

**The Geisinger Health System Continuing Medical Education Office
Application for Category 1 Credit**

Type of Activity: Conference or Lecture – *single or multi-day meeting presented only one time at one location*
 Regularly Scheduled Series – *activity that occurs on a regular basis with global objectives (e.g., Grand Rounds)*
 Reoccurring Series – *a single activity repeated several times at various locations*

Type of Credits: AMA (Physician) PSNA (Nurse) AAPA (PA-C) ACPE (Pharmacy)
 CDR (Dietitians) APA (Psychologist) NBCC (Counselors)
 ASRT (Rad-Tech) AOTA (Occupational Therapy)
 Other _____

Title _____

Date(s) _____ Time _____ Total Hours _____

Location _____ City _____ State _____

CME Activity Director _____ Phone _____

Mailing Address or internal zip _____

E-Mail Address _____

Planning Committee: Please complete the grid below for all individuals involved in the *planning* of this activity who have control over the content (attach an additional sheet if necessary). A **Disclosure Form** for each of the individuals listed must be attached to the application.

Name/Title (MD, DO, PhD, etc.)	Role in the Planning Process

Needs Assessment and Planning Process

1. Please identify the professional practice gap(s) addressed with this CME activity. A professional practice gap, or quality gap, is the difference between what is currently being achieved and what could be achieved using best practice guidelines. These can go beyond patient care and include systems-based practice, informatics, leadership and administration.

2. What data sources were used to identify learners' need(s)? (Check all that apply*)

- | | |
|---|--|
| <input type="checkbox"/> Literature/Web Research | <input type="checkbox"/> State or National Patient Care Data |
| <input type="checkbox"/> Performance Improvement Activity | <input type="checkbox"/> Quality Improvement Analysis |
| <input type="checkbox"/> Pre/Post Tests | <input type="checkbox"/> DRG's |
| <input type="checkbox"/> Medical Specialty Board – Maintenance of Certification | |
| <input type="checkbox"/> Other, please specify: _____ | |

***Copies must be attached to this application.**

With reference to the source(s) identified above, briefly summarize the need related to the practice gaps _____

3. The educational needs related to the practice gap(s) are: (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Knowledge-based | (Information) |
| <input type="checkbox"/> Competence-based | (Ability to apply information and skills) |
| <input type="checkbox"/> Performance-based | (Actual implementation or application of information or skills) |

4. **Instructional Objectives(s):** If you are requesting more than 2.0 credit hours, please identify the objectives for each presentation on a Program Agenda and attach the agenda to this application. Otherwise you may list the objectives below. Please use active, learner-centered objectives for this activity written to reflect the performance your learners should be able to exhibit as a result of participation in the activity.

At the completion of this conference, the participant will be able to:

A) _____

B) _____

C) _____

5. **Content Matter** –(attach outline of program or powerpoint of lecture)

6. Which ACGME/ABMS competencies are addressed with this CME activity?

(Check all that apply)

- Patient Care - compassionate, appropriate and effective for the treatment of health problems and the promotion of health
- Medical Knowledge – sound knowledge of biomedical, clinical and cognate sciences and the application to inpatient care
- Practice-based Learning and Improvement – investigation and evaluation of the physician's own patient care, appraisal and assimilation of scientific evidence and improvements in patient care
- Interpersonal and Communication Skills – effective information exchange and teaming with patients, their families and other health professionals
- Professionalism – commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse population
- Systems-based Practice – actions that demonstrate awareness of and responsiveness to the larger context and system for health care and the ability to effectively call on system resources to provide care that is optimal

7. **Educational design** - what presentation method(s) do you intend to use?

(Check all that apply)

- Lecture(s) only Workshop(s) Panel Discussions
- Case Presentations Demonstrations Role Playing
- Other _____

8. Who is the **Target Audience** _____

9. How is the content of this activity related to your target audience's current or potential scope of professional activities? _____

10. **Teaching Staff** - please list with appropriate titles. A CV for any outside speaker must accompany application. A Disclosure & Attestation form must be submitted to the CME Office prior to the activity for all faculty. All conflicts must be resolved prior to the activity.

Check to acknowledge understanding of this requirement

11. **Costs**- How do you propose to cover costs associated with this program?

- Pharmaceutical Support Foundation Grant
- System Grant Tuition Fees
- N/A Other _____

12. **Special Expenses** - Do you anticipate any special expenses?

- Honorarium \$ _____ Special Services \$ _____
- Special Meals \$ _____ Other \$ _____

13. Identify the anticipated changes in learners' competence, performance and/or patient outcomes as a result of the activity and describe how this activity will benefit the physician learners' and/or their patients:

14. In what ways does this event have value for the attendees, Geisinger Health System and/or the Community? _____

15. What would be the impact on the attendees, Geisinger Health System and/or the community if this event did not occur?

16. What mechanism(s) will you use to measure the effectiveness of meeting the expected outcomes? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Skills Assessment of Learners | <input type="checkbox"/> Formal Study |
| <input type="checkbox"/> Performance Improvement | <input type="checkbox"/> Pre and/or Post Tests |
| <input type="checkbox"/> Activity Objectives Evaluation | <input type="checkbox"/> Follow-up Survey |
| <input type="checkbox"/> Quality Improvement Analysis | <input type="checkbox"/> Chart Audits |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Statistical Review |

FOR CME OFFICE USE ONLY: do not write below this line

____Fast Track Approval

Signature_____ Date_____

Signature_____ Date_____

Signature_____ Date_____

CME Committee Action_____ Date_____