AUDIENCE QUESTIONS – GRANT REQUEST ROCK!!

Do you support one person MECCs or do you have a process to look into the viability of a company and what does historical performance play in your review process?

Kate Biles, Associate Director, Scientific Education, Bristol Myers Squibb: We like to have some history with a company before we support any of their programs. I see no reason why one-person MECCs would be an issue if the MECC has shown its capabilities.

Ann Marie DeMatteo, Director, Medical Education, Regeneron: Agree. Perhaps additional information regarding partners and their roles may be asked if the supporter is aware of a MECC applicant consisting of one employee. Additional due diligence would be warranted to assure that an initiative could be executed as proposed.

Antonio Meo, Medical Education and Investigator Initiated Study Grants, Sunovion: I am in agreement with Kate and Ann Marie. The number of actual employees a MECC has is not an important factor if they are able to develop and deliver a well structured proposal and, if approved, a good educational program. Historical performance is a metric we do use when evaluating new proposals from MECCS/organizations we have supported in the past. I encourage new MECCS to submit program examples or sample outcomes from completed programs in.

The therapeutic area in which you are submitting for to show a track record during review.

What "past experience with an applicant" would prevent a new grant from being awarded?

Kate: For example, one of our providers made some substantial mistakes on slides at a satellite symposium. Their next proposals would be weighed against those unnecessary mistakes.

Ann Marie: Agree. Past performance is always taken into consideration. A history of poorly executed initiatives would be taken into account with new requests.

Antonio: I am in agreement with Kate and Ann Marie. As we audit programs, we are reviewing for scientific accuracy, compliance with ACCME standards of support, and overall quality of the program. Recurring issues with quality of programs would be considered during review of future grants.

How do you navigate the ACCME SCS boundary regarding not directing evaluation of CME? How do you get what you want in outcomes assessment without directing it?

Kate: At BMS, we provide an Outcomes template (PPT) for providers to fill out so they know what we would like measured. We are not directing the outcomes, we are just suggesting what measures we would like to see in outcomes from all programs we support.

Ann Marie: Agree. There is no direction from supporters as to what and how you to conduct your outcomes study. What is shared are suggestions for presenting the study results back to the respective grantor, which has no influence over the study itself.

Antonio: We do not direct outcomes reporting or provide an template for reporting; if we are looking for additional information that may not be presented in the provided report that we think can be easily extracted, we will request more information.

How nitpick-y are you if the science in the needs assessment is valid but there is a "trigger" word or some other small nuance that a committee member is fixated upon. Does it equate to an automatic no?

Kate: It might. It all depends. I've seen proposals for lung cancer with breast cancer in the text. That could be an issue in terms of sloppiness with preparation of the proposal. If you are going to submit a sloppy proposal that is not well proofread, how do we know you will not provide a sloppy CME program?

Ann Marie: Agree. The grant request is perceived as a preview of the applicant's abilities. There is always a possibility of human error. But if there are consistent errors across multiple requests or multiple errors within a single request, then the lack of attention to detail would be noted and considered. Good business practices are always expected, especially when asking for large amounts of money.

Antonio: I am in agreement with Kate and Ann Marie. The needs assessment lays out the scientific knowledge and understanding your organization has in a disease state and is the foundation of a proposal and educational program. While there is not an identified "trigger word", mistakes in the need assessment would be an issue during review.

Can you speak a bit more about the outcomes section of a grant request and ideally what key components are you looking for?

Kate: We look for number of learners, types of learners, specialties, % changes in predicted behavior or actual changes in behavior, measures for knowledge/competence improvement, cost per learner, potential number of patients impacted by the program, key insights gained from program audience, verbatims from Q&As, noted gaps that still may exist.

Ann Marie: Saying "we will reach Level 5" is not enough. Instead, present your outcomes strategy. Start with the end in mind and show that you have a plan in place. Identify what you consider the expected educational impact of the proposed program to be and how you intend to get there. In addition, let us know if your strategy will include identifying new/ongoing needs and barriers to change. Will you provide cohort analyses by profession/specialty, region, practice setting, etc? Will you report on learner preferences in self-directed learning activities? Will you identify confidence versus competence discrepancies? Ideally a grant request will include obtainable educational impact goals for the proposed initiative and a realistic, well-thought out plan for how you intend to achieve them.

Antonio: I am in agreement with Kate and Ann Marie's comments. In addition to the above "traditional" metrics, we are becoming increasingly more interested in reporting around digital/online programming that could provide further insights. Learner click rate into a program, lead generation (are learners finding content on their own or accessing content from audience generation tactics like direct email), learner duration in programs, accessing and downloads of supporting documents or program slides.