**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** **.**
* 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: \_\_\_\_\_\_\_) |