



Key Pearls from Grants Anatomy 101 ([Fall CMEpalooza 2025](#))

• **Insight into Supporter Strategy**

- BMS: Strategy is an ongoing discussion, largely focused on current and new releases of clinical data and outcomes data from recent activities
- Lilly: Strategies are updated once a year and include key clinical care gaps (ex. screening/diagnosis)
- Great opportunity to show value of CME and what it adds to strategy discussions
 - Others buy data, CME creates it!
 - CME can educate in areas that can't be touched by company-led education
 - CME is more than a big number: can change behavior, competence, skills
- More targeted proposals are received when using a Call for Grants/Request for Proposals process vs. open submissions

• **What is *the* make-or-break section of the grant?**

- **Agenda**
 - Often go here first to see if the topics align with areas of interest
 - The agenda—topics, timing, order of presentation—brings the combined proposed program and platform to life
 - The more details provided in the agenda, the better. While some providers may see this approach as risky, thinking more detail can mean more possibilities for decline, it also can greatly improve chances of approval
- **Executive summary**
 - A good executive summary provides a quick snapshot of whether the proposal aligns with medical strategy.
 - It can also provide good prep for the grant manager when presenting the proposal in a GRC meeting
- **Tying together gaps→root cause→needs→learning objectives→outcomes**
 - A detailed chart *that makes sense* is hugely valuable

- **Instructional design**
 - Does the choice of ID—combination of educational strategy, live or online access, and platform selection—make sense for effectively engaging learners, providing learner interactivity with the content, delivering the promised level of outcomes, and, ultimately, changing learner behavior? (More below.)

- **Needs Assessment/References**

- “Triangulation of gaps”—3 separate resources that point at the same gap—is a strong approach to identification and support of gaps
- Supporters love to see unique resources that they cannot access or see on a regular basis, including patient perspectives, HCP and patient surveys, outcomes data and insights, and KOL insights
- The NA can be used to show understanding of the topic, expertise of area, and knowledge of clinical trial data and guidelines
- Make sure references are current!
- Science (what would likely appear in actual activity content) can be added to the NA or the agenda *if* the provider feels it’s valuable to include in the proposal

- **Program Tactics: Instructional design, Proposed Activity Format**

- Lilly has a ‘checklist’ of items they’re looking for (interaction is a critical component)
- Consider how you are explaining the rationale for why you chose this format and ID? Be thoughtful and intentional.
- Think about how you can effectively translate internal conversations on why format was selected into your proposal
- Consider clinicians varied “lifestyles” (ex. time limitations of PCPs vs. specialists’ unique needs) when selecting formats
- How important is an innovative format?
 - If a format is new to the supporter, start with a smaller program scope with strong outcomes to back up the format’s effectiveness
 - Be sure the innovative tactic is aligned with the proposed outcomes level. This often gets overlooked when striving to innovate.
 - Don’t innovate just to innovate; explain why the innovative approach is more valuable than proven methods

- **Using Artificial Intelligence in Proposal Development**

- Using AI to improve efficiency is not seen as a red flag; supporters also often use it to streamline proposal review
- If using AI, make sure the final proposal is reviewed for personal touch
- Make sure references provided by AI aren't hallucinations

- **Inclusion of Faculty Names**

- Be sure to check with each supporter (or supporter portal) to see if inclusion of faculty names is allowable
- It's generally understood that a provider can't guarantee that a proposed faculty/KOL will be able to participate (though it's still good to provide a disclaimer to clarify this)
- Supporters often value and appreciate expected faculty qualifications (global vs. US, primary care vs. specialty, level of expertise) more so than individual names

- **Audience generation**

- Even with the available [Outcomes Standardization Project \(OSP\) definitions](#), supporters are still seeing providers use a wide and vague range of terms such as reach, participant, learner, etc. Alignment with OSP definitions is preferred.
- There is increasing concern and skepticism towards seemingly inflated audience generation numbers provided simply to win a grant. Expect to see increased questions/RFIs about these
- Providers need to find the proper balance between providing a "big" number (anyone reaching the front matter) vs. a "right" number (target learners starting to engage with activity content)
- Cost of audience generation is "all over the board," with the big providers charging "10x more" than smaller providers. Supporters continually struggle to make sense of these differences.
- Supporters acknowledge that there is a difference between "cost" of audience generation vs. the "value" of reaching and educating the right audience. Providers can justify higher fees for AG by showing the value of the audience using past outcomes data.

- **Budget**

- Recurring "red flag" line items include (perceived) out-of-line audience generation fees and exceeding supporters' posted travel/meals/honoraria limits
- Contingency plans for partial funding are frequently requested but rarely seen. Consider if the proposal is scalable without compromising the integrity of the program.