**Activity Application for Continuing Medical Education**

**UT Health San Antonio - Office of CME**

7703 Floyd Curl Drive, MSC 7980

San Antonio, Texas 78229

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Phone: 210.567.4491

* Please submit one copy of this Activity Application **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 Activity Application along with required attachments should be submitted via email to** [**cme@uthscsa.edu**](mailto:cme@uthscsa.edu) **.**
* Payment of CME fees may be made by:
* Credit card (American Express/Discover/ MasterCard/Visa)
* Interdepartmental transfer
* Check made payable to the**Office of CME** and mailed to the address above

1. **Organization Information**

|  |  |
| --- | --- |
| **Name of Organization** |  |
| **Course Director** |  |
| Planning Members |  |
| E-Mail Address |  |
| Telephone Number |  |
| **Finance Administrator** |  |
| E-Mail Address |  |
| **Activity Coordinator** |  |
| E-Mail Address |  |
| Telephone Number |  |
| **UT Health SA Faculty Sponsor**  (if applicable) |  |

1. **Activity Information**

|  |  |
| --- | --- |
| **Activity Title** |  |
| **Beginning Date of Activity** (mm/dd/yyyy) |  |
| **End Date of Activity** (mm/dd/yyyy) |  |
| **Course Web Address**  (if applicable) |  |
| **Activity Location**  (City & State) |  |
| **Activity Type** | **\_\_** In-Person **\_\_** Virtual Meeting **\_\_** Distance Learning  **\_\_** Daily, **\_\_** Weekly, **\_\_** Monthly, **\_\_** Quarterly, **\_\_** Other |
| **Target Audience**  (MD, DO, RN, PharmD, etc) |  |
| **Expected Number of Participants** |  |
| **Educational Format**  (select all that apply) | **\_\_** Lecture **\_\_** Case Based Discussion    **\_\_** Panel  Simulation  Skill Based Training **\_\_** Small Group Discussion  **\_\_** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Brief Description of Course Content:**  Please consider when planning your activity:   * topics on diversity, inclusion and equity * diversity among your speakers |  |
| **State the Educational Need** |  |
| **What are the professional practice gaps to be addressed?** |  |
| **What evidence do you have to support these gaps?** | **\_\_** Survey data from stakeholders, target audience members, content experts, etc.  **\_\_** Input from stakeholders such as healthcare professionals, managers, or content experts  **\_\_** Evidence from quality studies and/or performance improvement activities to identify opportunities for improvements  **\_\_** Evaluation data from previous education activities  **\_\_** Trends in literature, law and health care  **\_\_** Direct observation  **\_\_** Other – Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Is it a gap in the healthcare professionals’ knowledge, competence, or performance?**  (select all that apply) | **\_\_** Knowledge  **\_\_** Competence (skills)  **\_\_** Performance |
| **Based on the need/gaps the activity is addressing, what is the activity designed to change?**  (select all that apply) | **\_\_** Competence  **\_\_** Performance  **\_\_** Patient Outcomes |
| **Upon completion of this course, learners will be able to:**  (learning objectives) |  |
| **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 |
| **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 |
| **Do you require any of these additional services for your activity?** | **\_\_** Educational grant solicitation**\*** *(please provide company names, budget and select competencies below)*  **\_\_** Exhibitor solicitation *(please provide company names)*  **\_\_** Marketing (e-blasts, website)  **\_\_** Live meeting planning  **\_\_** Onsite staffing  **\_\_** Virtual meeting coordination  **\_\_** Presentation/speaker recording  **\_\_** Online registration  *\*Please specify date to open registration:* **\_\_\_\_\_\_\_**  **\_\_** Other CE credits  *\*Please specify:* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\*\**If you require grant solicitation by us, please select competencies that will be addressed in the activity content. If not, you may skip.***  (select all that apply) | **ABMS/ACGME**  **\_\_** Patient care and procedural skills  **\_\_** Medical knowledge  **\_\_** Practice-based learning and improvement  **\_\_** Interpersonal and communication skills  **\_\_** Professionalism  **\_\_** Systems-based practice  **Institute of Medicine**  **\_\_** Provide patient-centered care  **\_\_** Work in interdisciplinary teams  **\_\_** Employ evidence-based practice  **\_\_** Apply quality improvement  **\_\_** Utilize informatics  **Interprofessional Education Collaborative**  **\_\_** Values/ethics for interprofessional practice  **\_\_** Roles/responsibilities  **\_\_** Interprofessional communication  **\_\_** Teams and teamwork  **National Quality Strategies**  **\_\_** Making care safer  **\_\_** Communication and care coordination  **\_\_** Prevention and treatment practices  **Barriers to Optimal Patient Care**  **\_\_** Conflicting Evidence  **\_\_** Lack of Training  **Quality Components**  **\_\_** Shared decision making  **\_\_** Treatment expectations  **\_\_** Care management  **\_\_** Preventable hospital admissions  **\_\_** Inappropriate or unnecessary care  **\_\_** Communication  **\_\_** Care transitions  **\_\_** Cross-provider coordination |
| **Required Documentation:**  Drafts are acceptable.  Please provide **anticipated date** of submission if documents are not attached. | * **Agenda**   **\_\_** Yes  \_\_ No (Date: \_\_\_\_\_\_\_)   * **Marketing Material (flyer/brochure)**   **\_\_** Yes  **\_\_** No (Date: \_\_\_\_\_\_\_)   * **Grants** (if applicable)   Educational grant company names & contact representative  **\_\_** Yes  **\_\_** No (Date: \_\_\_\_\_\_\_)  Estimated Budget  **\_\_** Yes  **\_\_** No (Date: \_\_\_\_\_\_\_) |