and/or improvements implemented**
Element 2.4	Review of collection of evaluation tools from all series	I asked each department offering an RSC to send me what they did for activity evaluation in September, January, and May. Three departments used questionnaires that were asking if the learners thought they learned anything. The tabular data showed that the learners reported that they learned something. Two departments used a different approach. They asked the QI department for performance data for the clinical problems. In September they just were getting aggregate data for the whole hospital. By May they had modified their approach to include the QI staff in the analysis of more detailed individualized data and in developing feedback to the learners.	Three departments are in COMPLIANCE and 2 departments are in EXEMPLARY COMPLIANCE.	We are planning a faculty wide workshop on the integration of CME into QI. We have included the minutes from initial planning meeting in our self study report for Element 2.5.
Accreditation Statement	Review of activity promotional pieces from Tumor Board	We used the same flyers collected to verify objectives to also check for the correct accreditation statement.	Although our sample demonstrates COMPLIANCE, we want to verify that sampling Tumor Board alone provided a true representation of all RSC activities.	We went back and got more data from a few of the sessions from other series. The results were the same: compliance. We now feel comfortable monitoring Tumor Board to represent our practice and performance in all series.
3.1 and 3.3 (SCS)	Review of planning documents, budgets, income and expense statements, meeting materials and written agreements from Pediatric Grand Rounds;	We relied upon budgets and income and expense statements to determine compliance with Element 3.1 and to also inform our conclusion on compliance with Element 3.3. Resources and support were present; commercial support was managed and used appropriately. We used planning meeting minutes to provide us with data on to ensure decision were free of control from commercial interests. The Pediatric Planners are in control. No commercial interests are involved in any decision making. A mechanism was implemented to identify and resolve conflicts of interest. Honoraria and expenses were paid in accordance with our policy. No promotion was associated with this series. We relied upon slide copies from 3 of the 10 sessions for review of content and other SCS issues. Content promotes improvements in healthcare. All disclosures are done appropriately. All written agreements were present (two of two).	3.1: COMPLIANCE 3.3 (SCS): COMPLIANCE For written agreements, we are in COMPLIANCE.	We will start to directly observe any series that relies on verbal disclosure. To help ensure we continue to be in compliance, we are sending faculty a sample disclosure slide and reminders about disclosure. We included in our self study report for Element 2.5 the reminders and sample disclosure slides we developed.

EXAMPLE #2
ABC Medical School Monitoring System Report

Prior to the implementation of ACCME's RSC policy, ABC Medical School had already decided to begin monitoring its RSCs in 2003 through a system separate from our internal RSC application process. The materials staff and CME committee members reviewed, as part of the monitoring system, included (1) planning meeting minutes; (2) letters to faculty; (3) flyers; (4) written agreements for commercial support; (5) evaluation tools; (6) moderator notes; and (7) other evidence that disclosure occurred, if disclosure was not done verbally (slide copies; syllabus materials, etc). In addition, staff and CME committee members audited via observation at least one session from each series each year in 2004 and 2005.

The attached table represents our analysis of the data collected. We collected data on ACCME Elements 2.1-3.1 and 3.3 in all of our series. We based our findings on the following assumptions:

Compliance findings for Elements 2.1-2.4 were based on staff and committee members' reviews of planning, meeting materials, and evaluation methods at the **series** level. Each series is planned and implemented as one activity. We used ACCME's criteria for compliance and utilized ACCME's documentation review form. In the table, E = Exemplary; C = Compliance; P = Partial; N = Noncompliance.

Compliance findings for ACCME's Element 3.1 and 3.3 (SCS) were based on **session** level data to ensure that each session adhered to ACCME's requirements for commercial support and disclosure. We felt that reviewing budgets, income and expense statements would not only help us determine compliance with Element 3.1 but also Elements of the SCS. Based on ACCME's standards, we used the following scale: ≥80% =Compliant (C); <80%=Non Compliance (NC).

CONCLUSIONS – REGARDING 2003 RSCs:

A review of our 2003 data revealed that our planning processes for several RSC series would not meet ACCME's expectations. While applications had been approved for the series, there was little to no back-up for those applications to support compliance with Elements 2.1 and 2.2. We noticed that there was little evidence of what planning process was used and how needs data were used. In addition, evaluation of the effectiveness of the activities had not occurred in two series. The one incident of noncompliance with Element 2.3 (purpose or objectives) was believed to be lack of documentation as opposed to lack of performance.

Regarding ACCME's SCS, there seemed to be a systemic problem with obtaining or maintaining signed agreements for commercial support and documenting that disclosure occurred.

IMPROVEMENTS MADE AFTER 2003

One of the first improvements made was to change the RSC application form so that more materials on the planning process would be collected upfront. This enabled us to be more confident that Elements 2.1 and 2.2 would be in compliance. We also gave 4 in-service training sessions for CME coordinators involved with each department's series to help ensure they understood what the ACCME requirements were. We began auditing sessions to ensure that disclosure did occur. In addition, we decided we needed to sample from more sessions for series in which we noted problems with ACCME's SCS. A copy of the revised evaluation form is included in the self study report for Element 2.1.

CONCLUSIONS – REGARDING 2004 RSCs:

We were pleased to see that our changes resulted in improvements, in most cases. Sporadic compliance problems occurred, which were handled by the CME committee chair and department chair for the series. Disclosure problems were detected from observation. Disclosure was occurring, but not properly. The moderators in two series were only announcing the name of the faculty member who disclosed a relationship. The type of relationship and the name of the company were not announced.

IMPROVEMENTS MADE AFTER 2004

We developed a script for moderators to use that included exactly what needed to be disclosed to the audience and the CME coordinator from each department is responsible for ensuring that the CME department receives a copy of the script. A copy of the script is included in the self study report for Element 2.5. Noting that most problems with obtaining compliance had been addressed, the CME committee decided to focus training and processes to obtain exemplary compliance. Multiple needs data sources for each RSC were expected to be submitted with each application. The CME Manager worked with each department to decide which series focused on physician performance or patient health status changes so that objectives and evaluations could be structured accordingly. Each series flyer was approved by the CME Manager to ensure that the objectives clearly articulated the physician performance or health status change that should be impacted as a result of the activity.

CONCLUSIONS – REGARDING 2005 RSCs:

We were very excited to see that our monitoring system revealed 100% compliance throughout our RSC activities. Our efforts to achieve exemplary compliance resulted in much success. Our training for CME coordinators continues, which we believe has contributed to compliance for all RSCs.

PLANNED IMPROVEMENTS:

We plan to add training sessions for physicians involved in the planning and presentation of RSCs. We have noticed some turnover in the group of physicians who normally are involved so we think it is prudent to provide for training for new and experienced physicians involved in our CME program. We plan to maintain our observations to help ensure that our scripts for moderators are being used consistently and that there are no problems with disclosure.

LEARNER PARTICIPATION:

Verification of physician participation is maintained in a database. When a physician attends an RSC session, he/she completes an evaluation form that asks for the physician’s name. When the evaluation forms are submitted to the CME office, a CME coordinator enters the name of the physician into the record of the CME activity. If a physician needed the CME office to verify participation, we could run a report that would include the physician’s name, activity title, date of activity, and hours of participation.

LIST OF COMMERCIAL SUPPORTERS FOR ABC MEDICAL SCHOOL'S RSCs – ALL YEARS

Pediatric Grand Rounds
ABC Pharmaceuticals
National Drug Company

Internal Medicine Grand Rounds
XYZ Pharmaceutical Company

Surgery Grand Rounds
Best Devices, Inc.
Universal Instrument Company
New Tomorrow Catheter Company

OB-GYN Grand Rounds
ABC Pharmaceuticals
National Drug Company

Tumor Board, Psychiatry Grand Rounds, Cardiac Cath Conference, Imaging Grand Rounds
No commercial supporters

ABC Medical School Monitoring System Analysis

	RSC Series	# of Sessions in Series	2.1	2.2	2.3	2.4		# of Sessions sampled	3.1	3.3 SCS 1	3.3 SCS 2	3.3 SCS 3	3.3 SCS 4	3.3 SCS 5	3.3 SCS 6
2003															
	Tumor Board	10	C	C	C	N		3	C	C	NA	N	C	C	N
	M & M Conference	10	C	C	C	N		2	C	C	NA	N	C	C	C
	Surgery Grand Rounds	50	P	N	N	C		5	C	C	NA	C	C	C	C
	Internal Medicine Grand Rounds	50	P	N	C	C		5	C	C	NA	C	C	C	C
	Pediatric Grand Rounds	50	C	C	C	C		5	C	C	NA	N	C	C	N
	Psychiatry Grand Rounds	50	P	P	C	C		5	C	C	NA	C	C	C	N
	Cardiac Cath Conference	10	C	C	C	C		1	C	C	NA	N	C	C	N
	OVERALL COMPLIANCE		**P**	**P**	**C**	**C**		**OVERALL COMPLIANCE**		**C**	**NA**	**N**	**C**	**C**	**N**
2004															
	Tumor Board	10	C	C	C	C		5	C	C	NA	C	C	C	N
	M & M Conference	10	C	C	C	C		2	C	C	NA	C	C	C	C
	Surgery Grand Rounds	50	C	C	C	C		10	C	C	NA	C	C	C	C
	Internal Medicine Grand Rounds	50	C	C	C	C		10	C	C	NA	C	C	C	C
	Pediatric Grand Rounds	50	C	C	C	C		10	C	C	NA	C	C	C	C
	Psychiatry Grand Rounds	50	C	C	C	C		5	C	C	NA	C	C	C	C
	Cardiac Cath Conference	50	C	C	N	C		5	C	C	NA	C	C	C	C
	Imaging Grand Rounds	12	C	C	C	C		2	C	C	NA	C	C	C	N
	OVERALL COMPLIANCE		**C**	**C**	**C**	**C**		**OVERALL COMPLIANCE**	**C**	**C**	**NA**	**C**	**C**	**C**	**N**
2005															
	Tumor Board	10	C	E	E	E		10	C	C	C	C	C	C	C
	M & M Conference	10	C	E	E	E		2	C	C	C	C	C	C	C
	Surgery Grand Rounds	50	C	E	C	C		10	C	C	C	C	C	C	C
	Internal Medicine Rounds	50	C	E	E	E		5	C	C	C	C	C	C	C
	Pediatric Grand Rounds	50	C	E	C	C		5	C	C	C	C	C	C	C
	Psychiatry Grand Rounds	50	C	E	C	C		5	C	C	C	C	C	C	C
	Cardiac Cath Conference	50	C	E	E	E		5	C	C	C	C	C	C	C
	Imaging Grand Rounds	12	C	E	E	E		5	C	C	C	C	C	C	C
	OVERALL COMPLIANCE		**C**	**E**	**E**	**E**		**OVERALL COMPLIANCE**	**C**	**C**	**C**	**C**	**C**	**C**	**C**

ACCME RSC Toolkit
Example #2
Page 4 of 4

EXAMPLE #3
Good Health System Monitoring System Report

Prior to the implementation of ACCME's RSC policy, Good Health System (GHS) had already decided to begin monitoring its RSCs in 2003 through a system separate from our internal RSC application process. The materials staff and CME committee members reviewed as part of the monitoring system included (1) planning meeting minutes; (2) letters to faculty; (3) flyers; (4) written agreements for commercial support; (5) evaluation tools; (6) moderator notes; and (7) other evidence that disclosure occurred, if disclosure was not done verbally (slide copies; syllabus materials, etc). In addition, staff and CME committee members audited via observation at least one session from each series each year in 2004 and 2005. We chose to collect data on our compliance with ACCME's Elements via sampling from at least 10% of sessions within different series.

Compliance findings for Elements 2.1-2.4 and 3.1 were based on staff and committee members' reviews of planning, meeting materials, and evaluation methods at the **series** level because each series is planned and implemented as one activity. All series were reviewed. We used ACCME's criteria for compliance and utilized ACCME's documentation review form. In the table, E = Exemplary; C = Compliance; P = Partial; N = Noncompliance. To make our final conclusions on compliance, we applied the following standard: Compliance = Met ACCME's expectation ≥ 80% of the time; Partial Compliance = Met ACCME's expectation 51 -79% of the time; Non Compliance = Meeting ACCME's expectation ≤50% of the time.

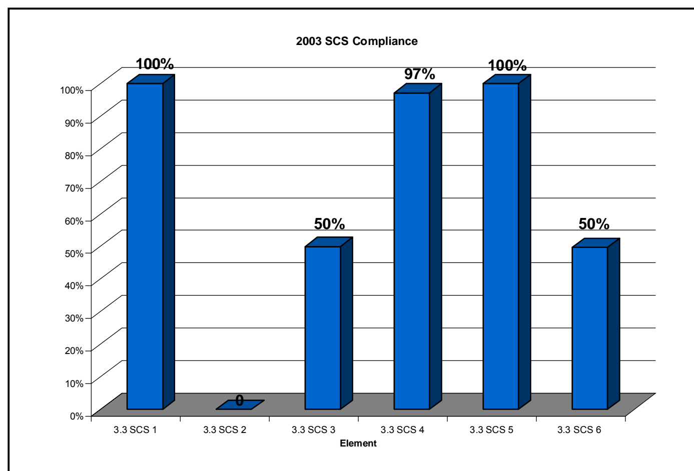
Compliance findings for ACCME's SCS were based on **session** level data to ensure that each session adhered to ACCME's requirements for commercial support and disclosure. We called the ACCME to determine what parameters should be used to determine compliance. Based on ACCME's feedback, we used the following scale: ≥80% =Compliant (C); <80%=Non Compliance (NC)

GHS Compliance Level - 2003

RSC Series	**# of Sessions in Series**	**2.1**	**2.2**	**2.3 & accred statement**	**2.4**	**3.1**
Tumor Board	10			C	N	C
M & M Conference	10			C	N	C
Surgery Grand Rounds	50	P	N			
Internal Medicine Grand Rounds	50	P	N			
Pediatric Grand Rounds	50			C	C	C
Psychiatry Grand Rounds	50	P	C		C	C
Cardiac Cath Conference	10	C	C	C	C	C
OVERALL COMPLIANCE		**P**	**N**	**C**	**P**	**C**

A review of our 2003 data revealed that our planning processes for several RSC series would not meet ACCME's expectations. While applications had been approved for the series, there was little to no back-up for those applications to support compliance with Elements 2.1 and 2.2. We noticed that there was little evidence of what planning process was used and how needs data were used. In addition, evaluation of the effectiveness of the activities had not occurred in two series.

Regarding ACCME's SCS, there seemed to be problems with obtaining or maintaining signed agreements for commercial support and documenting that disclosure occurred. We chose to sample all of our series for Element 3.3. With respect to signed letters of agreement, four RSC series received commercial support (Surgery, Internal Medicine, Cardiac Cath, and Pediatrics). A list of the commercial supporters is attached. Two RSC files had all signed agreements with the appropriate signatures. One had the agreements without a commercial supporter signature. One had only one of the three agreements that were necessary.



SCS Standard 2 was not applicable in 2003, so it appears on the graph at 0%.

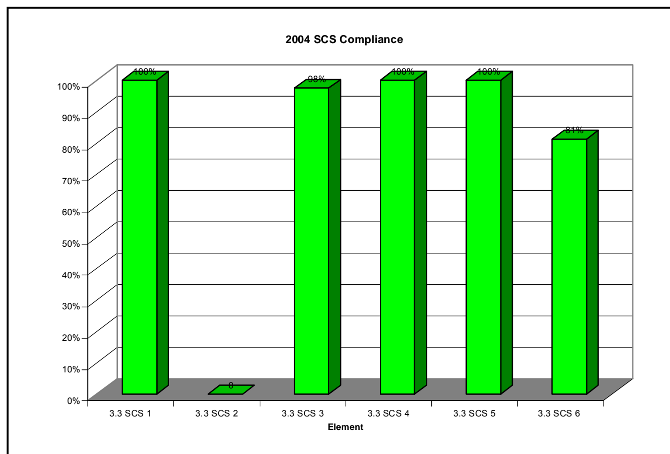
Improvements after 2003

One of the first improvements made was to change the RSC application form so that more materials on the planning process would be collected upfront. This enabled us to be more confident that Elements 2.1 and 2.2 would be in compliance. We also gave 4 in-service training sessions for CME coordinators involved with each department's series to help ensure they understood what the ACCME requirements were. We began auditing sessions to ensure that disclosure did occur. In addition, we decided we needed to sample from more sessions for series in which we noted problems with ACCME's SCS. A copy of the revised evaluation form is included in the self study report for Element 2.1.

GHS 2004 Compliance Levels

	# of Sessions in Series	2.1	2.2	2.3	2.4	3.1
Tumor Board	10				C	C
M & M Conference	10			C	C	C
Surgery Grand Rounds	50	C	C			
Internal Medicine Rounds	50	C	C			
Pediatric Grand Rounds	50	C	C			
Psychiatry Grand Rounds	50	C	C			
Cardiac Cath Conference	50	C	C	N	C	C
Imaging Grand Rounds	12			C	C	C
Overall Compliance		C	C	P	C	C

To determine compliance with Element 3.3, we chose to sample all SCS Elements in the series that had commercial support (Surgery, Internal Medicine, Cardiac Cath, Imaging and Pediatrics). Each series had four commercial supporters. There was only one series that had a problem. The Cardiac Cath file did not have one of the four written agreements needed.



When we drew our conclusions, we were pleased to see that our changes resulted in improvements, in most cases. Sporadic compliance problems occurred, which were handled by the CME committee chair and department chair for the series. Disclosure problems were detected from observation. Disclosure was occurring, but not properly. The moderators in two series were only announcing the name of the faculty member who disclosed a relationship. The type of relationship and the name of the company were not announced.

SCS Standard 2 was not applicable in 2004.

Improvements after 2004

We developed a script for moderators to use that included exactly what needed to be disclosed to the audience and the CME coordinator from each department is responsible for ensuring that the CME department receives a copy of the script. A copy of the script is included in the self study report for Element 2.5. Noting that most problems with obtaining compliance had been addressed, the CME committee decided to focus training and processes to obtain exemplary compliance. Multiple data sources for each RSC were expected to be submitted with each application. The CME Manager worked with each department to decide which series focused on physician performance or patient health status changes so that objectives and evaluations could be structured accordingly. Each series flyer was approved by the CME Manager to ensure that the objectives clearly articulated the physician performance or health status change that should be impacted as a result of the activity.

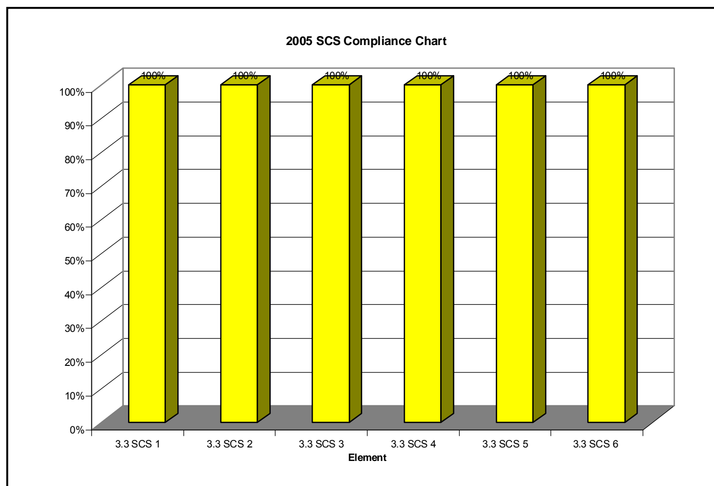
GHS 2005 Compliance Levels

Going into 2005, we chose to sample all series for all Elements to truly see how well each series was achieving exemplary compliance.

`		# of sessions	2.1	2.2	2.3	2.4	3.1
	Tumor Board	10	C	E	E	E	C
	M & M Conference	10	C	E	E	E	C
	Surgery Grand Rounds	50	C	E	C	C	C
	Internal Medicine Grand Rounds	50	C	E	E	E	C
	Pediatric Grand Rounds	50	C	E	C	C	C
	Psychiatry Grand Rounds	50	C	E	C	C	C
	Cardiac Cath Conference	50	C	E	E	E	C
	Imaging Grand Rounds	12	C	E	E	E	C
OVERALL COMPLIANCE			**C**	**E**	**E**	**E**	**C**

To determine compliance with Element 3.3, we chose to again sample all SCS Elements in the series that had commercial support (Surgery, Internal Medicine, Cardiac Cath, Imaging and Pediatrics). Each series had four commercial supporters. All letters of agreement were present in each file.

We were very excited to see that our monitoring system revealed 100% compliance throughout our RSC activities! Our efforts to achieve exemplary compliance resulted in much success. Our training for CME coordinators continues, which we believe has contributed to compliance for all RSCs.



Planned Improvements

We plan to add training sessions for physicians involved in the planning and presentation of RSCs. We have noticed some turnover in the group of physicians who normally are involved so we think it is prudent to provide for training for new and experienced physicians involved in our CME program. We plan to maintain our observations to help ensure that our scripts for moderators are being used consistently and that there are no problems with disclosure

Learner Participation

Verification of physician participation is maintained in a database. When a physician attends an RSC session, he/she completes an evaluation form that asks for the physician's name. When the evaluation forms are submitted to the CME office, a CME coordinator enters the name of the physician into the record of the CME activity. If a physician needed the CME office to verify participation, we could run a report that would include the physician's name, activity title, date of activity, and hours of participation.

EXAMPLE #4
East Medical School's Monitoring System Report

East Medical School's Monitoring System ensures 100% compliance with ACCME Essential Areas, Elements, and Policies. ACCME's Criteria for Compliance are used as the reference point to determine compliance. East Hospital has used several of ACCME's surveyor tools to help assess compliance.

Our Process
On a yearly basis, the CME staff retreat is held. During the retreat, approximately 20% of our RSC session files from our 15 series are pulled. Of the 15 series, 13 are held weekly (50 sessions) and two are held monthly (10 sessions). The CME director and two CME coordinators complete ACCME's Documentation Review Forms for CME Activities as we reviewed the files. For the past four years, all files demonstrated 100% compliance.

We believe our files demonstrate compliance because of the rigorous application used to approve RSCs. East Hospital requires each department or area in the hospital that would like to offer a RSC to submit an RSC CME application form to the CME department. The CME Director reviews each application to ensure compliance with all ACCME Elements. The application asks for information about use of needs data, planning process(es), how objectives will be made known, how the activity will be evaluated, how disclosure will be made known, and how commercial support funds will be managed, if commercial support is received. The application also asks for the names and contact information for the faculty. A budget is required.

The CME director tentatively approves an application if the information provided describes practices that would demonstrate compliance with ACCME's requirements. The CME director sends a packet of materials, including instructions on implementing mechanisms to identify and resolve conflicts of interest, to the department or area offering the RSC. The department can send out faculty invitations and confirmation letters, but disclosure forms are returned to the CME department.

Once the CME department receives a disclosure form from an RSC faculty, a CME coordinator reviews the form to see if the faculty member disclosed any relevant financial relationships. If any relevant financial relationships are disclosed, the CME director contacts the department offering the RSC to inform them of the need to implement a mechanism to resolve the conflict of interest. Depending on the nature of the conflict, the content of the CME activity and East Hospital's experience with the faculty member, an appropriate mechanism is implemented. In the past, East Hospital has used the following mechanisms in its RSC activities:

1. Letters informing faculty of expectations regarding any recommendations regarding patient care
2. Letters informing faculty of the need to disclose the level of evidence behind the recommendations given
3. Review of outlines of presentations
4. Review of slide copies
5. Removal of faculty from position

In most instances, #s 1 and 2 were used with success. There have only been a few occurrences when it was decided #3 or #4 was necessary. Only one faculty member was removed from an RSC activity.

The department or area is then required to submit promotional materials to the CME department for review and approval. This process enables the CME department to check for communication of purpose or objectives, use of accreditation statement, and acknowledgement of commercial support (if this is known at the time of printing the piece). The CME department works to make adjustments to the promotional pieces, if necessary.

Planning sheets are required to be submitted on an ongoing basis to the CME department so that the CME director can ensure that all decisions are made free of the control of a commercial interest.

The CME department works to secure written agreements if there is commercial support. The written agreements are maintained in the CME office.

A CME coordinator assists each department or area in developing a participant evaluation form. The form includes disclosure of relevant financial relationships. The form is handed out at the beginning of the session.

Moderator notes sheets are given to the moderator of each RSC session that script the announcements that must be made. It is the practice of East Hospital to disclose relevant financial relationships both verbally and in writing.

Evaluation forms, signed moderator sheets, attendance rosters, and handouts are turned into the CME office no later than 48 hours after a RSC session. As soon as it is available, a copy of the RSC session income and expense statement is sent to the CME department. Attendance, based on the rosters, is entered into the CME department's activity database that allows East Hospital to verify physician participation. An attendance form can be generated as evidence of attendance, if needed.

Once all documentation is present, the RSC session folder is considered complete. All folders are maintained in the CME department.

Improvements

One area we plan to improve upon is the opportunity for departments to demonstrate exemplary compliance. We recognized during the review process that our application and monitoring process does not offer a very good opportunity for us to demonstrate how certain RSCs are really in exemplary compliance. We plan on modifying our application and creating a system to allow us to track RSCs that we think would qualify for exemplary compliance with an Element.

NOTE: A copy of the list of the commercial supporters for our RSCs for each year of our term is attached.