

Check one: Chicago Peoria Rockford Urbana

CONTINUING MEDICAL EDUCATION ACTIVITY PROPOSAL

Attachments should indicate the referable section. (e.g., C. Marketing).

ACTIVITY TITLE:

EPISODIC ___ *short duration (e.g.,1 day); may be repeated more than once during the approval period*

ONGOING ___ *regularly scheduled series (eg., Grand Rounds, M & M, etc.)*

New
OR
Renewal

SPONSORING DEPARTMENT(S):

Joint or Co-Sponsor:

ACTIVITY DIRECTOR: (The faculty member responsible for the activity.)

Name and faculty rank

Department

Campus Address

Telephone

Fax
Email

Please name below the person responsible for revisions:

Administrative Contact

Phone
Email

B. PARTICIPANTS

1. INTENDED PHYSICIAN PARTICIPANTS: *(e.g., Primary Care Physicians)*

2. OTHER ANTICIPATED PARTICIPANTS/ATTENDEES: *(Please check all that apply)*

Other Health Professionals *(Specify)*

Students *(Specify)*

Others *(Specify)*

Indicate the number of
participants the course
is designed for:

anticipated
attendance

minimum

maximum

C. MARKETING

1. PLAN - *Please describe the marketing plan for the activity; how and to whom you will publicize it.*

2. ANNOUNCEMENT/BROCHURE - *Include a copy of all proposed promotional information, brochures, flyers, or advertisements. (Note: all material must show UIC sponsorship, target audience, specific activity objectives, and acknowledge commercial support. Please consult the Brochure Guidelines.) THE FINAL BROCHURE MUST BE APPROVED BY THE CME OFFICE. THE AGENDA MUST BE ATTACHED.*

D. CURRICULUM

Complete **either** ONGOING on page 5 **or** EPISODIC on page 6. See definitions below:

ONGOING - Multiple session series e.g., Grand Rounds, Tumor Boards, Morbidity & Mortality, etc.

EPISODIC - A single activity designed for one date or repeated dates

1. ONGOING

Since most ongoing programs do not have topics planned for the whole year, it is essential for the framework of the program to be well described. To accomplish this, the overall objectives of the activity should be defined. The overall objectives must include three components: Time, Scope and Objectives. (See example below).

Time *e.g. “Over the next twelve months,”*

Scope *e.g. “Patients presenting with uncommon symptoms or presentations of common problems encountered by a specified category of physician, and*

Objectives *e.g. “For the topics to be covered the participant will be able to:*

- 1. Correlate clinical diagnosis with pathologic, radiological, and surgical findings,*
- 2. Discuss the staging and grading of the specific presented tumors,*
- 3. List the treatment options for specific presented problems, and*
- 4. Identify the psychosocial aspects, and how they affect treatment.*

Topic-specific objectives for each session do not need to be provided here. However, they do need to be developed as each session is planned. These objectives should appear on all posted announcements.

A. LEARNING OBJECTIVES: *Please list the learning objectives on the lines below. State the activity's objectives in behavioral terms. A list of active verbs is available from the CME office.*

Upon completion of the activity, participants should be able to:

B. RELATE PROGRAM'S ACTIVITIES TO THE LEARNING OBJECTIVES

Please fill out the grid below. For each educational objective, identify the content and teaching/learning activity which addresses the objective. Use objectives listed above.

OBJECTIVES – <i>use numbers above</i>	TEACHING METHOD	TIME
<i>EXAMPLE - 1. Discuss the staging and grading of the specific presented tumors</i>	<i>EXAMPLE - Case presentation Expert discussion</i>	<i>EXAMPLE - Entire session</i>

2. EPISODIC

A. LEARNING OBJECTIVES: *Please list the learning objectives in the box below. State the activity's objectives in behavioral terms. (See example in grid below) A list of active verbs is available from the CME office.*

Upon completion of the activity, participants should be able to:

B. RELATE PROGRAM'S ACTIVITIES (Content and Format) TO THE LEARNING OBJECTIVES *Please fill out the grid below. For each educational objective, identify the content and teaching/learning activity which addresses the objective. Use the number of each objective listed above.*

OBJECTIVES—use numbers above	TEACHING METHODS	SESSION NAME
<i>EXAMPLE - 1. Explain advances in GI pathophysiology and disease.</i>	<i>EXAMPLE - Panel discussion Lecture</i>	<i>EXAMPLE - Tuesday morning session Wednesday afternoon session</i>

C. PROGRAM

Enclose an outline, draft or final copy of the agenda including dates, times, types of presentations, (e.g. keynote address, panel discussion, small group, etc.) and names of presenters.

FOR ALL ACTIVITIES, CONTINUE UNTIL THE END

E. EDUCATIONAL METHODS:

Which educational methods will be used?

Lecture or Lecture/Question

Formal prepared presentation or extemporaneous talk by one individual

Lecture/Discussion

Short lecture 15-30 minutes with active discussion by those present.

Case Presentation/Discussion

Short presentation of one or more cases followed by extended discussion with participants.

Workshop

Small group sessions with interactive groups of 8-12 with specific charges to be accomplished. May include short case presentations. May include performance of manipulative skills under supervision.

Panel Discussion

2 or more experts addressing individual issues, either with questions from floor or short topics presented by a Moderator.

Demonstration

Demonstration of procedure, including use of film, videotape, closed circuit television, and other mechanical aids.

Bedside rounds, simulated patients or similar observation and discussion of patients.

Individual study assignments

e.g. research and/or patient records on a specific diagnostic or problem category, and subsequent report to larger group for its consideration and discussion.

Other methods

F. FACULTY:

List or attach activity faculty. Include professional degree, institutional affiliation, and present position.

All speakers must provide Disclosure of Interest forms. Disclosure of financial interest must be made to the participants for ALL speakers before their presentations, regardless of whether or not they have anything to disclose.

G. BUDGET AND FEES

INCOME				EXPENSES	
Registration Fee	\$	X	\$	Instructional Staff	\$
				Honoraria (Attach itemized by individual)	\$
Pharmaceutical Grant Support			\$	Travel Expenses	\$
					\$
Other External Support				Promotion	
				Development and Printing	\$
Did you include a letter of agreement for each source of external support?			Y N	Mailing	\$
Pharmaceutical Exhibitors			\$	Advertising	\$
			\$	Supplies	\$
			\$	Instructional/Laboratory Materials	\$
			\$	Copying Expense	\$
Departmental Support			\$	Facilities	
Hospital/COM Support			\$	Room Set-up Fee	\$
				Audio-Visual Equipment Charges	\$
Any deficit is the responsibility of the sponsoring department. If this is not the case, please explain below.				Food Service	\$
					\$
				Other Expenditures specify below:	
				CME Administrative Fee*	\$
					\$
TOTAL INCOME			\$	TOTAL EXPENSES	\$

** See CME Coordinator for more information*

H. ACTIVITY EVALUATION PLAN:

Explain how the activity will be evaluated overall and include a copy of protocols to be used in the evaluation. All evaluations must include, at a minimum, the five items listed on page 10.

CHECK BOXES FOR ALL TECHNIQUES YOU PLAN TO USE TO EVALUATE THE EFFECTIVENESS OF THIS ACTIVITY IN TERMS OF INDIVIDUAL PHYSICIAN LEARNING.

1. EVALUATION METHODS

Written Test/Quiz

Participant Satisfaction Critique

Participant Activity Evaluation

Performance/Competency Test

Skills appraised during activity

Observer evaluation

Follow-up- Explain (e.g., postcard, phone survey, chart audit)

Self reporting follow-up

Other (Please Specify)

EXPLAIN

2. OUTCOME MEASUREMENT

All CME activities should have an impact. This is reflected in the wording of the objectives. Please describe how you plan to evaluate the changes in physician practice and/or the long-term impact of this program on physician behavior. Some examples of methods are surveys, postcards, or follow-up phone calls eg., “Is your approach to patient care (or diagnosis, treatment, therapy, prevention et al) altered due to the knowledge you gained at the conference?” “If so, in what way?”

REQUIRED EVALUATION ITEMS

At a minimum, **the following five items must be included in the evaluation instrument attached.** Examples are given as suggestions and are not meant to be exclusive.

1. Speaker/s evaluation -

eg., Please rate the speaker/s on the following points:

Timeliness of information, appropriate depth of materials, pace of session, length of session, effective use of time, quality of audio-visuals, quality of handout materials, opportunity to ask questions, etc.

2. Educational methods/objectives evaluation -ie, were the teaching methods appropriate to the learning objectives (list the learning objectives developed on page 4 or 5).

eg., At the end of the session, participants will be able to:

A. Describe clinically relevant information regarding the diagnosis of pre-eclampsia.

<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>
<i>Unmet</i>	<i>Minimally met</i>	<i>Mostly met</i>	<i>Completely met</i>

3. Future topics/speakers suggestions -

eg., Please list suggestions for future topics and speakers

4. Usefulness to one's practice or other healthcare activity -

eg., How will today's session impact on your practice?

5. Disclosure of financial interest -

eg., Speakers are required to disclose whether or not they have financial interests which may bias their presentations. Was such disclosure made by each speaker? ___ Yes ___ No

I. EVALUATION SUMMARY

1. EPISODIC ACTIVITY EVALUATION SUMMARY

Summaries are due in the CME Office two weeks after the activity takes place

2. ONGOING ACTIVITY EVALUATION SUMMARY

Summaries are due in the CME Office two weeks after the last session takes place. (ie. July 15)

3. FOR RENEWAL ACTIVITIES ONLY

***If you have presented this activity before, please include a copy of the evaluation summary.
The CME Committee will not consider renewal applications without these materials.***

Summaries should include the number of participants, number of physicians, and number of responses. In addition, please provide both a quantitative summary of responses and a narrative summary of suggestions or comments and how they will be used to design future activities.

UIC College of Medicine

REQUIRED SIGNATURES

CME Activity TITLE:

DEPARTMENT

ACTIVITY DIRECTOR (Type Name)	SIGNATURE (Faculty Member Responsible for Program)	DATE
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Signature of Department Head below indicates endorsement of this CME activity and the assumption of responsibility for any deficit incurred.

HEAD OF SPONSORING DEPARTMENT AT UIC (Type Name)	SIGNATURE	DATE
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CHAIR--SITE COMMITTEE ON CME (Type Name)	SIGNATURE	DATE
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CHAIR-COLLEGE COMMITTEE ON CME (Type Name)	SIGNATURE	DATE
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Approved () Disapproved ()

SENIOR ASSOCIATE DEAN FOR EDUCATIONAL AFFAIRS	SIGNATURE	DATE
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REVISED 4/15/03