

**Continuing Health Professional Education • 2500 North State Street • Jackson, Mississippi 39216-4505**

**Telephone: (601) 984-1300 • FAX: (601) 984-1309**

**APPLICATION FOR APPROVAL**

**OF A CONTINUING EDUCATION ACTIVITY**

1. Please contact UMMC Office of Continuing Health Professional Education (CHPE) to schedule a planning meeting as soon as possible. This meeting must be held to discuss preliminary program agenda, faculty and budget. All activities should have a committee of experts in the area(s) of the planned topic(s). Approval for individual healthcare disciplines requires a planner from each discipline to be a member of the planning committee.
2. Four to six months is preferable to adequately plan a quality CE program. Prior to the meeting and completion of the application, members of the planning committee should familiarize themselves with the application packet and attachments required. For more information visit our website <http://www.umc.edu/conted/>
3. Proposed activities should promote improvements and/or quality in healthcare and should be independent of commercial interests.
4. The application should be typed. It and all supplemental documents must be submitted to the office of Continuing Health Professional Education for review and approval.
5. Invitation letters to commercial supporters and exhibitors should be submitted to UMMC CHPE. Grants should be signed by UMMC CHPE and other organizations as applicable.
6. A draft copy of all brochures, flyers, postcards, advertisements and other forms of publicity must be submitted to UMMC CHPE for approval prior to printing. All materials must include the correct accreditation statements.
7. A short list of post-activity requirements will be sent to the activity designee with the application approval. This includes a post-activity evaluation.

If you need any assistance or have questions involving the CE application process, contact the office of Continuing Health Professional Education at 601-984-1300 or 601-815-5141.

 Vickie Skinner, Director, CHPE

**SECTION 1—ACTIVITY DESCRIPTION**

**Activity Information**

**Title:**

**Date(s):**

**Location (City, State, Facility):**

**UMMC School/Department/Division presenting this activity:**

**UMMC Activity Director (The activity director must be a UMMC faculty member with expertise in the subject of the activity):**

Name, degree, title:       Telephone No:       Email Address:

**Providership** *Note:**A pharmaceutical company or a medical device manufacturer is not considered a provider.*

See Joint Provider Policy

**[ ]  Directly provided - UMMC department/division works with CE office.**

**[ ]  Joint Providership – UMMC department/division and CE office works with the joint/co-provider.**

 **UMMC is the lead provider.**

 Joint Provider Name and Address:

 Is the Joint Provider accredited by - check all that apply: [ ]  ACCME [ ]  ADA CERP [ ]  ANCC

 Joint Provider Activity Director:Name, degree, and title:

 Contact Information: Telephone No:       Email Address:       Other means of contact:

**Joint Providership Activity Review Fee**:  $600

This is a non -refundable fee for the presentation of a live activity, the production of an enduring material or internet based activity.   Fee should be submitted with the activity application. Application is approved, in most instances, for a 2 year period. The joint providership fee of $600 should accompany the application. This fee is non-refundable. No application will be considered for approval until the fee and all applicable attachments are received by the UMMC CHPE office. Per person credit fee will be assessed following the conclusion of each activity date activity.

**Joint Providership Credit Fee per Presentation:**

**Fee for Each Additional Repeat Presentation of the Same Activity**:  **$100**

* 1—4 approved credit hours = $35 per attendee
* 4.25—8 approved credit hours = $45 per attendee
* 8.25—16 approved credit hours = $55 per attendee
* 16.25 and above approved credit hours = $65 per attendee

*Fees are due no later than 30 days after the activity along with the attendee registration list.*

No credit certificates will be issued until the fees are collected.

**Credit Requested** *Note: Select all that apply. The planning committee must include a member of each discipline for which credit is being sought.*

 **\*Non-UMMC approved accrediting bodies – additional time is required to apply for credit and additional fees apply.**

[ ]  \*Certified Case Managers: CCMC credit [ ]  Certified Athletic Trainers: BOC credit

[ ]  Dentists: ADA CERP credit [ ]  \*Dietitians: CDR CPEUs

[ ]  \*Nuclear Medicine Technologists: VOICE Credit [ ]  Nurses: MNF/ANCC

 (additional pages required – attached)

[ ]  \*Ophthalmology Allied Health Personnel: JCAHPO

[ ]  \*Pathologists (SAM)

[ ]  Pharmacists: ACPE

[ ]  Physicians: *AMA PRA Category 1 Credit(s) TM*

[ ]  \*Physicians: American Academy of Family

 Physicians (AAFP)

[ ]  \*Psychologists

[ ]  Social Workers: NASW, Mississippi Chapter

[ ]  \*Other: Please identify association name, contact person name, address and telephone number:

 **Number of CE hours requested:**

**SECTION 2—LEADERSHIP**

**Activity Director(s) and Planning Committee Members**

See Content Validity Policy

All directors and activity planners will be kept up-to-date on the requirements for adhering to ACCME (AMA Category 1), MNF (ANCC), AAFP, ADA CERP and any other applicable credit criteria via email and meetings as applicable.

All individuals listed on the planners form are required to complete a *conflict of interest disclosure form* related to the content of this activity before the application will be reviewed and approved. **Note: Please read this form carefully. A conflict of interest applies to any director, planning committee member, speaker or others that have control over the content of the activity, as it pertains to the content of the activity within the past 12 months. This could include a life partner of their institution also.**

**ACTIVITY DIRECTOR (including, joint if applicable)**

Must be a UMMC faculty member and/or joint provider with expertise in the subject of the activity. The director has overall responsibility for planning, developing, implementing, and evaluating the content and logistics of the activity.

**PLANNING COMMITTEE MEMBERS (including joint/co-providers if applicable)**

***Note: A member of each discipline for which credit is being provided should be on the planning committee***

Assists the director(s) with the responsibility for the design and implementation of this activity and must comprise of individuals in areas of required credit.

**DEPARTMENTAL ADMINISTRATIVE STAFF ASSISTANT (if applicable)**

May be assigned to assist the activity director and planning committee with necessary paperwork and act as a liaison between CHPE and the department.

**JOINT PROVIDERSHIP (if applicable)**

**UMMC department/division and CE office works with non-accredited provider or another approved provider.**

**UMMC acts as the lead provider.**

 ***Complete Attachment 2***

 ***(Planner Information Form*)**

 ***Attach CVs for all planners***

***A CHPE program administrator will be assigned to this activity once approved. She will be the advisory agent for the director and the planning committee.***

**SECTION 3—PLANNING**

**Target Audience (Learners)**

Note: The activity must match the learners’ current or potential scope of professional practice.

Who is your target audience? Include specific health care professionals, and targeted geographic area:

[ ]  **Dentists** [ ]  **Dental Hygienists** [ ]  **Dental Assistants**

[ ]  **Physicians – specify specialties:**       [ ]  **Social Workers**

[ ]  **Nurses – specify specialties:**       [ ]  **Nurse Practitioners - specify specialties:**

[ ]  **Pharmacists** [ ]  **Psychologists**

[ ]  **Allied Healthcare Professionals** – **specify specialties:**

 **Geographic Location:** [ ]  UMMC Only [ ]  Local (Tri-county area) [ ]  Mississippi (state-wide)

 [ ]  Regional/National - specify states:

**Anticipated number of attendees:**

**List any special background requirement(s) necessary to attend this activity**:

**Identified Professional Gap(s) and Need of the Learners on which the Activity is Based**

See Needs Assessment Data/ Professional Practice Gaps:

*Note:* Professional gap(s) are a description of a problem between current levels of knowledge, skills, or attitudes, and the necessary competencies needed to be improved or new competencies to be developed.

**What is the identified educational void or professional gap(s) being addressed through this activity?**

*The gaps to be addressed are:*

[ ]  Individual physicians

[ ]  Physician groups (example: internal medicine, institutional)

[ ]  Community

[ ]  Population-level

[ ]  Other, specify

*The gaps could be caused by:*

[ ]  Physician’s inabilities

[ ]  Physician challenges

[ ]  Environment that is present where the physician practices

[ ]  Other, specify

**How were these gaps identified to meet the needs of the target audience? Check below as applicable and attach expected documentation**. ***A check mark in the appropriate space below is not adequate documentation.***

**Method Example of Documentation**

[ ]  Evaluation of previous CE activities Written summary

[ ]  Peer-reviewed journal article(s) Abstracts/full article, government document describing

 educational need and physician practice gaps

[ ]  Expert opinion Expert names/medical professional association and summary

 of recommendations

[ ]  Interview/focus group Written summary

[ ]  Request/surveys from target audience Written Summary of requests or survey

[ ]  Quality improvement data Written summary

[ ]  Discussion in departmental meetings Written summary

[ ]  Practice guideline/clinical pathway Table of contents or executive summary

[ ]  Epidemiology report Abstract/report

[ ]  Medical Audit Audit reports, chart reviews

[ ]  New technology, methods of diagnosis/treatment Description of new procedure, technology, treatment, etc.

[ ]  Joint Commission Copy of competency to be addressed

[ ]  Legislative, regulatory or organizational

changes affecting patient care Copy of measure/change

[ ]  Core competencies Attach complete documentation

[ ]  Other (specify)       Attach complete documentation

 *Label Attachment 3*

**Desirable Attribute(s) To Be Addressed (See Links of Interest)**

Check the desirable attributes (ABIM/ACGME /IOM Core Competencies) that will be addressed by the activity.

[ ]  **Patient Care** Provide care that is compassionate, appropriate and effective treatment for health

problems and to promote health.

[ ]  **Medical Knowledge** Demonstrate knowledge about established and evolving biomedical, clinical and cognate

sciences and their application in patient care.

[ ]  **Practice-Based Learning and Improvement** – Able to investigate and evaluate their **patient** care practices,

appraise and assimilate scientific evidence and improve their practice of medicine.

[ ]  **Interpersonal and Communication Skills** – Demonstrate skills that result in effective information exchange

and teaming with patients, their families and professional associates. Fostering a

therapeutic relationship that is ethically sound, uses effective listening skills with non-

verbal and verbal communication; and working as both a team member and at times as a

leader.

[ ]  **Professionalism** Demonstrate a commitment to carrying out professional responsibilities, adherence to

ethical principles and sensitivity to diverse patient populations.

[ ]  **Systems-Based Practice** - Demonstrate awareness of and responsibility to larger context and systems of

 healthcare. Be able to call on system resources to provide optimal care. Coordinating care

 across sites or serving as the primary care manager when care involves multiple specialties,

 professions or sites.

[ ]   **Other, specify**

**POTENTIAL BARRIERS**

What potential barriers do you anticipate attendees may have in incorporating new knowledge, competency, and/or performance objectives in their practice? *Check all that apply* ***and*** *indicate how it will be addressed.*

 **Example: Perceived Barrier:** Cost

 **How Barrier will be addressed:** This activity will include a discussion of cost effectiveness and new billing practices

 **Perceived Barrier How will Barrier be addressed in the Activity**

[ ]  Lack of time to assess or counsel patients

[ ]  Lack of consensus on professional guidelines

[ ]  Lack of administrative support/resources

[ ]  Cost

[ ]  Insurance/reimbursement issues

[ ]  Patient compliance issues

[ ]  No perceived barriers

[ ]  Other, specify

**SECTION 4—DESIGN AND IMPLEMENTATION**

**Educational Design - Methodology**

 See Content Validation Policy

 The activity director/planning committee members are responsible for validating the clinical content so that the activity is objective, balanced, scientifically valid and free from bias. All recommendations involving clinical medicine in a CE activity must be based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in the care of patients. All scientific research referred to, reported or used in CE must conform to the generally accepted standards of experimental design, data collection and analysis.

The attached activity information form includes the proposed program agenda identifying dates, times, topics, objectives, content, speakers, teaching methods and audiovisual.

 *Note: Each topic should have at least one behavioral objective with the content identified.*

 *Complete Attachment 4/B*

 *(Activity Information Form)*

**Proposed Speakers**

See Consultant Fees & Travel Policy

The attached speaker information form includes all speaker information. Attach current curriculum vitae for each speaker. Payment of reasonable consulting fees and reimbursement of out-of-pocket expenses for faculty is customary and proper for non-UMMC.

*Note: All speakers are required to complete a conflict of interest disclosure form.*

 *Complete Attachment 5*

 *(Speaker Information Form)*

**Disclosure of Conflict of Interest**

See Conflict of Interest and Resolution of Conflict of Interest Policies

**Disclosure Forms**

Disclosure of financial support or financial relationships between the activity directors, author(s), speakers, planners, and others who have control over the content for this activity and commercial entities is required. Presenters are also required to disclose discussions of unlabeled/unapproved uses of drugs or devices during their presentations. Individuals who fail to return a disclosure form or refuse to disclose will be disqualified from participation in the development, management, presentation, or evaluation of the activity.

In accordance with CHPE policies, individuals who have identified any potential conflict of interest will be contacted by CHPE for a resolution prior to the activity.

This information must be made known to activity attendees via course syllabus/handout, publicity material, i.e., activity brochure/flyer, at the beginning of the activity via disclosure slide(s), or at the beginning of each speakers presentation*.*

 *Complete Attachment 7A*

 *(Disclosure Form)*

**Verification of Disclosure to Attendees - Monitor Critique Forms**

Documentation that verifies adequate disclosure occurred must be made via the UMMC disclosure monitor critique form.

These forms must be returned immediately following the activity.

 *Attachment 7B*

 *(Disclosure Monitor Critique Forms)*

 Complete Following the Activity

**Promotional Materials**

See Promotional Materials Policy

Note: All promotional materials must be approved by CHPE prior to printing and distributing to intended audience. There are required elements and statements that must be used in all materials. Failure to get prior approval and statements are incorrect, you will be required to make the necessary corrections and redistribute the materials or the activity may be denied approval.

What promotional materials will be distributed for this activity? Check all that apply:

[ ]  Save the date postcard

[ ]  Flyer - How many times will this be mailed?

[ ]  Journal(s) – specify:

[ ]  Website – specify:

[ ]  Other, specify:

**SECTION 5—EVALUATION AND OUTCOMES**

**Evaluation and Outcomes**

CHPE customarily administers evaluations. If department has one in place, please advise.

Evaluation information is mandatory to determine whether or not continuing education activities meet the stated program impact and the University’s overall CE mission.

What desired results you wish to accomplish and how will you measure these?

**Competence** Analyzes changes in learners. Participants should be able to describe a new or improved strategy that applies to the content in clinical practice or demonstrates application of the content in a simulated practice environment or educational setting.

**Performance** Identifies plans for and/or implements desired changes needed for improving professional practice.

**Patient Outcomes** Integrates CE into improving practice. Identifies factors that impact on patient outcomes. Addresses barriers to change. Builds bridges. Participates in quality improvement.

***Note: You must provide a post-activity summary of collected data checked below:***

1. Learner Competence

[ ]  UMMC standardized evaluation form immediately post activity. (See attached sample evaluation form)

[ ]  If a UMMC standardized evaluation form will not be used, please attach a copy of the proposed evaluation

 form. It must be approved by the UMMC Division of CHPE.

[ ]  Audience response system (ARS)

[ ]  Use of pre and/or post tests – attach copy

[ ]  Surveys – attach copy

[ ]  Other processes – please specify and attach a copy

 *Label Attachment 5/1*

1. Learner Performance (In addition to Number 1)

[ ]  Adherence to specified guidelines/core competencies

[ ]  Case-based studies – attach a copy

[ ]  Chart audits

[ ]  Observation by activity faculty or designee

[ ]  3-6 month follow-up survey/interview/focus group discussion regarding change in practice

[ ]  Other processes – please specify and attach a copy

 *Label Attachment 5/2*

1. Patient Outcomes (In addition to Numbers 1 and 2)

[ ]  Measure mortality and morbidity rates

[ ]  Changes in cost of care

[ ]  Feedback through patient interview/survey – attach summary

[ ]  Changes in health status measures

[ ]  Changes in quality

[ ]  Other processes – please specify:

*Label Attachment 5/3*

Following the activity, evaluation results must be compiled, reviewed and maintained in the UMMC Division of CHPE.

1. Who will review the results of the program evaluation?
2. How will the evaluation data be used?

**SECTION 6—BUDGET - FINANCIAL ASSISTANCE**

**Budget**

See Commercial Funds Policy

UMMC adheres to all applicable national and state government regulations for fiscal responsibility.

All activities are cost accounted on an individual basis. Projected income and expenses are determined through discussion with the activity director/planning committee and the CHPE program administrator assigned to the activity when the activity is directly provided or jointly provided and managed in entirety by CHPE. The program administrator will keep the activity director apprised of all income and expenses throughout the planning and implementation of the activity. Upon completion of the activity, a final budget analysis will be communicated to the activity director. If the activity incurs a surplus this may be used for future activities. If the activity incurs a deficit the providing department/division, or if applicable, the joint provider shall be responsible for reimbursing CHPE.

If the activity has a deficit, what will be the mechanism of reimbursement used (example UMMC account number/Joint Provider name**):**

**Financial Assistance (See Links of Interest)**

UMMC adheres to all State of Mississippi financial regulations, ACCME Standards for Commercial Support, ANCC regulations, and ADA CERP regulations. CHPE will assist with letters of invitation and/or on-line grant applications.

**Commercial Support**

UMMC complies with the policies and definitions of the **ACCME Standards for Commercial Support: Standards to Ensure the Independence of CME Activities (“SCS”)**

*The ACCME defines a* ***commercial interest*** *as any proprietary entity producing, marketing, re-selling,*

*or distributing health care goods or services, consumed by, or used on, patients.*

*The ACCME does not consider providers of clinical services directly to patients to be commercial interest.*

Commercial support is financial or in-kind contributions given by a commercial interest which is used to pay all or part of the costs of a CE activity.

Terms, conditions, and purposes of commercial support must be documented in a written agreement between the commercial entity and provider and, if applicable, the joint provider. UMMC Letter of Agreement (LOA) may be used or the commercial interest may provide their own*.* All monies should be made payable to UMMC-Continuing Health Professional Education.

 *See Attached UMMC LOA*

DO YOU ANTICIPATE FINANCIAL ASSISTANCE FROM COMMERCIAL ENTITIES?

[ ]  **YES** [ ]  **NO**

 If yes, have you contacted these sources: [ ]  **YES** [ ]  **NO**

If yes, attach copies of correspondence or other documentation.

 If no, email copies of correspondence or other documentation as soon as possible.

  *Label Attachment 6a*

DO YOU REQUIRE ASSISTANCE FROM CHPE REGARDING EDUCATIONAL GRANTS/VENDOR SUPPORT?

[ ]  **YES** [ ]  **NO If yes, please discuss with your assigned CHPE program administrator.**

**Vendor/Exhibit Space**

Commercial exhibits and advertisements are promotional activities and not continuing education. Monies paid by a commercial interest for these promotional activities are not considered “commercial support” and therefore a commitment form will suffice for their participation – no LOA is needed. CHPE commitment forms may be used for this purpose.

 *See Attached UMMC Commitment Form*

WILL VENDOR/EXHIBIT TABLES BE ALLOWED AT THIS ACTIVITY?

[ ]  **YES** [ ]  **NO**

 If yes, have you contacted these sources: [ ]  **YES** [ ]  **NO**

If yes, attach copies of correspondence or other documentation.

  *Label Attachment 6b*

**SECTION 7—SIGNATURES**

**By signature below the signee(s) agree to abide by all standards, policies and procedures indicated in this document and its attachments.**

**CHPE reserves the right to change these periodically in accordance with the UMMC CE mission, ACCME, ACPE, ADA CERP, MNF (ANNC), and other national accrediting body’s policies and procedures as applicable.**

***UMMC FACULTY ACTIVITY DIRECTOR***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name Signature Date**

***NURSING COORDINATOR (if applicable)***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name Signature Date**

***JOINT PROVIDER ACTIVITY DIRECTOR (if applicable)***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name Signature Date**

**For CE Office Use Only:**

**Number of credits approved:**       **AMA Learning Format approved, if applicable:**

**Approved by—Signatures as applicable**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pia Chatterjee Kirk, DDS

Director of Dental Continuing Education

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shirley Schlessinger, MD

Medical Director, Continuing Health Professional Education

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sally Self, MEd, LSW P. Renee Williams PhD, RN, ICCE

Coordinated Care Department Director, Continuing Education SON

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Randy Pittman, Pharm D Vickie Skinner, Director

Pharmacy Professional Development Continuing Health Professional Education

Rev 4/13; 6/13; 7/13; 8/13