Request for SCVMC Continuing Medical Education (CME) - Category I Credit

INSTRUCTIONS

1. **Ensure your request meets the definition for CME below:**

Definition of CME

The California Legislature (Business and Professions Code Section 2190-2196.7) defines CME as follows:
The Continuing medical education standard of section 2190 may be met by educational activities that meet the standards of the Division of Licensing and serve to maintain, develop or increase the knowledge, skills, and professional performance that a physician or surgeon uses to provide care, or improve the quality of care provided for patients, including, but not limited to, educational activities that meet any of the following criteria:

1. Have a scientific or clinical content with a direct bearing on the quality or cost-effective provision of patient care, community or public health, or preventive medicine
2. Concern quality assurance or improvement, risk management, health facility standards, or the legal aspects of clinical medicine
3. Concern bioethics or professional ethics
4. Designed to improve the physician/patient relationship

The definition expressly excludes: Educational activities that are not directed toward the practice of medicine, or are directed toward the business aspects of medical practice, including, but not limited to, medical office management, billing and coding, and marketing.

Examples of Courses Eligible for CME According to California Legislature

CME committees may consider courses related to the following as eligible:

- Quality assessment and clinical outcome measurements
- Risk management relative to preventive care
- The evolving role of physicians in managed care, (i.e., leadership, management/administration, policy development)
- Various organizational models - how they work; steps required to develop a model and physicians' roles in them

Examples of Courses Ineligible for CME According to California Legislature

CME committees should not consider courses related to the following as eligible:

- Medical office management in integrated healthcare delivery/group practice arrangements
- Marketing of integrated delivery systems/group practice arrangements
- Understanding corporate structure from a financial or legal perspective

IMQ Note: Under California law, courses on the coding aspects of ICD-10 do not qualify for CME credit. ACCME and some accrediting organizations outside of California do award CME credit for activities on billing and coding, such as ICD-10. However, any provider based in California and offering CME activities for California licensed physicians, cannot award *AMA PRA Category 1 Credit(s)*™ for a course covering billing and coding topics. CME credits may be awarded for any portion of the content that is focused on patient care and not financially related. If you have any questions about course content that is eligible for CME credit, please contact the IMQ/CMA CME Accreditation Program Office.

2. **Complete the Appropriate CME Program Planning Request:**

a) Refer to the Checklist provided
b) For a NEW Conference, a NEW Regularly Scheduled Series (RSS) e.g. Grand Rounds, Journal Club, M&M, Tumor Board and the annual Renewal of RSS complete the Planning Request Form;
c) For the Annual RSS Renewal of a previously approved, include the below:

1) Completed Program Planning Request
2) Summary Analysis for previous year
3) Completed and Signed Disclosure Forms
4) SCMVC RSS Worksheet for previous year

d) Submit your completed application and attachments (via email preferred, or hard copies) to:

SCVMC, Medical Staff Office, Cynthia Lopez, 751 S. Bascom Avenue, Room #7C081 San Jose, CA 95128 408/885-5109, cynthia.lopez@hhs.sccgov.org

e) DO NOT advertise Category I credit until you have received the approval from the CME Committee. CMA does not allow the use of such statements as "CME applied for" or "CME approval pending".

f) Your program request will be submitted to the CME Committee for review. If your program qualifies for Category I credit, you will receive:

- Approval via a copy of the approved application
- CMA/CME Logos to use (if requested)

Department CME document requirements:

- Each department must keep a record of M.D.'s annual hours of CME attended.
- Original signature sign-in sheets must be maintained in the department for six years.
- A written record of how the program was evaluated must also be kept for six years. For example: evaluation forms, questionnaires, etc.
- Use the results of program evaluations in the development of future programs.

Submission of Requirements:

- For new CME activity or regional conference, please submit your request at a minimum of **3 months prior** to the next CME Committee meeting.
- For a new RSS submit at a minimum of 3 weeks before next CME committee meeting.
- For RSS in the form of annual reporting (who has previously approved CME credits for RSS), please submit **2 weeks prior** to scheduled reporting month.
- **Requests not submitted in a timely manner will be declined.**

Commercial support:

- Speakers must complete the Disclosure for Commercial Support form for **each activity request**. The form must be submitted with the Planning Request.
- Relationships with commercial supporters shall be disclosed to participants prior to educational activities in brief statements in conference materials such as brochures, syllabi, exhibits, poster sessions, and any post-meeting publications or made they the moderator of the activity.
- To ensure any conflict of interests are resolved prior to the activity, presentation of all educational activity (including but not limited to PowerPoint presentation or interactive sessions) are suggested to undergo peer review to ensure the any conflict interests of planners or speakers has been resolved.

- Any unrestricted education grants must be deposited through the VMC Foundation and a written agreement completed and submitted with the request. Please refer to the VMC Policy #154.02 CME Standards for Commercial Support. (provide upon request)

- Any questions regarding the application request may be directed to Medical Staff Office, Cynthia Lopez at x55109

Describing the Practice Gap(s): Criteria-2 The provider incorporates into CME activities the educational needs (knowledge, competence, or performance) that underlie the professional practice gaps of their own learners

What practice needs to be improved? (What problem are we trying to solve?)
This is the "professional practice gap," defined as the difference between 1) currently observed health care performance/outcomes and 2) those potentially achievable on the basis of current professional knowledge and standards of care.

Example:
1. Description of current practice:
   a. Despite the fact that prophylactic mechanical and pharmacologic interventions have been shown to decrease the rate of VTE (venous thromboembolism) only one-third of all patients at risk for VTE who are appropriate candidates receive such therapy.
2. Description of desired or achievable practice
   a. All eligible patients should receive prophylaxis.
3. The Practice Gap is the 2/3 of eligible patients who don't receive in-hospital VTE prophylaxis but should.

Reference: National Quality Forum: National Voluntary Consensus Standards for Prevention and Care of Venous Thromboembolism: Policy, Preferred Practices, and Initial Performance Measures.
http://www.premierinc.com/safety/topics/Venous-Thromboembolism/downloads/5_NQF-VTE-Vote-draft22707b.pdf. Accessed 6-22-10
While practice gaps may seem unavailable for many activities, there are actually a surprising number that are available that can direct planning.

Identifying the Practice Gap (sources)
QA (quality assurance), QI (quality improvement), or PI (performance improvement) data / initiatives from your own department or campus. This is an ideal source for internal education programs such as Grand Rounds, which are directed towards the learners within your department or institution.

"Never Events:" The 2006 NQF report reflects consensus on a list of unambiguous, serious, preventable adverse events. The events on the list are identifiable and measurable, and the risk of occurrence of these events is significantly influenced by the policies and procedures of healthcare organizations. (28 reportable events -link to pgs 15-24) (Full report - link to full report)

Reported Quality Measures: This file contains 367 reported quality measures by Moffit hospital (link to file). The rates of these quality measures for Moffit and nationally can be found

Society Guidelines, Clinical Policies, and Practice Recommendations: These describe optimal or potentially achievable health care performance. While they *do not necessarily* define practice gaps, they often include descriptions of current practice or practice gaps.

The literature can provide a source of the Practice Gap when the above sources are not pertinent. To improve physician competence in the diagnosis of aortic dissection, the literature provides evidence that an estimated 38% of acute aortic dissections are missed on initial evaluation, which provides the practice gap for this competence.

- Sutherland A, et al. Ann Emerg Med. Oct 2008;52(4):339-43.
- Spittell PC, et al. Mayo Clin Proc. Jul 1993;68(7):642-51.
- von Kodolitsch Y, et al. Am J Med. Jan 15 2004;116(2):73-7.

In the rare cases where there is no data from the above sources or literature, expert experience can provide additional evidence of a gap, such as a description of frequent referrals of patients who have been misdiagnosed.

How Many Gaps?

Educational programs, such as a 3 day live course or a weekly grand round series, often contain multiple areas of instruction. In addition, topic selection may continue after the credit request is submitted, as for Grand Rounds or Performance Improvement conference. The goal of the credit request is to have one or more practice gaps addressed by the program. A practice gap does not need to be defined for every lecture or meeting of a multi-meeting series/course

Identify the Educational Need(s):

What improvement is needed to "close the gap?" (Why does the gap exist?)

Examples:

- **Knowledge improvements** may be needed to close the gap, such as the fact that VTE is a reported quality measure and prophylaxis decreases VTE events, or a description of organizational approaches that are associated with improved compliance (ref: National Quality Forum: National Voluntary Consensus Standards for Prevention and Care of Venous Thromboembolism: see above)

- **Competence improvements** (the application of knowledge) may be needed to close the gap, such as the ability to select the appropriate medication for individual patients, skills to implement prophylaxis in different clinical settings, the ability to counsel patients, or the ability to work in teams and advocate for organizational change

- **Performance improvements** may be needed to close the gap, such as system changes to elicit desired behaviors (electronic reminders , preprinted orders, etc..)

Identify the Desired Outcome(s):

The desired outcome is what you will *actually* measure after your activity. These should link directly to your Practice Gap. At a minimum, the goal of your activity should be improved competence. Note that while improved knowledge can be an educational need utilized to close the gap, improved knowledge is not considered by the current accreditation system to be a sufficient outcome. Only include the type of outcome that you plan to actually monitor.

Examples of desired CME activity outcomes:

- **Competence**: Such as the ability to identify patients eligible for prophylaxis, the ability to counsel patients, or ways to advocate for organizational change

This can be measured at the end of the course by intent to change surveys
or testing using clinical scenarios

- **Performance**: such as an increase in the number of eligible patients receiving

prophylaxis through implementation of changes such as reminders, or pre-printed order sets.

This can be measured subsequent to the course by a follow up performance survey

- **Patient Outcomes:** Such as decreased rates of VTE or death

This is measured subsequent to the course with follow up reporting of changes in patient data, for example with chart audits, or department or hospital performance improvement data.

Objectives

Describe the objectives for each presentation. Remember, these need to be linked to your identified practice gaps when appropriate and written to reflect the desired outcomes in competence, performance, or patient outcomes. Examples include:
Describe and implement current guidelines for VTE prophylaxis
Perform an effective problem-focused history and physical examination for evaluation of eligibility for VTE prophylaxis
Describe and implement systems which have been shown to increase selection accuracy and improve rates of implementation for VTE prophylaxis

New Cultural and Linguistic Policy

The provider must be in compliance with all California State laws regarding continuing medical education, including Assembly Bill 1195, effective July 1, 2006. The following policy applies to non- exempt CME activities and addresses the essential elements for compliance with Assembly Bill 1195. This policy was updated and approved by the Boards of CMA and IMQ in July and August 2013.

Effective September 26, 2014, AB 496 was approved as an amendment to AB 1195, the existing rule that serves as the basis for the IMQ/CMA Cultural and Linguistic Policy for CME-accredited organizations. As a result, Section 2190.1 of the Business and Professions Code expands the definition of cultural competency as follows:

> *(D) Understanding and applying cultural and ethnic data to the process of clinical care, including, as appropriate, information pertinent to the appropriate treatment of, and provision of care to, the lesbian, gay, bisexual, transgender, and intersex communities.*

Element 3.2.1 The provider must be in compliance with all California State laws regarding continuing medical education, including Assembly Bill 1195, effective July 1, 2006. Provider meets or exceeds minimum requirements of AB 1195 by the following:

a) Determine for each planned CME activity with a clinical care focus, if there are cultural or linguistic health disparities relevant to the targeted physician learners and/or their patient community. If no relevant cultural or linguistic health or health care disparities are identified, this should be documented.
b) When a relevant cultural or linguistic health disparity is identified, generate at least one educational component to address the specific need(s) related to the educational activity.

Note: In compliance with California law, relevant Cultural and Linguistic disparities need to be addressed in one or more sessions within a Regularly Scheduled Series (RSS).

Note: IMQ/ has always interpreted cultural and linguistic competence as more than language or ethnicity. With the introduction of AB 1195, IMQ instructional materials recommended gender and sexual orientation as disparities to be considered when developing clinical CME activities. Therefore, compliance with AB 496 should be easy for IMQ/CMA-accredited CME provider