

University of Rochester School of Medicine & Dentistry
Office of Continuing Professional Education

Continuing Medical Education (CME)
Proposed
Activity
APPLICATION
PACKET
(Revised 1/08)

This application is to be used for:

Regularly Scheduled
Series
(RSS)

[e.g., Grand Rounds)

601 Elmwood Ave., Box 677, Room G-8540
Rochester, NY 14642-8677
Phone: 585.275.4392
Fax: 585.275.3721

Email: office@cpe.rochester.edu
Website: www.urmc.rochester.edu/cpe

CME Activity Application Packet **TABLE OF CONTENTS**

FORM A) Preliminary Data for proposed Regularly Scheduled Series (RSS) CME Activity

Definition - Regularly Scheduled Conference:

Daily, weekly, monthly, or quarterly CME Activity that is primarily planned by and presented to the accredited provider's professional staff.

FORM B) CME Activity Needs Assessment

- Determination of the need for a continuing medical education activity is critical to the planning process.
- The need will lead directly to the formulation of program objectives and content.
- A comprehensive planning process will help ensure an educationally sound activity.

FORM C) Learning Objectives for Content Validation

- Objectives should describe overall learning outcomes desired for this series in terms of physician performance and/or patient health.
 - Indicate to the attending physicians for whom this activity is designed the instructional content and/or intended learning outcomes in terms of knowledge, skills and/or attitudes.
- Outline potential topics and speakers (where known) that will assist in achieving the identified learning outcomes for which this activity has been planned.

FORM D) Outcomes Measurement and Financial Support

- Evaluating the impact of the educational activity and how well the learning objectives were met.
- Any Financial Support should be identified and follow the Standards for Commercial Support.

FORM E) Activity Director/Planning Committee Declaration

- One form must be completed for each person who is in a position to influence the content of the activity
 - This includes
 - Activity/Course Director(s)
 - Planning Committee Member(s)

- **Prior to the final selection of faculty and any sessions being held, the CPE Office must be contacted. This includes, but is not limited to, application submission and approval.**
- All forms MUST be completed in their entirety for application to be reviewed.
- Please return completed packet to:

University of Rochester School of Medicine & Dentistry
Office of Continuing Professional Education
601 Elmwood Ave., Box 677
Rochester, NY 14642-8677

- Incomplete applications will be returned.
- A minimum of 1 - 2 weeks will be needed to review this request.
 - **Approval by the CPE Office is required prior to confirming presenters.**
- Formal written approval by the CPE Office is required prior to advertising event.

When Category 1 CME credit is awarded by the School of Medicine & Dentistry (SMD), the Office of Continuing Professional Education (CPE) is required by accreditation standards to document program development and implementation, and to insure that the activity meets all nationally established CME Guidelines.

FORM B) NEEDS ASSESSMENT

Proposed RSS Activity TITLE/DATE: _____

1. Departmental Goals: Describe your departmental goals for mounting this educational activity:

2. Purpose: Describe briefly the broad purpose or intent of this activity to change physician competence, performance in clinical practice, and/or improve patient health status.

3. Needs Assessment: Please provide a written paragraph from the physician perspective in which you describe the need for this proposed activity at this time and the choice of these particular topics. This paragraph should answer the following questions:

- Who is the **target audience** for this activity?
- Why is this activity being planned for this audience?
- What are the **practice gaps** in clinical or organizational practice you wish to address?

4. Needs Documentation: Please indicate the methods you have used to determine the clinical and/or organizational practice gaps for this proposed activity. **2 – 3 needs preferred; at least 1 need is required.** Appropriate documentation or supporting explanation for the methods checked below **MUST** be included as attachments.

- Health Care Issue**
- ___ continuing review of changes in quality of care as revealed by medical audits or patient-care reviews
 - ___ on-going census of diagnosis made by staff physicians
 - ___ summary of patient-problem logs kept by staff
 - ___ formal tests to determine physician competence (e.g., self-assessment tests)
 - ___ other or additional explanation: _____
- Evidence-Based Medicine Resources**
- ___ PubMed Clinical Queries
 - ___ TRIP Database
 - ___ Centre for Evidence-Based Medicine
 - ___ Centers for Health Evidence
 - ___ Evidence-Based Medicine
- Statistics**
- ___ mortality/morbidity statistics
 - ___ data from outside sources (e.g., public health statistics)
- Literature review (Check journals or list specific articles/List Journal articles by year, month and title)**
- ___ Academic Medicine _____
 - ___ American Journal of Medicine _____
 - ___ JAMA _____
 - ___ Journal of Family Practice _____
- Internet (Please provide specific url)**
- _____
- _____
- Professional Community**
- ___ utilization review committee
 - ___ peer review
 - ___ faculty perception of need
 - ___ judgment of Department Chair
 - ___ formal or informal requests from staff or faculty members
 - ___ target audience survey
 - ___ previous meeting evaluation(s)
 - ___ advice from authorities in the field
 - ___ periodic discussion in departmental meetings

FORM C) LEARNING OBJECTIVES FOR CONTENT VALIDATION

Proposed RSS Activity TITLE/DATE: _____

5. LEARNING OBJECTIVES:

Please list what you hope to achieve during this certification period. As a guideline: Prepare 1 to 2 measurable **overall** objectives for this RSS activity. For your reference, a brief article is provided to assist you in preparing educational objectives.

(See guidelines section V.) *Objectives for individual sessions should be requested of each presenter 2-4 weeks prior to their scheduled lecture date.*

By attending this RSS activity each week, participants should be able to:

6. INSTRUCTIONAL DESIGN:

Please indicate the format(s) you plan to use to implement the identified objectives.

- | | |
|--|--|
| <input type="checkbox"/> Large Group Lecture(s) | <input type="checkbox"/> Workshops/Small Group Discussions |
| <input type="checkbox"/> Hands-On Training | <input type="checkbox"/> Case-Based |
| <input type="checkbox"/> Other (please specify: _____) | |

Please indicate why you feel the identified format(s) will benefit the content of this RSS activity?

Please indicate which ACGME Core Competency is being addressed in this activity. (✓ Check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Patient Care | <input type="checkbox"/> Practice Based Learning & Improvement |
| <input type="checkbox"/> Medical Knowledge | <input type="checkbox"/> Systems Based Practice |
| <input type="checkbox"/> Professionalism | <input type="checkbox"/> Interpersonal Skills & Communication |

Please describe the proposed activity content along with proposed speakers, based on clinical and/or organizational gaps as determined by the Activity Director and/or Planning Committee.

**PLENARY LECTURE/WORKSHOP/
SMALL GROUP TOPICS**

PROPOSED SPEAKERS/AFFILIATIONS

FORM D) OUTCOMES MEASUREMENT & FINANCIAL SUPPORT

Proposed RSS Activity TITLE/DATE: _____

7. OUTCOMES MEASUREMENT:

Activities are encouraged to measure **level 3 outcomes** or above. Check all the levels of outcomes you intend to assess or measure and indicate the expected date of completion and attach proposed evaluation tools:

Outcome Level (✓ check <u>all</u> that apply)	✓ To Be Measured	Date (approximate)
Level 1 Participant satisfaction <i>(self-reported at end of program)</i>	<i>optional</i>	<i>date</i>
Level 2 Intent to change behavior of practice; change in participant knowledge, skills, or attitude <i>(self-reported or observed at end of program)</i>	<i>required</i>	<i>date</i>
Level 3 Change in participant behavior or practice <i>(self-reported 1-3 month(s) after program)</i>	<i>recommended</i>	<i>date</i>
Level 4 Change in organizational practice <i>(objectively measured before & after program)</i>	<i>recommended</i>	<i>date</i>
Level 5 Change in patient health status <i>(objectively measured before & after program)</i>	<i>recommended</i>	<i>date</i>

How will you know if your activity makes a difference or helps change clinician behavior or patient health status? For each Outcome Level you plan to use, **describe** what outcomes you intend to measure and how you will measure them.

Level 1:

-

Level 2:

-

Level 3:

-

Level 4:

-

Level 5:

-

8. FINANCES & COMMERCIAL SUPPORT:

- Will commercial support be solicited on behalf of this RSS activity? Yes No
- Will there be a registration fee charged for this RSS activity? Yes No
- The following must be submitted as an attachment:

Draft operating budget to include: CME certification fees; advertising costs; speaker honorarium and expenses; food and beverage and all other anticipated RSS Activity expenses.

If additional space is needed please attach additional sheet.

FORM E) ACTIVITY DIRECTOR/PLANNING COMMITTEE DECLARATION

Please complete as it relates to ALL relevant financial relationships with any commercial interests in relation to your involvement with the content of this activity. Attach additional sheet(s) if needed.

1) Complete **Section A** if relationships exist. **-OR-** 2) Initial **Section B** if no relationships exist. Then sign, date and return.

ACTIVITY TITLE _____
ACTIVITY DATE _____

First, describe your role.

Second, list the names of proprietary entities producing health care goods or services, with the exemption of non-profit or government organizations and non-health care related companies with which you AND your spouse/partner have, or have had, a relevant financial relationship (of any amount) within the past 12 months. For this purpose the ACCME considers the relevant financial relationships of your spouse or partner that you are aware of to be yours.

Third, describe **what** you or your spouse/partner received (ex: salary, honorarium etc). **Do NOT indicate how much (the value) you received.**

• **Section A:**

The following could be perceived as a potential conflict of interest (COI).	Nature of Relevant Financial Relationship (Include all those that apply)	
Role	Name of Organization(s)	What was Received
<input type="checkbox"/> Grant/Research Support		
<input type="checkbox"/> Consultant		
<input type="checkbox"/> Speakers' Bureau		
<input type="checkbox"/> Major Stock Shareholder		
<input type="checkbox"/> Other Financial or Material Support		
<input type="checkbox"/> Other (please identify)		

• **Section B:**

Initial if NO COI: _____	Neither I nor my spouse/partner has any RELEVANT financial relationships with any commercial interests in relation to my involvement with the content of the proposed activity.
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Name (please print) _____

Signature _____ Date _____

Example terminology

Role(s): Employment, management position, independent contractor (including contracted research), consulting, speaking and teaching, membership on advisory committees or review panels, board membership, and *other activities (specify).

What was received: Salary, royalty, intellectual property rights, consulting fee, honorarium, ownership interest (e.g., stocks, stock options or other ownership interest, excluding diversified mutual funds), or other financial benefit.

For the Activity Director's form – only Dept. Chair/Unit Chief initials are required.
For planning committee forms – BOTH Activity Director and Chair/Chief must initial.

ACTIVITY DIRECTOR	DEPT. CHAIR/ UNIT CHIEF
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After review, please initial the appropriate Conflict of Interest Statement from the following options:

INITIALS	INITIALS
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(A) I have reviewed the above information and feel that no further examination is required pertaining to this individual's involvement with the proposed activity. _____

(B) I have reviewed the above information and feel that further examination of identified conflict(s) is necessary. Explain concerns and suggest a review process based on the accompanying *Policy for Identifying and Resolving COI in CME, Sec. IV.* _____

(C) I have reviewed the above information and feel that this person's identified conflict(s) are not resolvable. _____

Your cooperation in complying with these guidelines is appreciated.