



DELTA HEALTH MEDICAL STAFF POLICY AND PROCEDURE

CONTINUED MEDICAL EDUCATION (CME) ASSISTANCE

1. PURPOSE:

To provide continued medical education opportunities for all Medical Staff and Allied Health Professionals employed with Delta Health. The Hospital encourages employees to pursue educational goals which contribute to their professional growth, competency development, CME requirements, and health care delivery improvement. Delta Health encourages CME participants to support the Hospital's CME program.

2. POLICY:

All Medical Staff Providers and Allied Health Professionals that have a CME allowance included in their Employment Agreement may be eligible to receive:

- i) CME Conference/Course Registration reimbursement
- ii) Travel expenses; i.e. airline, rental car expenses, Uber/shuttle expenses
- iii) Lodging expenses up to one day before and one day after course, depending on location and schedule of educational activity
- iv) Mileage expenses *
- v) Meal expenses **
- vi) Other costs as approved **

* *Auto Mileage reimbursement not to exceed \$500.00.*

** *Alcohol and entertainment expenses are not reimbursable.*

Detailed meal receipts must be submitted for reimbursement over \$50/day allowance.

- vii) Educational material, including online courses.
- viii) Electronic applications; for example Up-to-Date or Epocrates.
- ix) Subscriptions or membership dues that offer medical education as a benefit of membership.

3. TUITION ASSISTANCE ELIGIBILITY REQUIREMENTS

A. **Prior** to scheduling CME, or **before purchasing** CME educational products, Delta Health provider must complete a Request for CME Dollars Form including:

- i) An attached course description;
- ii) Detailed accounting of course/material costs;
- iii) Estimated travel expenses, etc.
- iv) Delta Health Department/Clinic Manager approval
- v) Delta Health Administrative approval

B. Once approval has been given for a scheduled CME, Delta Health Provider will be notified by the Medical Staff office. Provider may then register for the CME conference/seminar, and make airline, rental car and hotel reservations.

C. Once Delta Health Provider has returned from their CME education, a CME certificate of completion must be provided to the Medical Staff office. Submit proof of payment for registration, travel, lodging, meals, taxi/bus fare, baggage fees and mileage for reimbursement.

D. Amount of CME assistance will be limited to contracted amount per contract year. Funds not used in one contract year will not be rolled over to the following year. Each new contract year will start with an initial, new balance as set in the Provider's contract.

Cancellation fees and monies not reimbursed for cancelled educational activities must be paid by Delta Health Provider unless approved by Administration.

- E. If a Delta Health Provider's employment ends before their CME contract year is completed, reimbursement will only include registration expenses for approved, outstanding CME activity. All other expenses for CME conferences attended after a Delta Health Provider is no longer employed, will be the responsibility of the Delta Health Provider. Further, once notice has been received that a Delta Health Provider is voluntarily resigning their position, no further CME requests will be approved.
- F. CME assistance is contingent upon Delta Health Provider obtaining a minimum of 4 CME hours per contract year through the Delta Health CME program which may include: monthly scheduled Delta Health CME presentations, the Delta Health Tumor Board, Delta Health committee meeting presentations and Delta Health grand round discussions. Should Practitioner not meet 4 Delta Health CME hours per contract year; their CME assistance will be discontinued the following year. To have CME assistance reinstated, 4 Delta Health CME hours must be obtained in the year of their disqualification. If this is accomplished, CME Assistance will be awarded the following contract year.
- G. Approval is subject to Delta Health's contracted days off and CME fund balance.

Formulated: 07/11

Revised: 03/12, 12/13, 06/15, 04/16, 9/16, 12/16, 7/17, 8/18, 3/19, 5/21, 12/21, 09/22

Request for Continued Medical Education (CME) Dollars

As per Medical Provider's Allotted CME Reimbursement

Provider Name: _____ Clinic: _____

Medical Educational Conference / Seminar: ***

Registration / Tuition _____

Estimated Travel Expense _____

Estimated Lodging Expense _____

Estimated Meal Expense _____

Medical Educational Materials; Books, Memberships, Subscriptions, Electronic Media ***

TOTAL ESTIMATED COST: _____

*** Please attach copies of course description, registration, travel, books, memberships, etc.

Employee Signature

Date

APPROVAL

Employee has been approved for CME dates on clinic / department schedule and documentation is attached for requested items above.

Clinic / Department Manager

Date

Medical Staff Office

Julie Huffman, CLO

Date



Expense Summary for CME Reimbursement

As per Provider's Approved CME Request

Receipts Required for all items but meal allowance



CME Conference / Meeting / Certification Class			
Item	Description	Cost	Documentation Attached
CME Certificate	CME Certificate or proof of attendance is required.	N/A	<input type="checkbox"/> CME Certificate attached
Registration		\$	<input type="checkbox"/> Receipt attached
Auto Mileage	_____ miles x 2 (return) = _____ x .655 per mile <i>* As per CME Policy, 2. iv) Mileage not to exceed \$500</i>	\$	<input type="checkbox"/> Map attached from Hospital to destination
Parking		\$	<input type="checkbox"/> Receipt attached
Taxi / Shuttle		\$	<input type="checkbox"/> Receipt attached
Auto Rental		\$	<input type="checkbox"/> Invoice attached
Gas / Oil	<i>* Reimbursed for rental car only</i>	\$	<input type="checkbox"/> Receipt attached
Air Fare		\$	<input type="checkbox"/> Receipt attached
Baggage Fee		\$	<input type="checkbox"/> Receipt attached
Hotel / Motel		\$	<input type="checkbox"/> Hotel statement attached
2 nd Hotel / Motel		\$	<input type="checkbox"/> Hotel statement attached
Meals	<i>* As per CME Policy, 2. v) Alcohol not reimbursable</i>	\$	<input type="checkbox"/> Receipts attached
Meal Allowance	\$50 / day x _____ days	\$	<input checked="" type="checkbox"/> Receipts Not Required

Receipts Required for all items listed



CME Educational Material / Books / Subscriptions / Membership Dues		
	\$	<input type="checkbox"/> Receipt attached
	\$	<input type="checkbox"/> Receipt attached
	\$	<input type="checkbox"/> Receipt attached
	\$	<input type="checkbox"/> Receipt attached
	\$	<input type="checkbox"/> Receipt attached

TOTAL CME reimbursement requested:	\$
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Provider's Signature:	Date:	
Manager's Signature:	Date:	
<input type="checkbox"/> Please deliver check by Delta Health inner-office mail to Provider's Clinic <input type="checkbox"/> Please mail check to Provider's personal address on file <input type="checkbox"/> Please hold check for Provider to pick up from Accounting Office		