

CME Conference Planning Document

| **Program Title:** |
| --- |
| **Type of Activity:**   * **Live One-time** * **Internet Live Course (webinar)** * **Enduring Material** * **Enduring Material - Online Activity** * **Regularly Scheduled Series: Quarterly, Monthly, Weekly? Time:**   **Location:**  **Activity Date(s):**  **Would you like the CME office to apply for AAFP credit for this conference? \_\_\_\_\_\_\_\_\_\_\_\_** |
| **Number of participants expected:**  \_\_\_\_ Attendings \_\_\_\_\_\_ Residents/Fellows \_\_\_\_ Others, please specify: |

| **Organization:** |
| --- |
| **Activity Director:**  **Email Address:** |
| **Name of Person responsible for management and paperwork:**  Phone: Fax: e-address: |

**Program Planning Committee/ Departmental CME Committee**

Please list names and attach disclosure form for each of the following:

a. Activity Director \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTE: If the program director has relationships with companies whose products may discussed during this program **or** if there is commercial support, a planning committee with a majority who have NO relationships with relevant companies must be responsible for planning each session of this program**. UB units/departments should use the departmental CME Committee.**

Planning Committee Member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Planning Committee Member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For CME Office Use only

Date application received\_\_\_\_\_\_\_\_\_\_\_\_

Activity Code: \_\_\_\_\_\_\_\_\_\_\_\_

Number of credits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Tips for Writing a Needs Assessment Summary:**

Ask your educational planning committee meeting the following questions in order to address professional practice gaps\*:

* What are the patient cases that keep you up at night?
* What do you think your colleagues have the most trouble with?
* What type of patient cases do you refer the most?
* If you are a specialty group, what types of cases are referred to you that you don’t think received the right work up?
* What new science or technology is available for the target audience?

***\*Professional Practice or Education Gap(s)*** *A professional practice gap is the difference between actual and ideal performance and/or patient outcomes. When there is a gap between what the professional is doing or accomplishing compared to what is "achievable on the basis of current professional knowledge," there is a professional practice gap.*

**Target Audience.** Please identify the learners' characteristics e.g. specialties; types of professionals; level of training.

**Curriculum Development**

Please indicate which of the **Accreditation Council for Graduate Medical Education (ACGME)**

**Core Competencies** will be addressed in this series (check all that apply):

* Patient Care
* Medical Knowledge
* Professionalism
* Practice based learning and improvement
* Systems based practice
* Interpersonal and Communication skills

Please indicate which of the **Institute of Medicine Competencies** will be addressed in this series (check all that apply):

* Provide Patient Centered Care
* Work in Interdisciplinary Teams
* Employ Evidence-based Practice
* Apply Quality Improvement
* Utilize Informatics

Please indicate which of the **Interprofessional Collaborative Competencies** will be addressed in this series (check all that apply):

* Value/Ethics for Interprofessional Practice
* Roles and Responsibilities
* Interprofessional Communication
* Teams & Teamwork

**General Needs Assessment**: Identify the problem, the current approach and the ideal approach. Please support your statements with references and data.

**Goals:** Please identify the goals of the program. (Goals are a broad statement of what you plan to accomplish through the program)

Please use the table below to match the needs of the learner with the educational goals and objectives. Objectives must be specific, realistic and measurable. For each objective please indicate if the desired change is intended to improve learner **C**ompetence, **P**erformance or **P**atient **O**utcome

| **Need** | **Goal** | **Educational Objective** | **Desired change in learner**  **(C, P, or PO)** |
| --- | --- | --- | --- |
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Educational design: How do you plan on structuring the program? How will the information be disseminated? How do you plan to address barriers to physician change in this program? **(please attach an agenda)**

**Evaluation.** The CME office will draft an evaluation form based on your objectives or desired results.

**Assessment:** How do you plan to assess the success of the program? Were you successful in meeting your objectives? How will you use the information collected during assessment to improve the program?

Please identify factors outside the provider’s control that impact patient outcomes.

Please identify any non-educational strategies that may be utilized to enhance changes in patient care (eg: reminders, patient feedback)

**CME Program Application (Conference)**

**~ Preliminary Budget ~**

**II. Anticipated Sources of Support**

a. Your organization, hospital, department $ \_\_\_\_\_\_\_\_\_\_\_\_

b. List each grant from commercial or other sources, e.g., foundations

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c. Registration fee @ $\_\_\_\_\_\_\_\_\_\_ x \_\_\_\_\_\_\_\_\_\_ number of attendees = $ \_\_\_\_\_\_\_\_\_\_\_\_

d. Other support (please specify), e.g. exhibit fees, equipment loan $ \_\_\_\_\_\_\_\_\_\_\_\_

**Total Anticipated Income: $ \_\_\_\_\_\_\_\_\_\_\_\_**

**III. Anticipated Expenses**

a. Printing and mailing $ \_\_\_\_\_\_\_\_\_\_\_\_

b. Food $ \_\_\_\_\_\_\_\_\_\_\_\_

c. Audio-visual services, facilities, $ \_\_\_\_\_\_\_\_\_\_\_\_

d. List each speaker, honorarium and expenses:

Refer to UB policies, please.

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e. CME fee $ \_\_\_\_\_\_\_\_\_\_\_\_

1. Management/administrative services $ \_\_\_\_\_\_\_\_\_\_\_\_
2. Other $ \_\_\_\_\_\_\_\_\_\_\_\_

**Total Estimated Expenses** $ **\_\_\_\_\_\_\_\_\_\_\_\_**

**IV. Organizational account where funds for this program will be deposited? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**V. If income exceeds expenses, what will happen to the surplus?**

**VI. If expenses exceed income, how will you cover the costs?**

**[Note:** A final report of actual income and expenses is required after the conference and before certificates are sent. The CME Office will provide the report form for this purpose.]