



VMC CME APPLICATION CHECKLIST

Type of Activity: _____ Live/One Time Course _____ RSS (new) _____ RSS (renewal) _____ Other
This activity is: _____ Directly (VMC) Sponsored Activity _____ Jointly Sponsored Activity

- CME Planning Activity Request form Completed
- Request is reviewed and signed by activity chairs, department chairs, department CME representative
- The educational needs (knowledge, competence, or performance) that underlie the Professional Practice Gaps of the learners C2- (performance indicators, quality measures e.g., minutes of planning committee meeting, QI/QA minutes, relevant literature) is incorporated
- Activity program/schedule (Include a draft of the brochure, if available)
- For Repeat Activity – For previous year, the Analysis of Changes in Learners as a result of the activity – (C 11)
- Projected budget showing Income and Expenses (cannot be zero)
- For a repeat activity (course) – Submit the prior year’s financial statement/Final budget (closeout)
- Completed and signed disclosure forms for all planning committee members and speakers (all must be included at time of the submission of the application)

Will there be commercial Support? _____ NO _____ YES (will require the below)

Will there be Exhibits and Advertisements? _____ NO _____ YES (will require the below)

- For commercial support complete attachment A of SCVMC Policy 154.02- Commercial Support Agreement
- For any exhibiting at the CME activity, complete attachment B of SCVMC Policy 154.02 Exhibitor Form
- Include the CME Application Fee (when applicable) Make Check Payable to:

Medical Executive Committee, Inc.

Note: In compliance with California law, relevant Cultural and Linguistic disparities need to be addressed in one or more sessions within a Regularly Scheduled Series.

AFTER DEPARTMENT REVIEW AND APPROVAL, SUBMIT the COMPLETED APPLICATION TO:
Cynthia Lopez, Medical Staff/CME Coordinator, 751 S. Bascom, Ave., 7th Floor Old Main, 7C081, 408/885-5109



CME Activity Planning Request

Request for Continuing Medical Education (CME) Credit To be completed by CME Planner(s)

Return the completed form and supporting documentation at least 90 days prior to the conference.

Date:

Date Submitted:

Activity Title:

Type of Activity: One Time Activity Repeat Activity Other _____

Speaker(s):

Activity Date(s):

Contact/Planner Name:

Phone:

Total **AMA PRA Category 1 Credit™** Requested: _____

FINANCIAL INFORMATION/COMMERCIAL SUPPORT (Criteria 8-10)

Directly Sponsored Activity (VMC)

If planning on conducting this activity in conjunction with other organizations, indicate type below:

Joint Providership Activity (activity between VMC and one non-accredited organization)

VMC is responsible for compliance with all criteria and policies. NAME: _____

Documentation of revenue and expenses. (attached to Planning Request)

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 CME activity. When there is commercial support there must be a written agreement that is signed by the commercial interest and the accredited provider prior to the activity taking place. Attach the signed agreement when submitting this request.

Will this activity receive commercial support?

NO Yes, Name of company for unrestricted grant: _____

NOTE: Arrangement for commercial support or advertisements cannot influence planning or interfere with the presentation, nor can they be a condition of the provision of commercial support for CME activities.

Commercial Exhibits and Advertisements: Commercial exhibits and advertisements are promotional activities and not continuing medical education. Therefore, monies paid by commercial interests to providers for these promotional activities are not considered to be commercial support. However, accredited providers are expected to fulfill the requirements of SCS 4 and to use sound fiscal and business practices with respect to promotional activities. A signed agreement is required.

Will this activity receive Commercial Exhibit and Advertisement Income?

NO YES if yes, NAME: _____ AMOUNT: \$ _____



Program Review and Approval

This series is submitted for CME credit review by the Department of SCVMC, for review and full compliance with the IMQ/CMA accreditation requirements, SCVMC policies.

 Activity Chair Signature (PRINT NAME) Department Date

 Department CME Member Representative Signature: (PRINT NAME & SIGN) Date

 SCVMC Chair or Division Chief (PRINT NAME & SIGN) Date

 CME Committee Chair Approval: Christina Anderson, M.D. Committee Date

CME Dept. Use Only		Date Completed Request Submitted:
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Disclosure (Criterion 7)

*A completed and signed disclosure form is required for each planner and each presenter, author or other person who can influence the content of the activity. The results of this process must be disclosed to the learner prior to or at the start of the activity. **Include the attached individual completed and signed disclosures for each.***

Planner	County Employee? *YES ____ NO ____	Date Disclosure Received/ Reviewed	Any Financial Relation with Commercial Interest?	Any Potential Conflict of Interest? (COI)	If Yes, describe COI and How it Was Resolved
Honorarium Received?	*YES ____ NO ____	*Amount \$ _____			
Planner	County Employee? *YES ____ NO ____	Date Disclosure Received/ Reviewed	Any Financial Relation with Commercial Interest?	Any Potential Conflict of Interest? (COI)	If Yes, describe COI and How it Was Resolved
Honorarium Received?	*YES ____ NO ____	*Amount \$ _____			
Planner	County Employee? *YES ____ NO ____	Date Disclosure Received/ Reviewed	Any Financial Relation with Commercial Interest?	Any Potential Conflict of Interest? (COI)	If Yes, describe COI and How it Was Resolved
Honorarium Received?	*YES ____ NO ____	*Amount \$ _____			



Presenter	County Employee? *YES ____ NO ____	Date Disclosure Received/ Reviewed	Any Financial Relation with Commercial Interest?	Any Potential Conflict of Interest? (COI)	If Yes, describe COI and How it Was Resolved
Honorarium Received?	*YES ____ NO ____	*Amount: \$ _____			
Presenter	County Employee? *YES ____ NO ____	Date Disclosure Received/ Reviewed	Any Financial Relation with Commercial Interest?	Any Potential Conflict of Interest? (COI)	If Yes, describe COI and How it Was Resolved
Honorarium Received?	*YES ____ NO ____	*Amount: \$ _____			
Presenter	County Employee? *YES ____ NO ____	Date Disclosure Received/ Reviewed	Any Financial Relation with Commercial Interest?	Any Potential Conflict of Interest? (COI)	If Yes, describe COI and How it Was Resolved
Honorarium Received?	*YES ____ NO ____	*Amount: \$ _____			

***Refer to Policy VMC #154.03 -**

Note: No Santa Clara County employee may be paid honoraria, travel, lodging, registration fees or personal expenses from Commercial Support sources, Commercial Interests, the VMC Foundation, or any other third party.

Any outside speakers receiving honorarium exceeding \$1,000.00 will require SCMVC CME Committee and approval by the MS President.

Disclosure to the Audience

Describe the method to be used to disclose to audience, if any, and **attach** the documentation of disclosure. (e.g., slides at beginning, flyers, brochures)

Who Identified the Speaker(s) and Topic(s)

What Criteria were used in the selection of speaker(s):

- Subject Matter Expert
- Excellent Teaching Skills/Effective Communicator
- Other, Please Specify:

Were any employees of a pharmaceutical company and/or medical device manufacturer involved with the identification of speaker(s) and/or topic(s):



NO YES, please explain:

Activity Planning: (Criterion 2 - 5)	IMQ/CMA Updated Criteria
<p>For this CME activity, state the overall expected improvement or change in the learner’s competence or performance, or in patient outcome, that will occur by successfully completing or participating in this activity.</p> <p>What is the professional practice gap (PPG) identified by the planner(s) for the learners? NOTE: A GAP is defined as the difference between actual (what is) and ideal (what should be) in regard to physician competence, performance, and/or to patient outcomes.</p> <hr/> <hr/> <p>*List the sources used to identify the PPG(s) (data/information used):</p> <hr/> <hr/> <p>*Educational Need(s): (Criterion 2) For each gap, identify one or more underlying learning need or cause that, if met, would help close the gap.</p> <p>a) _____</p> <p>b) _____</p>	<p>C-2 Identify the gaps between current practice or outcomes and desirable or achievable practice or outcomes (i.e., professional practice gaps. The key for compliance is to be able to show that planning included the identification of a professional practice gap from which needs were identified. *E.g., through review of new practice guidelines, national data, professional society, study published in the journal of “?”, pre-activity survey to define the learner(s) practice gaps.</p>

<p>Type of Need. Identify the specific needs, (knowledge, competence, performance) (Click all that apply below and describe how the educational needs were identified, measured and/or determined)</p> <p><input type="checkbox"/> Knowledge, Explain: _____ _____</p> <p><input type="checkbox"/> Competence, Explain: _____ _____</p>	<p>C2</p> <p>Knowledge = Facts & information acquired through experience/education</p> <p>Competence = applies knowledge to knowing how to do something (ability, skills, strategies);</p> <p>Performance = what</p>
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<input type="checkbox"/> Performance, Explain: _____ _____	one actually does in practice with skills, abilities, strategies
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<p>Based on each identified educational need, specify what is essential for the learner to do or achieve as a result of successful participation in this activity. What are the desired results of this activity? Or, what is your activity designed to change?</p> <p><input type="checkbox"/> Competence (to give the physicians new abilities/skills/strategies) Explain: _____</p> <p><input type="checkbox"/> Performance (to help physicians modify their practice) Must provide data Explain: _____</p> <p><input type="checkbox"/> Patient care outcomes (to help improve patient outcomes) Must provide Data Explain: _____</p>	<p>C3 This criterion is the implementation of Criterion 2 in the provider's overall program of CME. In the planning of its program of CME activities, the provider must attempt to change physicians' competence, performance, or patient outcomes, based on what was identified as needs (that underlie a PPG)</p>
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<p>Based on the desired outcome results of the activity, list at least three (3) measurable objectives designed to change competence, performance or patient care outcome.</p> <p><i>At the completion of this activities, the learner will be able to:</i></p> <ol style="list-style-type: none"> 1. 2. 3. 	<p>C3 Identify how these activities contribute to the overall program's efforts to change learner's competence, or performance, or patient outcomes</p>
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<p>Instructional Format: Check what may be appropriate for the setting, objectives and desired results of the activity.</p> <p> <input type="checkbox"/> Lecture <input type="checkbox"/> Seminar <input type="checkbox"/> Workshop <input type="checkbox"/> Case Presentation <input type="checkbox"/> Enduring Materials <input type="checkbox"/> Moderated AV Presentation <input type="checkbox"/> Other _____ </p>	<p>C5 The provider chooses educational formats for activities/interventions that are appropriate for the setting, objectives, and desired results of the activity</p>

<p>Desirable Physician Attributes/Core Competencies (Criterion 6) <i>CME activities should be developed in the context of desirable physician attributes. Please indicate which American Board of Medical Specialties/Accreditation Council for Graduate Medical Education (ACGME) or Institute of Medicine (IOM) core competencies will be addressed in this activity</i></p>		
<input type="checkbox"/> Patient Care or Patient-Centered Care <input type="checkbox"/> Medical Knowledge <input type="checkbox"/> Works Effectively in interdisciplinary teams <input type="checkbox"/> Employ Evidence-Based Practice <input type="checkbox"/> Interpersonal and Communication Skills	<input type="checkbox"/> Utilizes informatics <input type="checkbox"/> Professionalism <input type="checkbox"/> Practice Based Learning and Improvement <input type="checkbox"/> Applies Quality Improvement <input type="checkbox"/> System Based Practice	<p>C6 The provider develops activities/educational interventions in the context of desirable physician attributes or core competencies, such as those developed by the Institute of Medicine (IOM, Accreditation Council for Graduate Medical Education (ACGME), American Board of Medical Specialties (ABMS), or by medical boards relevant to your target audience.</p>
<p>Describe how the selected desirable physician attribute(s)/Core Competencies will be integrated into this activity:</p>		



Clinical Content Validation (Criterion 10)

<p>List each presentation or material with clinical content.</p> <p>a) _____</p> <p>b) _____</p> <p>a) _____</p> <p>b) _____</p> <p>*Describe your mechanism to resolve conflict of interest and ensure your presentation is commercial bias free.</p> <p>Identify the physician reviewer validating content: _____</p>	<p>C10</p> <p>The provider actively promotes improvements in health care and NOT proprietary interests of a commercial interest. Providers are expected to ensure that their CME program and activities advance the public interest without bias that would influence overuse or misuse of products or services of a commercial interest.</p>
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Evaluation and Outcomes (Criterion 11)

<p>What types of evaluation methods will you use to know if your activity was effective at meeting the change in competence, performance, or patient care outcome?</p> <p>Competence</p> <p><input type="checkbox"/> Post-Program Evaluation - intent to change behavior or practice based on the content of activity</p> <p><input type="checkbox"/> Customized post-test/activity (Conducted 3-6 months after activity)</p> <p><input type="checkbox"/> Audience Response System (ARS) tests learning before, during and after activity (Knowledge/Competence).</p> <p><input type="checkbox"/> Case-based studies (learner must make decisions)</p> <p><input type="checkbox"/> Other, specify; _____</p> <p>Performance</p> <p><input type="checkbox"/> Customized follow-up surveys/focus groups about actual changes in practice.</p> <p><input type="checkbox"/> Customized post-test/activity (Conducted 3-6 months after activity)</p> <p><input type="checkbox"/> Measurement of adherence to best practices/guidelines</p>	<p>C11</p> <p>The provider analyzes the overall changes in the learners' competence, performance, or patient outcomes achieved as a result of the overall program's activities/educational interventions.</p>
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Other, specify: _____

Patient Outcomes *

- Observed changes in health status measures
 - Changes in hospital/department/practice quality and patient safety related measures, registry data, etc.
- Customized post-test/activity (Conducted 3-6 months after activity)
- Other, Specify: _____

***(e.g., sepsis rate from hospital QI data)**

Cultural and Linguistic Competence (CLC) AB1195

If this activity addresses clinical patient care, it is required to list any identified cultural and/or linguistic disparities that were determined to be relevant to this activity. Describe below how the disparity will be addressed in the activity (see graph below from various topics of CLC)

NOTE: It is the responsibility of the VMC planner to identify, as part of the planning process, at least one linguistic or cultural health disparity that is related to the identified professional practice gap. If no CLC or disparity is identified, **document** that not relevant.





**PRELIMINARY CME ACTIVITY BUDGET
SCVMC CME COMMITTEE
(To be used for One Time and RSS Course Submissions)**

INCOME

Registration Fee Anticipated (if any): \$ _____

Total income from registration fee (if any): \$ _____

*Honorarium (if any) \$ _____

Administrative Support \$ _____

Activity Planner(s) Support \$ _____

**Commercial Exhibit Income \$ _____

Other : _____ \$ _____

TOTAL INCOME (cannot be zero): \$ _____

EXPENSES

*Honorarium (if any): \$ _____

Brochure & Printing cost : \$ _____

Venues/ Audio Visual Cost : \$ _____

Meal Expense: \$ _____

Administrative Support \$ _____

Activity Planner(s) Support \$ _____

**Commercial Exhibit Expenses (if any) \$ _____

Other : _____ \$ _____

TOTAL EXPENDITURE (cannot be zero) \$ _____

NOTE: Expenditure cannot be higher than income



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** Exhibit Agreement completed and submitted at time of CME planning request