**Office of Continuing Medical Education Activity Planning Guide**

**7703 Floyd Curl Drive, MSC 7980**

**San Antonio, Texas 78229**

**Email: cme@uthscsa.edu**

**Phone: 210.567.4491**

**Fax: 210.562.5579**

* Please submit one copy of this planning guide **at least 14 days in advance of event or at the beginning of planning the event**. Processing will usually be completed in a shorter timeline, but cannot be guaranteed.
* Completed Planning Guide along with required attachments should be submitted via email to cme@uthscsa.edu.
* Payment for CME fees may be made via credit card (American Express/Discover/ MasterCard/Visa), check or interdepartmental transfer
* Payments for CME fees by check should be made payable to the***Office of CME*** and mailed to the address above.

1. **Sponsoring Organization**

|  |  |
| --- | --- |
| Name of Organization |  |
| Course Director |  |
| Planning Members |  |
| Street Address/City/State/Zip |  |
| E-Mail Address |  |
| Telephone Number |  |
| For UT Health SA dept/div only:  Finance Director or Finance Manager |  |
| E-Mail Address |  |
| Activity Coordinator |  |
| Street Address/City/State/Zip |  |
| E-Mail Address |  |
| Telephone Number |  |
| Fax Number |  |
| Type of Organization |  |
| Co-Sponsors (*if applicable*) |  |
| UT Health SA Faculty Sponsor  (*if applicable*) |  |

1. **Activity Information**

|  |  |
| --- | --- |
| **Title of Activity** |  |
| **Begin/Ends Date(s) of Activity** |  |
| **Start Time(s)/End Time(s)** |  |
| **Course Web Address**  *(if applicable)* |  |
| **Venue Name** |  |
| **Venue City & State** |  |
| **Activity Format** | \_\_ Live Activity \_\_\_\_\_ Virtual Meeting  \_\_ Distance Learning  \_\_Grand Rounds, \_\_M&M, \_\_Lecture Series,  \_\_Case Conference, \_\_Journal-based  \_ Daily, \_\_Weekly, \_\_Monthly, \_\_Quarterly, \_\_Other    \_\_Monday, \_\_Tuesday, \_\_Wednesday, \_\_Thursday,  \_\_Friday |
| **Target Audience**  **(MD, DO, RN, PharmD, etc)** |  |
| **Expected Number of Participants** |  |
| **Teaching Methods**  *(check all that apply)* | \_\_ Lecture  \_\_ Case Based Discussion  \_\_ Panel  Simulation  Skill Based Training  Small Group Discussion  Other: |
| **Brief Description of Course Content** |  |
| **Statement of Need on which the Professional Practice Gaps will be identified for this Activity in 4-5 sentences (should answer the question: What conditions, issues, or problems exist that make it necessary or advantageous for physicians to participate in this activity)** |  |
| **Professional Practice Gap(s) of your learners on which this activity is based.**  **(Please add additional professional practice gaps as needed)** | **Professional Gap 1:**  The Current Practice: \_\_\_  The Source used: \_\_\_  The Gap to identify the type of outcomes: \_\_\_  Learning Objective(s): \_\_\_  **Professional Gap 2:**  The Current Practice: \_\_\_  The Source used: \_\_\_  The Gap to identify the type of outcomes: \_\_\_  Learning Objective(s): \_\_\_ |
| **Specialty Boards and Maintenance of Certification**  **Has the relevant specialty board(s) and/or national association developed standards that affect the content of this activity?** | If so, indicate curriculum reflective of these standards: \_\_\_ |
| **Maintenance of Certification II** | Will this activity provide Maintenance of Certification II (MOC II)? If so, an additional CME administrative fee will be assessed.  \_\_Yes \_\_\_ No |
| **Competencies that will be addressed in the Activity content (*check all that apply*)** | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  | | --- | --- | |  | Yes | | ABMS/ACGME-Patient Care and Procedural Skills |  | | ABMS/ACGME-Medical Knowledge |  | | ABMS/ACGME-Practice-based Learning and Improvement |  | | ABMS/ACGME-Interpersonal and Communication Skills |  | | ABMS/ACGME-Professionalism |  | | ABMS/ACGME-Systems-based Practice |  | | Institute of Medicine-Provide patient-centered care |  | | Institute of Medicine-Work in interdisciplinary teams |  | | Institute of Medicine-Employ evidence-based practice |  | | Institute of Medicine-Apply quality improvement |  | | Institute of Medicine-Utilize informatics |  | | Interprofessional Education Collaborative-Values/Ethics for Interprofessional Practice |  | | Interprofessional Education Collaborative-Roles/Responsibilities |  | | Interprofessional Education Collaborative-Interprofessional Communication |  | | Interprofessional Education Collaborative-Teams and Teamwork |  | | Other Competencies-Competencies other than those listed were addressed |  | | |
| **Ethics Credit** | **Will this activity include content related to ethics (check one)?**  \_\_\_\_ Yes *(please provide presentation to Office of CME at least two weeks prior to start of activity for review/approval by a UT Health SA ethicist)*  \_\_\_\_ No |
| **Pain Management and the Prescription of Opioids** | **Will this activity include any of the following topics related to Pain Management and the Prescription of Opioids?**  **• best practices, alternative treatment options, and multi-modal approaches to pain management** that may include physical therapy, psychotherapy, and other treatments;  **• safe and effective pain management related to the prescription of opioids and other controlled substances, including education regarding:**  - standards of care;  - identification of drug-seeking behavior in patients; and  - effectively communicating with patients regarding the prescription of an opioid or other controlled substances; and  **• prescribing and monitoring of controlled substances.**  \_\_\_\_ Yes  \_\_\_\_ No |
| **Commercial Support** | **Will this activity require educational grant support?**  \_\_Yes \_\_\_ No  (*If yes, please attach list of company names, therapeutic interests/areas of focus and amount of grant requests*) |
| **Sources of Financial Support** | \_\_Registration  \_\_Other (exhibitors, sponsorships, etc) |
| **Registration Fees** (if applicable) | Amount Per Learner: \_\_\_\_\_\_ |
| **Documents to attach and email along with the Planning Guide** | **Please attach:**   * **Agenda** * **Brochure** * **List of company information for grants (*if applicable*)** * **List of planning committee members (First Name Last Name, credentials (MD, DO, RN, PharmD, etc), email address, telephone number** * **List of speakers (First Name Last Name, credentials (MD, DO, RN, PharmD, etc), email address, telephone number** |
| **Do you require any of these additional Office of CME services?** | \_\_Educational Grants (please provide company names and budget)  \_\_Exhibitor Solicitation (please provide company names)  \_\_Marketing (e-blasts, website)  \_\_Meeting Planning  \_\_Onsite Staffing  Virtual meeting coordination  Recording presentations/speakers  \_\_Online Registration  \_\_CE Credits  \_\_RN/NP  \_\_PT  \_\_ATC/LAT |

**Email the completed planning guide and required documents to cme@uthscsa.edu.**

|  |  |
| --- | --- |
| ***This section to be completed by the Office of Continuing Medical Education*** | |
| Date Received by Office of CME |  |
| Date Approved by Office of CME |  |
| Conference Coordinator Assigned |  |
| **Educational Planning - select Yes or No**  (to be completed by the Senior Administrative Assistant)   |  |  |  | | --- | --- | --- | |  | Yes | No | | Designed to change Competence? |  |  | | Changes in Competence evaluated? |  |  | | Designed to change Performance? |  |  | | Changes in Performance evaluated? |  |  | | Designed to change Patient Outcomes? |  |  | | Changes in Patient Outcomes evaluated? |  |  | | |