***FORM CMERSS-1***

**OFFICE OF CONTINUING MEDICAL EDUCATION**

**6 MONTH RSS REPORT**

**January 1, 2019 – June 30, 2019**

 (This report is due in the CME office no later than **July 31, 2019)**

*Please submit one hard copy of the report and attachments. In addition, please email an electronic copy (in word format) of the evaluation summary to cme@med.cornell.edu*

**Department:**

**Title of Activity:**

**Course Director:       / e-mail**

**Coordinator:       / e-mail**

**Date of Activity: January 1, 2019 – June 30, 2019**

**Location:**

|  |
| --- |
| **Course Director Section** |

[ ]  I attest to the accuracy of this information.

[ ]  I understand that I must retain activity records/files for all sessions for at least six years.

[ ]  I have shared evaluation data with faculty for this activity.

[ ]  I attest that at least 2 sessions directly related to Quality Assurance and Patient Safety issues were included in this RSS during this reporting period. I verify that an assessment of Quality and Patient safety needs has been performed and that the curriculum for this activity includes activities aimed at addressing deficiencies and closing quality gaps.

|  |  |
| --- | --- |
| **INTERPROFESSIONAL CME - PLANNERS**As per new ACCME guidelines, whenever possible members of interprofessional teams should be engaged in the **planning** of CME activities that are intended to improve interprofessional clinical care. Please indicate which professions were involved as planners in this activity (**Select 2 or more**):[ ]  Physicians[ ]  Medical Students[ ]  Graduate House staff[ ]  Psychologists [ ]  Physician Assistants [ ]  Nurses [ ]  Nurse Practitioners [ ]  Medical Students [ ]  Social Workers [ ]  Physical Therapists [ ]  Pharmacists [ ]  Patients[ ]  Nutritionists [ ]  Public health Professionals [ ]  Other (specify):       | **INTERPROFESSIONAL CME - EDUCATORS**As per new ACCME guidelines, whenever possible members of interprofessional teams should be engaged in the **delivery** of CME activities. Please indicate which professions were involved as teachers or educators at this activity (**Select 2 or more**):[ ]  Physicians[ ]  Medical Students[ ]  Graduate House staff[ ]  Psychologists [ ]  Physician Assistants [ ]  Nurses [ ]  Nurse Practitioners [ ]  Medical Students [ ]  Social Workers [ ]  Physical Therapists [ ]  Pharmacists [ ]  Patients[ ]  Nutritionists [ ]  Public health Professionals [ ]  Other (specify):       |

**COURSE DIRECTOR’S Signature**:

|  |  |
| --- | --- |
|       |   |
| **Print Name** |  | Date |
|  |  |  |
| **Signature** |  |  |

 (By signing, you verify that you have reviewed and approved this CME report.)

**REQUIRED DATA**

**January 1, 2019 – June 30, 2019**

The following are required documentation for all WCM RSS’s for 01/01/2019-06/30/2019.

 Attached?

1. Attendance Summary [ ]  Yes [ ]  No
2. List of Sessions (Dates/Topics/Speakers) [ ]  Yes [ ]  No
3. CME Information Page for each session [ ]  Yes [ ]  No

 3a. Full Disclosure Forms for each presenter [ ]  Yes [ ]  No

 3b. CD/ICR COI Form for each speaker, as required [ ]  Yes [ ]  No [ ]  N/A

 3c. CD/ICR COI Form for Individual Speakers, if applicable [ ]  Yes [ ]  No [ ]  N/A

4. Evaluation Data and Summary [ ]  Yes [ ]  No

5. Budget Summary [ ]  Yes [ ]  No

**ATTENDANCE SUMMARY**

**January 1, 2019 – June 30, 2019**

A. Total # of sessions

B. Total # credits approved per session (e.g. 1, 1.5)

C. Total hours of instruction (A x B)

D. Total # of MD hours

*Multiply the number of MDs attending by the number of sessions attended.*

*(e.g. Dr. X attended 12 sessions for one hour each. This equals 12 attendee hours. Add totals for all MD’s.)*

E. Total # of NonMD hours

 *Multiply the number of nonMDs attending by the number of sessions attended.*

 *(e.g. Dr. X attended 12 sessions for one hour each. This equals 12 attendee hours. Add totals for all nonMD’s.)*

Please attach a summary of attendance spreadsheet documenting the names of attendees, dates of attendance and total hours of attendance for this activity for January 1, 2019 to June 30, 2019.

F. Summary of Attendance Spreadsheet attached? [ ]  Yes [ ]  No

Reviewed and approved by OCME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPENDIX A**

Attendance Spreadsheet

Please attach here

**LIST OF SESSIONS**

**January 1, 2019 – June 30, 2019**

**Total # of Sessions:**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | *2, 3, or 4 attachments required per session****Attachment Attachment Attachment Attachment*** |
| Date | Speaker(Include Name,Academic Titleand Affiliation) | Topic | CME InformationPage *(please**submit clear**Copies)*  | Full Disclosure Form *(please**submit clear**Copies)* | CD/ICR COI ResolutionForm *(required**for anyone with**industry**relationship)* | CD/ICR COI Form for For IndividualSpeakers*(when required by* *CME Office)* |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |
|  |  |  | [ ]  Yes | [ ]  Yes | [ ]  Yes [ ]  N/A | [ ]  Yes [ ]  N/A |

**APPENDIX B**

Please attach chronologically:

CME Information Page (Form CMERSS-4)

Full Disclosure Form (Form CME-A)

Course Director/ICR Documentation of COI Resolution Form for each session (Form CME-B) *– if applicable*

Course Director/ICR COI Resolution Form for Individual Speakers – *if applicable*

**Please make sure that all submitted copies are clear and legible**

Reviewed and approved by OCME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EVALUATION DATA**

**January 1, 2019 – June 30, 2019**

A. Number of attendees surveyed

B. Total # of evaluations collected for this report

C. Response Rate      %

*(>50% response rate required)*

Please attach the evaluation summary for this activity for January 1, 2019 to June 30, 2019.

Evaluation summary attached? [ ]  Yes [ ]  No

Reviewed and approved by OCME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EVALUATION SUMMARY**

**January 1, 2019 – June 30, 2019**

***(Please hand in one hard copy and one electronic copy of this summary)***

A. Did participants feel the activity was free of commercial bias or influence? # Yes # No

 Please describe any concerns and identify the presenter(s) and presentation title(s):

B. Did participants feel the activity was scientifically sound, evidence-based, objective, and balanced? # Yes # No

 Please describe any concerns and identify the presenter(s) and presentation title(s):

C. Please indicate the extent to which participants felt this series will enhance their performance as a physician in the following areas of medical competence:

 1. Medical Knowledge (e.g. Biomedical, clinical, epidemiological, and social sciences):

 **Average Score of all responses:**

**List areas of enhanced knowledge participants stated they gained from this series:**

Bottom of Form

 2. Diagnostic and Treatment Strategies – Competence (e.g. New evidence, evidence-based practice recommendations):

 **Average Score of all responses:**

 **List diagnostic or treatment strategies participants stated they would be likely to implement in their practices.**

 3. Professionalism and Effectiveness with Patients and Care Teams – Performance (e.g. Interpersonal skills, identification of different patient values and needs, medical informatics).

 **Average Score of all responses:**

**List patient care and management strategies participants stated they would be likely to implement in their practices:**

Bottom of Form

4. Quality and patient safety – Patient Outcomes (e.g. Identification of opportunities for clinical improvement, evaluation of patient care systems, quality improvement methodology).

 **Average Score of all responses:**

**List continuous quality improvement strategies participants stated they would be likely to implement in their practices:**

Bottom of Form

D. Please list topics participants stated they would like to see covered in future series at Cornell that would improve this activity.

Bottom of Form

E. If participants have any other comments or concerns about this series please describe below:

**BUDGET SUMMARY**

**January 1, 2019 – June 30, 2019**

***1. TOTAL REVENUE (INCOME)***

Sources of Revenue/Income:

 A. Departmental Funding $

 B. Other Support$

 ***TOTAL REVENUE/INCOME*** $

***2. TOTAL EXPENSES***

A. Speaker Honoraria (list each speaker):

       $

       $

       $

       $

       $

 **TOTAL HONORARIA** $

B. Faculty housing, travel, meals, misc. $

C. Meals/Coffee Breaks $

D. Other Expenses: (please list)      $

 ***TOTAL EXPENSES*** $      \*

 ***NET INCOME/LOSS*..............$** **\***

*(Calculation: income minus expenses)*

*\* Expense must be offset by either Departmental or other income.*

*\* Negative balances are not acceptable.*

**January 1, 2019 – June 30, 2019 : Criteria for Accreditation with Commendation**

**Department:**

**Title of Activity:**

**Course Director:       / e-mail**

**Coordinator:       / e-mail**

In order to maintain our current ACCME accreditation status, we are required to provide documentation that our RSS program (e.g. Grand Rounds, Clinical Case conferences, etc.) fulfills certain educational criteria.  As such, please review your curriculum for the 6 month period and respond to the following questions. Please provide examples of each where indicated.

1. **Multidisciplinary Education (C23):**
2. Were any sessions *planned* by a multidisciplinary team during this report period? [ ]  Yes [ ]  No

 Please list the non-MD team members involved in planning:

2. Was this activity *attended* by health care professionals other than MD’s during this report period? [ ]  Yes [ ]  No

 Please provide a list of types of other providers and the attendance data to support this:

3. Did non-MD health care professionals participated in the *teaching* of any sessions during this reporting period? (e.g. Ph.D., RN, NP, Social Worker, other related professional) [ ]  Yes [ ]  No

Please provide a list of sessions taught by non-MD professionals:

**B.  Education for Students of the Health Professions (C25):**

1. Were medical students, residents, fellows, or other health care students involved in the planning of any lectures during this reporting period? [ ] Yes [ ]  No

If so, please list any trainees involved:

1. Were any sessions in this RSS TAUGHT by trainees (any students/learners within the health care professions) during this reporting period? (This can include a case presentation by a student) [ ]  Yes [ ]  No

Please list those sessions which fulfill this criteria:

1. Did trainees (any students of the health care professions) regularly attend any sessions during this reporting period?   [ ]  Yes [ ]  No

If so, please describe:

**C.  RSS’s are required to demonstrate that they have used health and practice data for healthcare improvement (C26, C37):**

1. Please list all sessions during this reporting period that used Quality Improvement and Patient Safety Data in the planning, and were created to address this need. (***This is required for at least 2 sessions each academic year by the Weill Cornell CME Committee.***)

1. Were any studies or observations done during this reporting period to demonstrate that this led to improved patient care?

1. Were any additional strategies used outside of this RSS to reinforce this? (e.g. signage, EMR changes, e-mails, notices)

**D.  CME should lead to improved Communication Skills (C29):**

During this reporting period did any session in your RSS series focus upon patient or interprofessional communication skills? [ ]  Yes [ ]  No

If so, please list any sessions devoted to this:

**E.  Optimization of Technical and Procedural Skills (C30):**

 Did any of the sessions during this reporting period specifically focus on learning technical or procedural skills in patient care?   [ ]  Yes [ ]  No

 If so, please list:

**F.   Creative Educational Formats (C35):**

CME programs are encouraged to move away from standard lecture formats in teaching healthcare professionals.

Was this course a traditional lecture series? [ ]  Yes [ ]  No

1. If **YES**,

 a. Did any sessions during this reporting period deviate from the conventional lecture and Question/Answer format?

 Please describe:

b. Please describe how you might remedy this for some sessions in the next reporting period:

2. If **NO**, please describe the educational format (e.g, case conferences, journal clubs, etc.):