Office of Continuing Medical Education

Certification Request for Sponsorship of a CME Activity and AMA PRA Category 1 Credit(s)™
Introduction

The Wake Forest University Health Sciences (WFUHS)/Wake Forest University School of Medicine (WFUSM) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The ACCME requires that accredited providers maintain high standards of quality and documentation in the development and provision of continuing medical education (CME). This Certification Request is intended for faculty, departments, and organizations developing CME activities who agree to support and abide by these standards. Each section is specifically designed to link with the ACCME’s Updated Accreditation Criteria (http://www.accme.org/dir_docs/doc_upload/b03aa5cc-b017-4395-a41f-8d5d89ac31ca_uploaddocument.pdf).

The Office of Continuing Medical Education (OCME) is responsible for maintaining the CME accreditation granted to Wake Forest University Health Sciences (WFUHS)/Wake Forest University School of Medicine (WFUSM). Activities for which CME sponsorship or joint sponsorship is sought must be reviewed and approved by the institutional Continuing Medical Education Committee. Appropriate CME credit is awarded if sponsorship/joint sponsorship is approved. Credit can be withdrawn from previously certified activities if actions by the faculty, staff, planning committee members, or teachers/authors threaten WFUHS’/WFUSM’s accreditation.

As set forth in the core mission statement of WFUSM, the OCME is committed to providing superior, ethical, timely CME to healthcare professionals, specifically physicians, thereby supporting them in constant self-evaluative improvement and lifelong learning of biomedical knowledge and better enabling them to provide optimal, safe patient care leading to the improved health and well-being of the general public. All certified CME activities must help fulfill this mission. In addition, when developing CME activities, it is important to: 1.) build bridges with other stakeholders through collaboration and cooperation and 2.) participate in a framework for quality improvement.

The OCME uses the American Medical Association (AMA) House of Delegates’ definition of CME – “educational activities that serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is the body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of healthcare to the public.” All content must promote improvements in patient care and not a specific proprietary business or commercial interest. (Criterion 10 and the Standards for Commercial Support) Recommendations involving clinical medicine must be based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in the care of patients. In addition, all scientific research referred to, reported, or used in support or justification of a patient care recommendation must conform to the generally accepted standards of experimental design, data collection, and analysis.

Instructions

- Contact/meet with an OCME Program Coordinator.
- Complete the attached Certification Request and return it to the OCME with all required documentation, including all completed Full Disclosure Statements and resolution of conflicts. Material should be submitted to the OCME 6-8 months in advance of the proposed CME activity.
- No accreditation, sponsorship, or credit statements can be used in publicity materials unless approved by the OCME.
- All application fees are non-refundable.

Joint Sponsorship

For CME activities proposed by organizations outside WFUHS/WFUSM, NCBH, or WFUBMC:

- The proposed activity must be consistent with the overall CME mission and policies of WFUHS/WFUSM and follow all ACCME Essential Areas, Policies, and Updated Accreditation Criteria, including the 2004 ACCME Standards for Commercial Support.
- A member of the OCME staff as well as a WFUSM faculty member must serve on the planning committee.
- WFUSM must be listed as a joint sponsor of the activity.
- A commercial interest cannot serve as a joint sponsor. A commercial interest is defined as any entity producing, marketing, re-selling, or distributing healthcare goods or services consumed by or used on patients (excludes non-profit and government organizations).
- All costs not covered by tuition and other activity income must be defrayed by the outside organization.
Certification Request for Sponsorship of a CME Activity and AMA PRA Category 1 Credit(s)™

CME Activity Name: First Annual Brenner Children’s Hospital Pediatric Trauma Conference

Start Date: Nov 3, 2010  End Date: Nov 3, 2010  Venue (including city and state): Hawthorne Inn and Conference Center, Winston-Salem, NC

Activity Type: X Formal Activity (conference, course, workshop, symposium)
☐ Minifellowship
☐ Enduring Material (monograph, journal article, CD, live or archived Internet, podcast)
☐ RSS (regularly scheduled series, e.g. grand rounds/teaching conferences/tumor boards/journal clubs)

RSS Frequency (e.g. 3rd Monday of the month, 10:00-11:00 am):

Activity Director: Dr. John Petty  Phone: 336-716-0546  Fax: 336-716-6637

Address: Dept of General Surgery, WFUBMC

E-mail Address: jpetty@wfubmc.edu  Pager: 806-8044

Staff Coordinator: Ginger Wilkins, RN, MSN, Pediatric Trauma Coordinator, Brenner Children's Hospital

E-mail Address: ggwilkin@wfubmc.edu  WFUHS Department Chair/Section Head: Dr. J. Wayne Meredith (Dept of Surgery)/Dr. Larry Givens (Dept of Peds)

Organization* (if not part of WFUHS/WFUSM, NCBH, or WFUBMC):
*Attach the organization’s mission statement/purpose/description.

If part of WFUHS/WFUSM, NCBH, or WFUBMC, list other departments, sections, divisions, institutes, offices, centers, etc., if any, that are co-hosting this CME activity.

A.) Planning Committee Structure:
In addition to the above individuals, list all persons responsible for planning, designing, developing, and implementing this CME activity. Include names, degrees, titles, and affiliations. [Note: No employee of a commercial interest may serve on the planning committee nor be allowed to influence educational content (nuanced or direct).]*

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/ Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crystal Hopkins, RN, MSN</td>
<td>Nursing Education Dept, WFUBMC</td>
</tr>
<tr>
<td>Susan Hathcock, RN, MSN</td>
<td>Nursing Education Dept, WFUBMC</td>
</tr>
<tr>
<td>Alisa Starbuck, RN, MSN, NNP-BC</td>
<td>Director of Nursing, Pediatric Critical Care, Brenner Children's Hospital</td>
</tr>
</tbody>
</table>

OFFICE USE ONLY  X PG  JS  AR  EM  MF  RSS  Renewal

Date Received: 9/14/10  Date Reviewed: 9/27/10  Date Approved: ___________  OCME Program Coordinator: JP

Approved for ___________ AMA PRA Category 1 Credit(s)™ Activity #: ________________

Disapproved (description): __________________________________________________________________________
*All decisions must be free of the control of commercial interests including: (a.) identification of needs; (b.) the determination of educational objectives; (c.) the selection and presentation of content; (d.) the selection of all persons and organizations in a position to control the content; (e.) the selection of educational methods; and (f.) the evaluation of the activity. (Criterion 7 and the Standards for Commercial Support)

B.) Professional Practice Gaps, Educational Needs, Desired Results, & Learner Objectives:
As outlined in its mission statement, by identifying educational gaps, the OCME helps physicians and other healthcare providers recognize the difference between their current practice patterns and those potentially achievable that would lead to practice improvement and thus better, safer care for individuals, communities, and populations. [For this section, you may complete the following chart or Questions #1-4.]

<table>
<thead>
<tr>
<th>Professional Practice Gap</th>
<th>This is a Gap in (check all that apply):</th>
<th>Educational Need</th>
<th>Desired Result (check all that apply):</th>
<th>Designed to Change</th>
<th>Learner Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Knowledge</td>
<td></td>
<td>Competence</td>
<td>Patient Outcomes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Competence</td>
<td></td>
<td>Performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.)</td>
<td>Knowledge</td>
<td></td>
<td>Competence</td>
<td>Patient Outcomes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Competence</td>
<td></td>
<td>Performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.)</td>
<td>Knowledge</td>
<td></td>
<td>Competence</td>
<td>Patient Outcomes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Competence</td>
<td></td>
<td>Performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.)</td>
<td>Knowledge</td>
<td></td>
<td>Competence</td>
<td>Patient Outcomes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Competence</td>
<td></td>
<td>Performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.)</td>
<td>Knowledge</td>
<td></td>
<td>Competence</td>
<td>Patient Outcomes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Competence</td>
<td></td>
<td>Performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OR

1. A professional practice gap is the difference between healthcare processes and outcomes currently in practice and those potentially achievable. Put simply, it is actual practice (what learners currently know and/or do) vs. best practice (what they should know and/or do). These gaps are measured in terms of:
   • Knowledge – being aware of what to do
   • Competence – knowing how to do it
   • Performance – actually doing it

Describe the identified professional practice gap for this CME activity. (Criterion 2)


Pre-hospital emergency care providers may not be as familiar with pediatric emergency management issues as they are with adult care due to infrequent exposure to critically ill children. Mechanisms for knowledge and skill retention are crucial for pre-hospital personnel (Management of Pediatric Trauma. Pediatrics 2008;121:849-854), as well as healthcare providers in the community setting.

It is essential that the components of the trauma system (EMS, referring hospitals, and tertiary care centers) collaborate in their efforts to provide best-practice care of injured children. “It has been shown that younger and more seriously injured children have better outcomes at a trauma center within a children's hospital or at a trauma center that integrates pediatric and adult trauma services” (Management of Pediatric Trauma. Pediatrics 2008; 121:849-854).
As the Level 1 Trauma Center for the entire catchment area, with annual pediatric trauma admissions of approximately 650 injured children (*National Trauma Registry of the American College of Surgeons*), we have the responsibility to offer education on caring for injured children to our referring hospitals/providers and pre-hospital providers. Having experts in the care of injured children address professional practice gaps in knowledge, competence, and performance via didactic learning including case studies and according to current best practice guidelines serves to improve the overall care of the child from point of injury through rehabilitation.

Is the gap in *(check all that apply)*:

- [X] Knowledge
- [X] Competence
- [X] Performance

2. CME activities incorporate the educational needs (knowledge, competence, or performance) that underlie the professional practice gaps. Done prospectively, needs assessments look at gaps from various points of view, showing current practice vs. ideal practice. Possible methods include: review of previous CME activity evaluations; identification by medical staff; requests from affiliated institutions, groups, or community organizations; referral data; expert opinion; legal, government, or regulatory requirements; institutional requirements or strategic plans; focus groups; interviews; survey results; national or specialty society guidelines; committee findings; literature reviews; library requests; Internet searches; community health needs assessments; practice/QI data; quality initiatives; patient chart audits; feedback from third party payers and regulators; P&T committees; Joint Commission standards; Maintenance of Certification (MOC) requirements; Institute of Medicine (IOM), Accreditation Council for Graduate Medical Education (ACGME), and/or American Board of Medical Specialties (ABMS) core competencies; research findings; Translational Science Institute (TSI) research; and/or new medical information. [Note: For RSS, additional needs assessments can be performed for a specific session to further define a professional practice gap. A need can be addressed in more than one session, and new needs can be incorporated over time into a series as long as they are appropriate to the target audience.]

Describe the needs assessments used for this CME activity. How was the need brought to the attention of the planning committee? *(Criterion 2)*

All injured and/or burned children transferred to Brenner Children’s Hospital with ICD-9 codes of 800-959.9 are entered into a national trauma registry database (*Resources for the Optimal Care of the Injured Patient, 2006*). All admissions undergo a primary, secondary, and tertiary review by the trauma registrar, the Trauma Coordinator, and the Trauma Medical Director to ensure that care and treatment is according to guidelines and standards as required by the American College of Surgeons Committee on Trauma (*Resources for the Optimal Care of the Injured Patient, 2006*). Both discretionary and non-discretionary care standards are screened/reviewed for issues that do not follow recommended standards of care per the American College of Surgeons. Any deviations in patient care or systems issues result in Performance Improvement process review and appropriate action is required for loop closure.

Through this biweekly review process, gaps in knowledge and inconsistencies in care have been identified. These include initial management of burned children, management of Traumatic Brain Injury in children, challenges in airway management and intravenous access in children, comprehensive management of the child with non-accidental trauma (child abuse), and current practices and recommendations for Injury Prevention. The case study format is effective in providing insight and guidance for all disciplines in providing comprehensive care of the injured child.

Based upon the identified professional practice gap and the needs assessments used, state the educational need.

Based upon trauma registry data from Wake Forest University Baptist Medical Center’s Trauma Registry and review of injured children (age 0-16) who are transferred and treated in our Emergency Department and Inpatient settings, there is demonstrated need for increased knowledge in the management of the injured child. This data is available upon request and customized reports can be run to ascertain specific statistics regarding type of injury, response times, length of stay, mortality and morbidity, and overall outcome. Review of our hospital’s trauma registry statistics reveal that the majority of complications in the care and treatment of injured children arise in burns, airway management, management and treatment of traumatic brain injuries and illustrate the importance and ongoing need for targeted, effective injury prevention strategies addressing proper use of safety restraints (seatbelts), use of helmets, and falls prevention.
3. Based on the identified gap/need the CME activity is intended to address, what are the desired results? What is the activity designed to change? (Criterion 3) Improvement in outcomes for injured and burned children

This CME activity is designed to change (check all that apply with explanations and measurement plans for each):

- **Competence (give physicians new abilities/strategies/knowledge):** To provide the attendee with the most current practice, knowledge, and experience to improve outcomes and management of injured/burned children across the spectrum of care, from point of injury through rehabilitation.
  
  How do you intend to measure these changes? Possibilities include evaluation questions, audience response system, pre-tests, post-tests, surveys, etc. Evaluations provided by the Office of CME. Results will be used to elicit feedback from participants and to assess effectiveness of the presentations and knowledge gained. Evaluations will be used as a tool to plan for this annual pediatric trauma conference. The trauma registry will be queried for specific “filters” (such as airway and fluid resuscitation complications) for incidence of occurrence before the conference and after. With the guidance of the Trauma Medical Director, Dr. John Petty, the results can be published. We anticipate a positive effect on patient care related to increased knowledge base and will have statistical data via the trauma registry to prove the hypothesis.

- **Performance (help physicians modify their practices):** This conference will serve to give physicians in the community hospital setting the information they need to more effectively manage the pediatric trauma patient.
  
  How do you intend to measure these changes? Possibilities include adherence to guidelines, interviews, focus groups, chart audits, peer review, direct observation, etc. Change will be measured by chart audits (currently already done within the trauma registry/trauma program), peer review (Pediatric Multidisciplinary Trauma Committee; meets biweekly with surgery services represented – NSU, Ortho, Pediatric Surgery) and Emergency Medicine, Anesthesia, and Critical Care Medicine services.

- **Patient Outcomes (help improve patient outcomes):** Mortality, morbidity and complications will be compared prior to and subsequent to the Pediatric Trauma Conference. We will specifically be looking for a decrease in airway complications, adherence to American Burn Association guidelines and recommendations for the management of pediatric burns, delays in transfers, delays in IV access, and expedient management and transfer when indicated of all injured children according to the standards to maintain a Level 1 Trauma Center verification from the American College of Surgeons.
  
  How do you intend to measure these changes? Possibilities include patient feedback, patient chart audits, hospital QI data, etc. This will be measured by review of the Trauma Registry data and specific query of the registry statistics as indicated.

4. Learner objectives should connect the identified need with the desired result and are framed in terms of the expected changes in competence, performance, and/or patient outcomes. Based on the desired, identified results, list the learner objectives for this CME activity. What should the attendees know or be better able to do as a result of participating? Be specific and use the attached list of action-oriented verbs. The number of objectives is not as important as being sure they adequately reflect what is to be achieved at the end of the CME activity.

At the conclusion of this CME activity, the learner should be better able to (list learner objectives):

- Recognize the principles of the management of the injured child according to standards from the American College of Surgeons.
- Distinguish the indications for the need for transfer of the injured child to a higher level of care.
- Discuss current issues in child abuse.
- Recognize the need for comprehensive and multidisciplinary care of the injured child.
- Discuss the management of the burned child and determine when a higher level of care/burn center transfer is necessary.
- Recognize and address challenges in airway management and venous access in the injured child.
- Discuss the ongoing need and benefits for targeted, effective Injury Prevention activities.

C.) Target Audience:
The content of a CME activity should be designed to match learners’ current or potential scope of professional activities. (Criterion 4)
5. Is this CME activity targeted to an internal, local/regional, national, and/or international audience? This CME activity is mainly targeted to the local/regional area. As there is always a need for education on the topic of pediatric trauma, we anticipate the conference growing next year to a statewide and even national level.

6. List what types of practice settings will be represented in the target audience, e.g. academic, tertiary care, community hospital, private/group practice, managed care, non-profit organization, research, public health, mental health, education, government, veterans affairs, military, etc. Emergency Departments, operating room settings, community hospitals, EMS facilities

7. Indicate which specialties of medicine will be targeted (check all that apply):

- Anesthesiology
- Cardiothoracic Surgery
- Family & Community
- Gerontology & Geriatrics
- Molecular Medicine
- Neurosurgery
- Otolaryngology
- Plastic & Reconstructive
- Radiation Oncology
- Surgery
- Biochemistry
- Dermatology
- Gastroenterology
- Hematology & Oncology
- Nephrology
- Obstetrics & Gynecology
- Pathology
- Psychiatry & Behavioral
- Radiology
- Urology
- Cancer Biology
- Emergency Medicine
- General Internal Medicine
- Infectious Diseases
- Neurobiology & Anatomy
- Ophthalmology
- Pediatrics
- Public Health Sciences
- Regenerative Medicine
- Others:
- Cardiology
- Endocrinology/Metabolism
- General Surgery
- Microbiology/Immunology
- Neurology
- Orthopaedic Surgery
- Physiology & Pharmacology
- Pulmonary/Critical Care/Allergy/Immunologic Disease
- Rheumatology

8. Indicate the target audience’s level of experience (check all that apply).

- Beginner
- Intermediate
- Advanced
- Expert

9. Will medical students, residents, and/or fellows be included? Yes No

10. Is the target audience multidisciplinary, e.g. targeted to both physicians and non-physicians? Yes No

If yes, list other healthcare providers/practitioners that are part of the target audience. RN, EMS (EMT-P, EMT-I), Pharmacists, Respiratory Therapists, Social Workers, Physical and Occupational Therapists are also included, as trauma care requires a multidisciplinary focus. The core group of attendees is anticipated to be Emergency Department physicians and registered nurses.

11. What is the estimated attendance size? 110

12. If additional types of continuing education credit, e.g. American Academy of Family Physicians (AAFP), American College of Obstetrics & Gynecology (ACOG), Accreditation Council for Pharmacy Education (ACPE), American Nurses Credentialing Center (ANCC) are needed, list them. Nursing Contact hours will be awarded. (6.25)

D.) Core Competencies & Governor’s Task Force Health Issues:

13. A CME activity should be developed in the context of desirable physician attributes. (Criterion 6) Indicate which of the Institute of Medicine (IOM), Accreditation Council for Graduate Medical Education (ACGME), and/or American Board of Medical Specialties (ABMS) core competencies will be addressed by this CME activity (check all that apply). [Note: Post-activity evaluations will ask learners to identify which core competencies they felt were addressed.]

- Quality Improvement
- Use of Informatics
- Evidence and Practice-Based Learning & Improvement
- Working in Interdisciplinary Teams
14. If this CME activity has a primary target audience from North Carolina, indicate which of the health issues from the Governor’s Task Force for Healthy Carolinians will be addressed (check all that apply):

- Access to Healthcare
- Chronic Disease
- Cultural Competency
- Disability
- Health Disparities
- Infant Mortality
- Injury
- Community Health
- Environmental Health
- Health PROMOTION
- Mental Health
- Oral Health
- Complementary Med
- Info/Library Services
- Older Adult Health
- Leadership, Management, Education, & Communication
- Women’s Health

E.) Barriers to Change, Collaborations, & Non-Educational Strategies:

15. Often times, factors exist outside the control of the learner that can impact patient outcomes. List any potential or real barriers facing the learner for this need/gap to be addressed. Examples include lack of time; too few resources or administrative support; insurance/reimbursement issues; larger, healthcare system-type issues; patient compliance; costs; etc. (Criterion 18) Potential barriers for learners include lack of resources – both human and equipment – that are chronic barriers in today’s healthcare environment.

16. Describe the educational strategies that will be included in this CME activity to help remove, overcome, or address these barriers. (Criterion 19) Through didactic presentations including, but not limited to case studies, members of the audience will gain knowledge about best practice care of the injured child from point of injury through rehabilitation as well as key concepts of injury prevention. Cite one specific example.

17. List other stakeholders with whom collaboration or cooperation in the development or execution of the CME activity is possible in order to build bridges to quality. Could they help address any of the potential or real barriers listed? Examples include other institutional departments/sections; QI staff/committee; risk management staff; pharmacy and P&T committee; infection control staff/committee; library services; electronic health record staff; compliance office; billing office; office practice managers; managers of institutional initiatives; government agencies; local or national societies; community organizations; patient organizations; etc. (Criterion 20) There are many stakeholders involved in the care of injured children. We have included all stakeholders as attendees for this conference. Pre-hospital providers, referral hospital emergency department staff, respiratory therapists, pharmacists, social workers, RNs, emergency medicine physicians, and physical and occupational therapists are all integral to the positive outcome of an injured/burned child. The multidisciplinary nature of trauma care requires that all disciplines have access to education which serves to enhance injury prevention, care, and outcomes. The Pediatric Trauma Program has developed a mature PI process and works in collaboration with Brenner Children's Hospital PI/QI Programs to facilitate the continual improvement of patient care throughout the Children's Hospital.

18. List any non-educational strategies to enhance/reinforce change as an adjunct to the CME activity. Examples include post-activity reminders to attendees; patient feedback or surveys; patient education materials; algorithms; flow sheets; personal patient outcomes data; display posters; newsletters; protocols; order sets; chart or electronic record reminders; forms; etc. (Criterion 17) Post-activity interaction with attendees, evaluations, and discussion from attendees. A call for posters from within our Trauma Center is out – we anticipate posters on the role we have developed within out Pediatric ED of the “Trauma Nurse Leader” as well as posters/displays on proper fitting of car seats.

F.) Adult Learning Principles & Educational Methodology:
Adult learning is a complex, multistage process that incorporates the learner into the planning and evaluation process. Learning tends to be problem-centered rather than content-oriented, and experience provides the basis for learning, which is focused on material that has immediate relevance. Adults learn by solving genuine problems (reviewing their own issues and daily encounters); reflecting via analogy/comparison (comparing their own experiences to others); practicing and applying new knowledge and strategies; and developing a framework for application (creating plans for implementation). There are five stages of physician learning:

1. Recognizing a need for learning – when a physician becomes aware that something in his/her practice needs improvement
2. Searching for learning resources, which is driven by cognitive dissonance (the difference between what is and what should be)
3. Engaging in learning – when learning (formal or informal) becomes more intentional and focused on the problem at hand
4. Trying out what was learned – when a physician begins to use newly acquired knowledge or skills and looks to confirm the benefits
5. Incorporating what was learned – when a physician integrates the new knowledge or skills into daily practice

Describe how this CME activity will incorporate adult, more specifically physician, learning principles. This CME activity will provide opportunities for the physician to recognize a knowledge gap. For example, a case study may give him/her the opportunity to reflect on the course of a particular patient’s care and realize possible opportunities for improvement (or may validate that best-practice care was provided). The physician will also gain knowledge to take back to his/her practice setting about possible improvements in resources or equipment that would cause a positive impact on care. Professional networking will be very beneficial as most of the speakers are the physicians who actually accept the transfer calls via the PAL line from outside hospitals and EMS agencies. The audience will be given the opportunity to ask questions related to the topic as well as to interact with speakers at breaks and lunch. We anticipate that the physicians will take the learning points back to their areas of practice and incorporate them, resulting in overall improvement in care and treatment of the injured child. This improvement will be shared with them in a regional venue – the quarterly Triad Regional Advisory Council meetings with representatives from 26 counties in the Piedmont area as well as through professional peer review processes.

20. Educational formats should be appropriate for the setting, objectives, and desired results of the CME activity. (Criterion 5)
Indicate what educational design/format will be used for this CME activity (check all that apply). Attach a schedule of events (as applicable) and the teachers/authors of the content including name, degree, academic/professional title, and institutional/organizational affiliation.

- [X] Lecture/Didactic
- [ ] Webcast/Webinar
- [ ] Simulated Patients
- [ ] Lab Exercises
- [ ] Roundtable Discussion
- [ ] Panel Discussion
- [ ] Case Studies
- [X] Question & Answer
- [ ] Live Demonstration
- [ ] Journal Clubs
- [ ] Podcast
- [ ] Videoconference
- [ ] Interact. Workshop
- [ ] Pro/Con Debate
- [ ] Academic Detailing
- [ ] Other (describe)

G.) Evaluation:

21. The OCME requires use of its evaluation form, but Activity Directors may request questions to be added. Describe how the results of the evaluation will be used for this CME activity, including determining the effectiveness in meeting the educational need and creating changes in competence, performance, and/or patient outcomes. (Criterion 11) Evaluations will be used to plan next year’s conference as a needs assessment for desired topics/information, any specialized areas of interest related to the care of injured and burned children, and/or any improvements and suggestions for types of learning strategies or format.

H.) Funding Sources:

22. Indicate what funding sources will be used (check all that apply):

- [X] Registration Fee (Amount: $100 – Physicians; $75 – RN/Pharmacy; $70 – Pre-hospital EMS)
- [ ] Department/Institutional/Organization Funds
23. Will teachers/authors be paid an honorarium? □ Yes* (Amount: $ )  X No  Not even guest speaker?

*WFUSM policy states honoraria higher than $1500 per day must be approved by the Associate Dean for Faculty Services. Planners, teachers, and authors may be reimbursed for out-of-pocket expenses consistent with WFUHS policies. If teachers or authors are listed on a CME activity agenda as facilitating or conducting a presentation or session, but participate in the remainder of the activity as a learner, their expenses can be reimbursed and honoraria can be paid for their teacher or author role. No other payment, apart from those paid by WFUHS, shall be given to the Activity Director, planning committee members, teachers, authors, joint sponsor, or others involved with the CME activity. (Criterion 8 and the Standards for Commercial Support)

I.) Required Attachments:
- Full Disclosure Statements for Activity Director, Staff, Additional Planning Committee Members, and Teachers/Authors
- Resolution of Conflict of Interest Forms Documenting How Conflicts Will Be Managed
- Signed CME Financial Agreement
- Organization’s mission statement/purpose/description (for those apart from WFUH/WFUSM, NCBH, or WFUBMC)
- Schedule of events (as appropriate) listing the teachers/authors of the content including name, degree, academic/professional title, and institutional/organizational affiliation

Application Fee Payment Options:
- Application fee will be mailed in the form of a check or money order (payable to Wake Forest University Health Sciences). This fee will be paid out of the “Special Purposes Fund” from the Department of Nursing Education. Contact: Susan Hathcock
- Charge the following credit card: □ MasterCard  □ Visa  □ American Express
  Card #:  Expiration Date:
  Name of Credit Card Holder:
- Deduct application fee from the following WFUHS Chartfield:
- Deduct application fee from CME activity income managed by the OCME.

By submitting this Certification Request, the Activity Director and his/her staff understand that the proposed CME activity must be consistent with the overall CME mission and policies of WFUHS/WFUSM and follow all ACCME Essential Areas, Policies, and Updated Accreditation Criteria, including the 2004 ACCME Standards for Commercial Support.

Submitted by: Ginger Wilkins, RN, MSN  Date: 09/14/2010
Office of Continuing Medical Education

Certification Request for Sponsorship of a CME Activity and AMA PRA Category 1 Credit(s)™
Introduction

The Wake Forest University Health Sciences (WFUHS)/Wake Forest University School of Medicine (WFUSM) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The ACCME requires that accredited providers maintain high standards of quality and documentation in the development and provision of continuing medical education (CME). This Certification Request is intended for faculty, departments, and organizations developing CME activities who agree to support and abide by these standards. Each section is specifically designed to link with the ACCME’s Updated Accreditation Criteria (http://www.accme.org/dir_docs/doc_upload/b03aa5cc-b017-4395-a41f-8d5d89ac31ca_uploaddocument.pdf).

The Office of Continuing Medical Education (OCME) is responsible for maintaining the CME accreditation granted to Wake Forest University Health Sciences (WFUHS)/Wake Forest University School of Medicine (WFUSM). Activities for which CME sponsorship or joint sponsorship is sought must be reviewed and approved by the institutional Continuing Medical Education Committee. Appropriate CME credit is awarded if sponsorship/joint sponsorship is approved. Credit can be withdrawn from previously certified activities if actions by the faculty, staff, planning committee members, or teachers/authors threaten WFUHS'/WFUSM’s accreditation.

As set forth in the core mission statement of WFUSM, the OCME is committed to providing superior, ethical, timely CME to healthcare professionals, specifically physicians, thereby supporting them in constant self-evaluative improvement and lifelong learning of biomedical knowledge and better enabling them to provide optimal, safe patient care leading to the improved health and well-being of the general public. All certified CME activities must help fulfill this mission. In addition, when developing CME activities, it is important to: 1.) build bridges with other stakeholders through collaboration and cooperation and 2.) participate in a framework for quality improvement.

The OCME uses the American Medical Association (AMA) House of Delegates’ definition of CME – “educational activities that serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is the body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of healthcare to the public.” All content must promote improvements in patient care and not a specific proprietary business or commercial interest. (Criterion 10 and the Standards for Commercial Support) Recommendations involving clinical medicine must be based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in the care of patients. In addition, all scientific research referred to, reported, or used in support or justification of a patient care recommendation must conform to the generally accepted standards of experimental design, data collection, and analysis.

Instructions

• Contact/meet with an OCME Program Coordinator.
• Complete the attached Certification Request and return it to the OCME with all required documentation, including all completed Full Disclosure Statements and resolution of conflicts. Material should be submitted to the OCME 6-8 months in advance of the proposed CME activity.
• No accreditation, sponsorship, or credit statements can be used in publicity materials unless approved by the OCME.
• All application fees are non-refundable.

Joint Sponsorship

For CME activities proposed by organizations outside WFUHS/WFUSM, NCBH, or WFUBMC:

• The proposed activity must be consistent with the overall CME mission and policies of WFUHS/WFUSM and follow all ACCME Essential Areas, Policies, and Updated Accreditation Criteria, including the 2004 ACCME Standards for Commercial Support.
• A member of the OCME staff as well as a WFUSM faculty member must serve on the planning committee.
• WFUSM must be listed as a joint sponsor of the activity.
• A commercial interest cannot serve as a joint sponsor. A commercial interest is defined as any entity producing, marketing, re-selling, or distributing healthcare goods or services consumed by or used on patients (excludes non-profit and government organizations).
• All costs not covered by tuition and other activity income must be defrayed by the outside organization.
Certification Request for Sponsorship of a CME Activity and AMA PRA Category 1 Credit(s)TM

CME Activity Name: 2010 Annual CASE Workshop and Conference

Start Date: May 14, 2010   End Date: May 15, 2010   Venue (including city and state): Graylyn International Conference Center, Winston-Salem, NC

Activity Type: X Formal Activity (conference, course, workshop, symposium)
- Minifellowship
- Enduring Material (monograph, journal article, CD, live or archived Internet, podcast)
- RSS (regularly scheduled series, e.g. grand rounds/teaching conferences/tumor boards/journal clubs)
  RSS Frequency (e.g. 3rd Monday of the month, 10:00-11:00 am):

Activity Director: Dr. Christopher Ohl
Phone: 336-716-4507   Fax: 336-716-3825

Address: Wake Forest University School of Med/Department of Internal Medicine/Section on Infectious Diseases/W-S, NC
E-mail Address: cohl@wfubmc.edu
Pager: 336-806-6687

Staff Coordinator: Michelle L. Wallis
Phone: 336-716-6342   Fax: 336-716-3825
E-mail Address: mwallis@wfubmc.edu

WFUHS Department Chair/Section Head: Dr. Kevin High

Organization* (if not part of WFUHS/WFUSM, NCBH, or WFUBMC): Carolinas Antimicrobial Stewardship Effort (CASE) is an organization comprised of WFUSM (housed in the Section on Infectious Diseases), MUSC, Duke, UNC, ECU/Pitt Memorial Hospital, University of SC Medical and Pharmacy Schools, and both NC and SC State Departments of Health. Also involved with the CASE organization is the CDC in Atlanta, GA. Some part of each has a part in the planning and running of the meeting.
*Attach the organization’s mission statement/purpose/description.

If part of WFUHS/WFUSM, NCBH, or WFUBMC, list other departments, sections, divisions, institutes, offices, centers, etc., if any, that are co-hosting this CME activity.

A.) Planning Committee Structure:
In addition to the above individuals, list all persons responsible for planning, designing, developing, and implementing this CME activity. Include names, degrees, titles, and affiliations. [Note: No employee of a commercial interest may serve on the planning committee nor be allowed to influence educational content (nuanced or direct)].*

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vicki Fair</td>
<td>Administrative Assistant, CASE Conference Assistant Coordinator, Infectious Diseases, WFUSM</td>
</tr>
<tr>
<td>Joseph John, MD</td>
<td>Planning Committee, Medical University of South Carolina and VA Hospital, Charleston, SC</td>
</tr>
<tr>
<td>Roger White</td>
<td>Co-Director, CASE Conference, Medical University of South Carolina, Charleston, SC</td>
</tr>
<tr>
<td>Brandon Bookstaver, PharmD</td>
<td>Planning Committee, University of South Carolina School of Pharmacy, Richland Hospital, Columbia, SC</td>
</tr>
</tbody>
</table>

Disapproved (description): ______________________________________________________________________________________________________
*All decisions must be free of the control of commercial interests including: (a.) identification of needs; (b.) the determination of educational objectives; (c.) the selection and presentation of content; (d.) the selection of all persons and organizations in a position to control the content; (e.) the selection of educational methods; and (f.) the evaluation of the activity. (Criterion 7 and the Standards for Commercial Support)

**B.) Professional Practice Gaps, Educational Needs, Desired Results, & Learner Objectives:**
As outlined in its mission statement, by identifying educational gaps, the OCME helps physicians and other healthcare providers recognize the difference between their current practice patterns and those potentially achievable that would lead to practice improvement and thus better, safer care for individuals, communities, and populations. [For this section, you may complete the following chart or Questions #1-4. ] Completed both in order to further map practice gaps, educational needs, and desired results.

<table>
<thead>
<tr>
<th>Professional Practice Gap</th>
<th>This is a Gap in (check all that apply):</th>
<th>Educational Need</th>
<th>Desired Result</th>
<th>Designed to Change (check all that apply):</th>
<th>Learner Objective</th>
</tr>
</thead>
</table>
| 1.) Antimicrobial stewardship programs in terms of formal, implemented programs within the medical facility are still considered a recent effort, becoming mandated and standardized each year. In the next 3-4 years, stewardship will become a requirement of all hospitals, but most providers don’t have the knowledge or experience to implement and manage a program. (NC Guidelines for Control of Antibiotic Resistant Organisms, Specifically MRSA and VRE; NC Statute: Session Law 2007-480 – An Act to Establish the Advisory Commission in Hospital Infection Control and Disclosure; MRSA BSI – 2008 SC List of Reportable Conditions; 2006 Hospital Infections Disclosure Act – SC Statute 44-7-2410 to 2460; Yokoe et al. Infect Control Hosp Epidemiol 2008; 29:S12-21.) | X Knowledge  
X Competence | Antimicrobial stewardship programs have been targeted as a means to gather those healthcare providers who need to participate in this type of activity, bringing them together in a formal training setting to educate and collaborate on information. (R. Drew. Antimicrobial Stewardship Programs: How to Start and Steer a Successful Program. Supplement to the Journal of Managed Care Pharmacy. March 2009; 15(2):S18-23.) | For workshop and meeting attendees to leave the conference with the tools to return to their perspective healthcare facilities with an understanding of the principles and procedures of how to implement an antimicrobial stewardship effort. | X Competence  
X Performance | Recognize the principles and objectives of an antimicrobial stewardship program. |
| 2.) How to implement an antimicrobial stewardship effort in an academic medical center is much | X Knowledge  
X Competence | As CASE reaches out every year to community hospitals, new people come to gain knowledge of how | For the attendee to leave the conference feeling more equipped to go back to his/her own healthcare facility (whether academic or community) and | X Competence  
X Performance | Distinguish the key elements of an antimicrobial stewardship program for a community |
different from a community hospital. This is a large professional practice gap. Academia has an educational advantage compared to a community hospital (of which there are many). It is important to identify and address knowledge gaps, provide prevention training, and communicate available data to all healthcare providers. *(Keys for the Elimination of Healthcare-Associated Infections. Centers for Disease Control. http://www.cdc.gov.)*

| 3.) There is a gap in knowing available resources needed to implement an effective antimicrobial stewardship program. | X Knowledge | Need to be supported at all levels/departments of healthcare facilities when developing an antimicrobial stewardship program. | For the attendee to have a list of available resources at both their own and other facilities. To have met and networked with people who have other ideas and experiences, with whom they can later collaborate. As an example, the Center for Disease Control’s Get Smart Campaign, with which CASE is a partner, has contributed to a 25% reduction in antimicrobial use per outpatient office visits for presumed viral infections, while intervention studies show a reduction of 8% to 26% for antibiotic prescriptions. *(Center for Disease Control’s Get Smart Campaign: Know When Antibiotics Work. http://www.cdc.gov/getsmart.)* | X Competence X Performance | Determine where to find and then assemble needed resources in order to create a successful stewardship program. |

| 4.) There is a lack of education pertaining to who should be involved to effectively initiate and efficiently sustain an antimicrobial stewardship effort program. If the healthcare provider is not already knowledgeable about implementing and sustaining this type of program, they will | X Knowledge X Competence | At this conference, the attendee will be given the opportunity to listen to presenters and educators from each of the required disciplines with the experience of implementing proven antimicrobial stewardship programs that work. | After attending, attendees can return to their healthcare institutions and recruit the needed personnel to implement and sustain a proper antimicrobial stewardship effort. IDSA’s first recommendation for institutions developing an antimicrobial stewardship program is for the team to include both an infectious disease physician and a clinical pharmacist with experience in the treatment | X Competence X Performance | Determine which medical faculty and/or staff need to participate in an antimicrobial stewardship effort and how to interact with them in order to facilitate an antimicrobial stewardship effort within his/her healthcare facility. |
need to know what type of medical specialties and services need to be involved in the successful carrying out of an antimicrobial stewardship effort. “New guidelines on developing antimicrobial stewardship programs emphasize the importance of a team approach that involves pharmacists and physicians.” (Effective Antimicrobial Stewardship Requires Clinical Pharmacists’ Expertise. Feb 1, 2007, American Society of Health-System Pharmacists News.)

5.) Healthcare professionals cannot know all barriers specific to the individualized facilities at all times; therefore, they need educational guidance to assist them to cross over such barriers as they occur.

| X Knowledge | This activity has the best situation of delivering quality information from the experts in this area of medicine– infectious disease specialists, all collaborating on difficulties that arise, in one place at one time, sharing input of prior experiences. | X Competence | They will have gained information on barriers which can be foreseen as well as able to troubleshoot possible future barriers and approaches in order to maintain efficacy in each of their antimicrobial stewardship operations. | X Performance | Define the barriers to implementing a successful stewardship program and the approaches to efficiently and appropriately overcome them.

OR

1. A professional practice gap is the difference between healthcare processes and outcomes currently in practice and those potentially achievable. Put simply, it is actual practice (what learners currently know and/or do) vs. best practice (what they should know and/or do). These gaps are measured in terms of:

- Knowledge – being aware of what to do
- Competence – knowing how to do it
- Performance – actually doing it

Describe the identified professional practice gap for this CME activity. (Criterion 2) Antimicrobial resistance continues to increase in hospitals, longterm care facilities, and in the community across North and South Carolina. On a national level, “about 2 million people acquire bacterial infections in US hospitals each year, and 90,000 die as a result. About 70% of those infections are resistant to at least one drug…The total cost to US society is nearly $5 billion annually.” (Bad Bugs, No Drugs – Infectious Diseases Society of America. July 2004.)

One of the factors which remains responsible for this increasing resistance is inappropriate and excessive antimicrobial use in healthcare facilities and in the outpatient sector. “Approximately 50% of upper respiratory tract infections and 80% of acute bronchitis are treated with antibiotics despite evidence that antibiotics have little impact in the resolution or outcome of these predominately viral illnesses. Antimicrobial overuse has contributed to the alarmingly rapid rise in the prevalence of antibiotic-resistant Strepococcus pneumoniae in the US. North Carolina, in fact, has some of the highest levels of S. pneumoniae drug resistance seen in this country.” (Antimicrobial Stewardship. Department of Internal Medicine/Infectious Diseases.)
Diseases, WFUBMC. [http://www wfubmc edu.) Antibiotics cause more than 127,000 emergency department visits each year, and 18% of these visits are for adverse drug events, approximately 10% of which are caused by seven antibiotics—penicillin, ampicillin, amoxicillin, ciprofloxacin, SMZ-TMP, cephalaxin, and erythromycin. (D. Budnitz et al. JAMA 2006; 296:1858-66. A. Cohen et al. J Pediatr, in press.) According to 2006 Healthcare Effectiveness Data and Information (HEDIS) on inappropriate treatment of adults with acute bronchitis, the rates of inappropriate use for commercial was 66% and 70% for Medicaid, with little variation by region, accreditation, or plan size. (Center for Disease Control's Get Smart Campaign: Know When Antibiotics Work. [http://www cdc gov getsmart.) More locally, there continues to be much variation in antimicrobial prescribing in NC and SC hospitals, and it still remains that over 50% of antimicrobial use in these facilities is either unneeded or excessively broad.

There is a tremendous need for physicians, pharmacists, microbiologists, and infection control practitioners to understand and gain knowledge pertaining to the principles of appropriate antibiotic use and how to structure, implement, and sustain antimicrobial stewardship programs in their hospitals, facilities, clinics, and healthcare networks. As a result, we continue to reach out to community as well as smaller hospitals, delivering knowledge to them as well as giving them the tools and resources needed to implement a successful antibiotic stewardship program.

Is the gap in (check all that apply):

- [X] Knowledge
- [X] Competence
- [X] Performance

2. CME activities incorporate the educational needs (knowledge, competence, or performance) that underlie the professional practice gaps. Done prospectively, needs assessments look at gaps from various points of view, showing current practice vs. ideal practice. Possible methods include: review of previous CME activity evaluations; identification by medical staff; requests from affiliated institutions, groups, or community organizations; referral data; expert opinion; legal, government, or regulatory requirements; institutional requirements or strategic plans; focus groups; interviews; survey results; national or specialty society guidelines; committee findings; literature reviews; library requests; Internet searches; community health needs assessments; practice/QI data; quality initiatives; patient chart audits; feedback from third party payers and regulators; P&T committees; Joint Commission standards; Maintenance of Certification (MOC) requirements; Institute of Medicine (IOM), Accreditation Council for Graduate Medical Education (ACGME), and/or American Board of Medical Specialties (ABMS) core competencies; research findings; Translational Science Institute (TSI) research; and/or new medical information. [Note: For RSS, additional needs assessments can be performed for a specific session to further define a professional practice gap. A need can be addressed in more than one session, and new needs can be incorporated over time into a series as long as they are appropriate to the target audience.]

Describe the needs assessments used for this CME activity. How was the need brought to the attention of the planning committee? (Criterion 2) This is the 10th year of this conference and the 5th year it will be sponsored by WFUSM for AMA PRA Category 1 Credit™. It is not only the national infectious diseases communities advised method of educating specialized healthcare practitioners in the area of infectious disease and the use of antibiotics (see above), but we also have 10 years of follow-up evaluations provided by the attendees requesting further activities of this nature be provided. (Evaluation Results. 9th Annual CASE Workshop and Conference. April 24-25, 2009.) Additional resources included:

- 2010 PQRI Measures List: Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use.
3. Based on the identified gap/need the CME activity is intended to address, what are the desired results? What is the activity designed to change? (Criterion 3)

This CME activity is designed to change (check all that apply with explanations and measurement plans for each) See above chart etc.

- **X Competence (give physicians new abilities/strategies/knowledge):** To provide the attendee with the most current practices, knowledge, and experience, which comes with the changing medical applications and resources.
  - How do you intend to measure these changes? Possibilities include evaluation questions, audience response system, pre-tests, post-tests, surveys, etc. Evaluations provided by the Office of CME. The results will be used to give speakers and teachers feedback and to assess knowledge gained. In order to provide attendees with the key information and education needed to implement a successful stewardship program, the results of the evaluations are a valuable tool used at the planning meeting for the next year's conference.

- **X Performance (help physicians modify their practices)**
  - How do you intend to measure these changes? Possibilities include adherence to guidelines, interviews, focus groups, chart audits, peer review, direct observation, etc. Performance will be by peer review and direct observation of these programs as they develop and are implemented across the region. Assistance can then be given to physicians through the CASE network to adjust their individual antimicrobial stewardship programs according to the requested need for such instruction to help them improve efficiency within their facility.

- **X Patient Outcomes (help improve patient outcomes):** We will continue to develop and modify this conference relating to reported, current patient treatment outcomes available from NC and SC registries as well as CASE network reports.
  - How do you intend to measure these changes? Possibilities include patient feedback, patient chart audits, hospital QI data, etc. By following the trends within the communities of North and South Carolina's antimicrobial stewardship programs in relation to institutional cost towards antibiotics as well as the different type and rate of resistant bacterial infections reported by the institutions (using the CASE network).

4. Learner objectives should connect the identified need with the desired result and are framed in terms of the expected changes in competence, performance, and/or patient outcomes. Based on the desired, identified results, list the learner objectives for this CME activity. What should the attendees know or be better able to do as a result of participating? Be specific and use the attached list of action-oriented verbs. The number of objectives is not as important as being sure they adequately reflect what is to be achieved at the end of the CME activity.

- Recognize the principles and objectives of an antimicrobial stewardship program.
- Distinguish the key elements of an antimicrobial stewardship program for a community hospital vs. an academic medical center.
- Practice how to implement an antimicrobial stewardship program in either a community hospital or an academic medical center.
- List evidence-based resources from guidelines already implemented and in use which have proven successful.
- Determine where to find and then assemble needed resources in order to create a successful stewardship program.
- Determine which medical faculty and/or staff need to participate in an antimicrobial stewardship effort and how to interact with them in order to facilitate an antimicrobial stewardship effort within his/her healthcare facility.
- Define the barriers to implementing a successful stewardship program and the approaches to efficiently and appropriately overcome them.
- Determine how once an antimicrobial stewardship effort is implemented to continue to identify the needs of the healthcare facility in order to advance and sustain the program.

**C.) Target Audience:**
The content of a CME activity should be designed to match learners’ current or potential scope of professional activities. (Criterion 4)
5. Is this CME activity targeted to an internal, local/regional, national, and/or international audience? This CME activity is mainly targeted to the regions of North and South Carolina with an objective to reach out beyond the boundaries of the two states to the remaining contiguous states in the Southeast.

6. List what types of practice settings will be represented in the target audience, e.g. academic, tertiary care, community hospital, private/group practice, managed care, non-profit organization, research, public health, mental health, education, government, veterans affairs, military, etc. Academia from the medical and pharmacy schools of both NC and SC, the Centers for Disease Control and Prevention in Atlanta, the Public Health Departments for both NC and SC, public health educators from both NC and SC, private pharmacies, community healthcare practices, community hospital facilities, and veterans affairs/medical institutions from Charleston and Columbia, SC as well as the NC Veterans Affairs located in Salisbury, NC. There is always a possibility that other types of practice settings will register and attend, but the core group of attendees will be present from the above listed settings.

7. Indicate which specialties of medicine will be targeted (check all that apply):
- [ ] Anesthesiology
- [ ] Cardiology
- [ ] Cardiothoracic Surgery
- [ ] Cardiology/Endocrinology
- [ ] Cancer Biology
- [ ] Cardiology/Endocrinology/Immunology
- [ ] Dermatology
- [ ] Dermatology/Gastroenterology
- [ ] Emergency Medicine
- [ ] General Internal Medicine
- [ ] Gastroenterology
- [ ] General Surgery
- [ ] Gerontology & Geriatrics
- [ ] General Surgery/Microbiology
- [ ] Gerontology & Geriatrics/Infectious Diseases
- [ ] Hematology & Oncology
- [ ] Infectious Diseases
- [ ] Hematology & Oncology/Neurobiolgy
- [ ] Infectious Diseases/Neurology
- [ ] Molecular Medicine
- [ ] Infectious Diseases/Neurology
- [ ] Neurobiology & Anatomy
- [ ] Infectious Diseases/Pediatrics
- [ ] Neurology
- [ ] Neurosurgery
- [ ] Orthopaedic Surgery
- [ ] Obstetrics & Gynecology
- [ ] Orthopaedic Surgery/Pulmonary/Critical Care/Allergy/Immunologic Disease
- [ ] Otolaryngology
- [ ] Pathology
- [ ] Pediatrics
- [ ] Psychiatry & Behavioral
- [ ] Public Health Sciences
- [ ] Regenerative Medicine
- [ ] Rheumatology
- [ ] Surgery
- [ ] Radiation Oncology
- [ ] Radiology
- [ ] Others:
- [ ] Urology

8. Indicate the target audience’s level of experience (check all that apply).
- [X] Beginner
- [X] Intermediate
- [X] Advanced
- [X] Expert

9. Will medical students, residents, and/or fellows be included?  [X] Yes  [ ] No

10. Is the target audience multidisciplinary, e.g. targeted to both physicians and non-physicians?  [X] Yes  [ ] No

   If yes, list other healthcare providers/practitioners that are part of the target audience.
   Nurse practitioners and physicians assistants specializing in infectious diseases as well as both states’ public healthcare officials and educators

11. What is the estimated attendance size? 60-70

12. If additional types of continuing education credit, e.g. American Academy of Family Physicians (AAFP), American College of Obstetrics & Gynecology (ACOG), Accreditation Council for Pharmacy Education (ACPE), American Nurses Credentialing Center (ANCC) are needed, list them.

D.) Core Competencies & Governor’s Task Force Health Issues:

13. A CME activity should be developed in the context of desirable physician attributes. (Criterion 6) Indicate which of the Institute of Medicine (IOM), Accreditation Council for Graduate Medical Education (ACGME), and/or American Board of...
Medical Specialties (ABMS) core competencies will be addressed by this CME activity (check all that apply). [Note: Post-activity evaluations will ask learners to identify which core competencies they felt were addressed.]

- Quality Improvement
- Evidence and Practice-Based Learning & Improvement
- Patient-Centered Care
- Medical Knowledge
- Systems-Based Practice
- Use of Informatics
- Working in Interdisciplinary Teams
- Interpersonal Communication Skills
- Professionalism

14. If this CME activity has a primary target audience from North Carolina, indicate which of the health issues from the Governor’s Task Force for Healthy Carolinians will be addressed (check all that apply):

- Access to Healthcare
- Cultural Competency
- Health Disparities
- Injury
- QI/Quality Assurance
- Chronic Disease
- Disability
- Infant Mortality
- Mental Health
- Women’s Health
- X Community Health
- Environmental Health
- X Infectious Disease
- Older Adult Health
- Leadership, Management, Education, & Communication
- Complementary Med
- Health Promotion
- Info/Library Services
- Oral Health

E.) Barriers to Change, Collaborations, & Non-Educational Strategies:

15. Often times, factors exist outside the control of the learner that can impact patient outcomes. List any potential or real barriers facing the learner for this need/gap to be addressed. Examples include lack of time; too few resources or administrative support; insurance/reimbursement issues; larger, healthcare system-type issues; patient compliance; costs; etc. (Criterion 18) Person nel support at the participating institutions (compliance)

16. Describe the educational strategies that will be included in this CME activity to help remove, overcome, or address these barriers. (Criterion 19) Workshop groups will discuss to varying degrees of information as determined by the instructor and by questions generated by the attendees.

17. List other stakeholders with whom collaboration or cooperation in the development or execution of the CME activity is possible in order to build bridges to quality. Could they help address any of the potential or real barriers listed? Examples include other institutional departments/sections; QI staff/committee; risk management staff; pharmacy and P&T committee; infection control staff/committee; library services; electronic health record staff; compliance office; billing office; office practice managers; managers of institutional initiatives; government agencies; local or national societies; community organizations; patient organizations; etc. (Criterion 20) Infectious disease specialists, infectious disease pharmacists, hospital epidemiologists, national societies related to infectious diseases and appropriate antibiotic prescribing, state and federal government departments of public health, hospital administration governing spending for such programs at all levels of services to a community (academic, large, medium, and small community hospitals), CDC, NC & SC Public Health Departments, and all NC and SC medical & pharmacy schools. The multifaceted nature of antimicrobial stewardship is such that many organizations and societies have collaborated, reviewed, and now support CME to the masses for the development, implementation, and sustainability of an antimicrobial stewardship effort which is effective and efficient.

18. List any non-educational strategies to enhance/reinforce change as an adjunct to the CME activity. Examples include post-activity reminders to attendees; patient feedback or surveys; patient education materials; algorithms; flow sheets; personal patient outcomes data; display posters; newsletters; protocols; order sets; chart or electronic record reminders; forms; etc. (Criterion 17) Post activity interaction with attendees, evaluations, and discussion (feedback) from attendees.

F.) Adult Learning Principles & Educational Methodology:

19. Adult learning is a complex, multistage process that incorporates the learner into the planning and evaluation process. Learning tends to be problem-centered rather than content-oriented, and experience provides the basis for learning, which is
focused on material that has immediate relevance. Adults learn by solving genuine problems (reviewing their own issues and daily encounters); reflecting via analogy/comparison (comparing their own experiences to others); practicing and applying new knowledge and strategies; and developing a framework for application (creating plans for implementation). There are five stages of physician learning:

1. Recognizing a need for learning – when a physician becomes aware that something in his/her practice needs improvement
2. Searching for learning resources, which is driven by cognitive dissonance (the difference between what is and what should be)
3. Engaging in learning – when learning (formal or informal) becomes more intentional and focused on the problem at hand
4. Trying out what was learned – when a physician begins to use newly acquired knowledge or skills and looks to confirm the benefits
5. Incorporating what was learned – when a physician integrates the new knowledge or skills into daily practice

Describe how this CME activity will incorporate adult, more specifically physician, learning principles.

It has been determined by the American Academy of Pediatrics, the American Society of Health-System Pharmacists, the Infectious Diseases Society for Obstetrics and Gynecology, the Pediatric Infectious Diseases Society, the Society for Hospital Medicine and the Society of Infectious Disease Pharmacists, which comprise the Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America, that the only way to educate for effective and efficient antimicrobial stewardship programs is through the dissemination of material and knowledge derived by studies of interventions to improve antimicrobial use for hospitalized adults. CME relating to such a vital program as antimicrobial stewardship would inadequately meet the healthcare providers’ needs if not in a conference-type learning environment. This type of education needs to be done face-to-face and presented to smaller groups, broken down by knowledge level of antimicrobial stewardship programs as well as the conference group at large as a collective resource of expertise, knowledge, and experience.

As more community hospitals come under antimicrobial medications management (antimicrobial stewardship efforts), there will be practitioners as well as institutions becoming aware they need to improve and get more training in this area of quality control. In the past, we have used a bimodal educational program and breakout sessions for different size healthcare facilities in order to increase knowledge in antimicrobial stewardship and to teach implementation. During the workshops, attendees will attend a general session to begin the activity and assess from which breakout group they would most benefit. There will be both formal and informal settings in which attendees can participate. Through this workshop program, the attendees will be placed in groups within the breakout groups and together guided by the breakout group instructor to help develop an antibiotic stewardship program, tackle barriers which have proven difficult at the attendees’ institutions, as well as ones experienced by the instructor deemed essential to discuss for overcoming possible barriers that the attendees might face. At the end of the workshop, all breakout groups will return to the general meeting for a plenary session to discuss what each group learned and how they think they will integrate this knowledge into their medical institutions. While the number of faculty is large, these members are experts in antimicrobial stewardship from across North and South Carolina and represent all disciplines that are involved in such activities including infectious diseases, pharmacy, microbiology, hospital epidemiology, and hospital administration. Their participation as panel members greatly facilitates discussion and gives attendees an opportunity for one-on-one discussion and interaction. It also facilitates networking for attendees that establishes longterm participation in education and consultative activities that will support the attainment of the conference objectives.

20. Educational formats should be appropriate for the setting, objectives, and desired results of the CME activity. (Criterion 5)
Indicate what educational design/format will be used for this CME activity (check all that apply). Attach a schedule of events (as applicable) and the teachers/authors of the content including name, degree, academic/professional title, and institutional/organizational affiliation.

- [X] Lecture/Didactic
- [X] Panel Discussion
- [X] Webcast/Webinar
- [X] Case Studies
- [X] Simulated Patients
- [X] Tumor Boards
- [X] Lab Exercises
- [X] Hands-On Practicum
- [X] Roundtable Discussion
- [X] Other (describe)
- [ ] Question & Answer
- [ ] Live Demonstration
- [ ] Videoconference
- [ ] Interact. Workshop
- [ ] Journal Clubs
- [ ] Pro/Con Debate
- [ ] Podcast
- [ ] Academic Detailing
G.) Evaluation:

21. The OCME requires use of its evaluation form, but Activity Directors may request questions to be added. Describe how the results of the evaluation will be used for this CME activity, including determining the effectiveness in meeting the educational need and creating changes in competence, performance, and/or patient outcomes. (Criterion 11) For the planning of next year's conference and workshop as needs assessment for more of a certain type of information, more specialized areas of interests, and/or any improvements.

H.) Funding Sources:

22. Indicate what funding sources will be used (check all that apply):

- Registration Fee (Amount: $TBD)
- Government Funds
- Professional Society Funds
- Pharmaceutical/Medical Device Educational Grants (Criterion 8 and the Standards for Commercial Support)
- Exhibit Fees (Criterion 9 and the Standards for Commercial Support)
- Department/Institutional/Organization Funds
- Foundation Grants
- Other (describe)

23. Will teachers/authors be paid an honorarium? Yes* (Amount: depends on the scheduling, who is lecturing, and what distance they travel as to whether it is $1000 or $1500) No

*WFUSM policy states honoraria higher than $1500 per day must be approved by the Associate Dean for Faculty Services. Planners, teachers, and authors may be reimbursed for out-of-pocket expenses consistent with WFUHS policies. If teachers or authors are listed on a CME activity agenda as facilitating or conducting a presentation or session, but participate in the remainder of the activity as a learner, their expenses can be reimbursed and honoraria can be paid for their teacher or author role. No other payment, apart from those paid by WFUHS, shall be given to the Activity Director, planning committee members, teachers, authors, joint sponsor, or others involved with the CME activity. (Criterion 8 and the Standards for Commercial Support)

I.) Required Attachments:

- Full Disclosure Statements for Activity Director, Staff, Additional Planning Committee Members, and Teachers/Authors
- Resolution of Conflict of Interest Forms Documenting How Conflicts Will Be Managed
- Signed CME Financial Agreement
- Organization’s mission statement/purpose/description (for those apart from WFUHS/WFUSM, NCBH, or WFUBMC)
- Schedule of events (as appropriate) listing the teachers/authors of the content including name, degree, academic/professional title, and institutional/organizational affiliation

Application Fee Payment Options:

- Application fee will be mailed in the form of a check or money order (payable to Wake Forest University Health Sciences).
- Charge the following credit card: MasterCard Visa American Express
- Card #: Expiration Date:
- Name of Credit Card Holder: X
- Deduct application fee from the following WFUHS Chartfield: 31-155060-16380-105
- Deduct application fee from CME activity income managed by the OCME.

By submitting this Certification Request, the Activity Director and his/her staff understand that the proposed CME activity must be consistent with the overall CME mission and policies of WFUHS/WFUSM and follow all ACCME Essential Areas, Policies, and Updated Accreditation Criteria, including the 2004 ACCME Standards for Commercial Support.

Submitted by: Michelle L. Wallis Date: January 26, 2010 (Revised 2/9/10)
Office of
Continuing Medical Education

Certification Request for Sponsorship of a CME Activity and AMA PRA Category 1 Credit(s)™
Introduction

The Wake Forest University Health Sciences (WFUHS)/Wake Forest University School of Medicine (WFUSM) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The ACCME requires that accredited providers maintain high standards of quality and documentation in the development and provision of continuing medical education (CME). This Certification Request is intended for faculty, departments, and organizations developing CME activities who agree to support and abide by these standards. Each section is specifically designed to link with the ACCME’s Updated Accreditation Criteria (http://www.accme.org/dir_docs/doc_upload/b03aa5cc-b017-4395-a41f-8d5d89ac31ca_uploaddocument.pdf).

The Office of Continuing Medical Education (OCME) is responsible for maintaining the CME accreditation granted to Wake Forest University Health Sciences (WFUHS)/Wake Forest University School of Medicine (WFUSM). Activities for which CME sponsorship or joint sponsorship is sought must be reviewed and approved by the institutional Continuing Medical Education Committee. Appropriate CME credit is awarded if sponsorship/joint sponsorship is approved. Credit can be withdrawn from previously certified activities if actions by the faculty, staff, planning committee members, or teachers/authors threaten WFUHS’/WFUSM’s accreditation.

As set forth in the core mission statement of WFUSM, the OCME is committed to providing superior, ethical, timely CME to healthcare professionals, specifically physicians, thereby supporting them in constant self-evaluative improvement and lifelong learning of biomedical knowledge and better enabling them to provide optimal, safe patient care leading to the improved health and well-being of the general public. All certified CME activities must help fulfill this mission. In addition, when developing CME activities, it is important to: 1.) build bridges with other stakeholders through collaboration and cooperation and 2.) participate in a framework for quality improvement.

The OCME uses the American Medical Association (AMA) House of Delegates’ definition of CME – “educational activities that serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is the body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of healthcare to the public.” All content must promote improvements in patient care and not a specific proprietary business or commercial interest. (Criterion 10 and the Standards for Commercial Support) Recommendations involving clinical medicine must be based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in the care of patients. In addition, all scientific research referred to, reported, or used in support or justification of a patient care recommendation must conform to the generally accepted standards of experimental design, data collection, and analysis.

Instructions

- Contact/meet with an OCME Program Coordinator.
- Complete the attached Certification Request and return it to the OCME with all required documentation, including all completed Full Disclosure Statements and resolution of conflicts. Material should be submitted to the OCME 6-8 months in advance of the proposed CME activity.
- No accreditation, sponsorship, or credit statements can be used in publicity materials unless approved by the OCME.
- All application fees are non-refundable.

Joint Sponsorship

For CME activities proposed by organizations outside WFUHSWFUSM, NCBH, or WFUBMC:

- The proposed activity must be consistent with the overall CME mission and policies of WFUHS/WFUSM and follow all ACCME Essential Areas, Policies, and Updated Accreditation Criteria, including the 2004 ACCME Standards for Commercial Support.
- A member of the OCME staff as well as a WFUSM faculty member must serve on the planning committee.
- WFUSM must be listed as a joint sponsor of the activity.
- A commercial interest cannot serve as a joint sponsor. A commercial interest is defined as any entity producing, marketing, re-selling, or distributing healthcare goods or services consumed by or used on patients (excludes non-profit and government organizations).
- All costs not covered by tuition and other activity income must be defrayed by the outside organization.
Certification Request for Sponsorship of a CME Activity and AMA PRA Category 1 Credit(s)™

CME Activity Name: NC Association of Free Clinics Clinical Mini-Conference

Start Date: April 8, 2010  End Date: April 8, 2010  Venue (including city and state): Hilton Greenville Convention Center, Greenville, NC

Activity Type: X Formal Activity (conference, course, workshop, symposium)  [ ] Minifellowship  [ ] Enduring Material (monograph, journal article, CD, live or archived Internet, podcast)  [ ] RSS (regularly scheduled series, e.g. grand rounds/teaching conferences/tumor boards/journal clubs)

RSS Frequency (e.g. 3rd Monday of the month, 10:00-11:00 am):

Activity Director: Gary Greenberg, MD  Phone: 919-256-2167  Fax: 919-834-7306

Address: Urban Ministries Open Door Clinic, PO Box 26476, Raleigh, NC 27611

E-mail Address: gngreenberg@gmail.com  Pager:

Staff Coordinator: Cindy Jones, Dir. of Training & Support, NC  Association of Free Clinics

E-mail Address: cindy@ncfreeclinics.org  WFUHS Department Chair/Section Head: N/A

Organization* (if not part of WFUHS/WFUSM, NCBH, or WFUBMC): See attached

*Attach the organization’s mission statement/purpose/description.

If part of WFUHS/WFUSM, NCBH, or WFUBMC, list other departments, sections, divisions, institutes, offices, centers, etc., if any, that are co-hosting this CME activity.

A.) Planning Committee Structure:

In addition to the above individuals, list all persons responsible for planning, designing, developing, and implementing this CME activity. Include names, degrees, titles, and affiliations. [Note: No employee of a commercial interest may serve on the planning committee nor be allowed to influence educational content (nuanced or direct).]*

<table>
<thead>
<tr>
<th>Name: Pamela Stephens</th>
<th>Title/Affiliation: Dir. of Communications, NC Association of Free Clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Michael Lischke, EdD, MPH</td>
<td>Title/Affiliation: Associate Professor, Family &amp; Community Med and Director, Northwest AHEC, WFUSM; Board Member, NC Association of Free Clinics</td>
</tr>
<tr>
<td>Name:</td>
<td>Title/Affiliation:</td>
</tr>
</tbody>
</table>

OFFICE USE ONLY  PG  X JS  AR  EM  MF  RSS  X Renewal

Date Received: 2/9/10  Date Reviewed: 2/22/10  Date Approved: 2/26/10  OCME Program Coordinator: KF

Approved for 3.0 AMA PRA Category 1 Credit(s)™  Activity #: 30197

Disapproved (description):
*All decisions must be free of the control of commercial interests including: (a.) identification of needs; (b.) the determination of educational objectives; (c.) the selection and presentation of content; (d.) the selection of all persons and organizations in a position to control the content; (e.) the selection of educational methods; and (f.) the evaluation of the activity. (Criterion 7 and the Standards for Commercial Support)

B.) Professional Practice Gaps, Educational Needs, Desired Results, & Learner Objectives:
As outlined in its mission statement, by identifying educational gaps, the OCME helps physicians and other healthcare providers recognize the difference between their current practice patterns and those potentially achievable that would lead to practice improvement and thus better, safer care for individuals, communities, and populations. [For this section, you may complete the following chart or Questions #1-4.]

<table>
<thead>
<tr>
<th>Professional Practice Gap</th>
<th>This is a Gap in (check all that apply):</th>
<th>Educational Need</th>
<th>Desired Result (check all that apply):</th>
<th>Designed to Change</th>
<th>Learner Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.)</td>
<td>Knowledge</td>
<td></td>
<td>Competence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Competence</td>
<td></td>
<td>Performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.)</td>
<td>Knowledge</td>
<td></td>
<td>Competence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Competence</td>
<td></td>
<td>Performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.)</td>
<td>Knowledge</td>
<td></td>
<td>Competence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Competence</td>
<td></td>
<td>Performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.)</td>
<td>Knowledge</td>
<td></td>
<td>Competence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Competence</td>
<td></td>
<td>Performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OR

1. A professional practice gap is the difference between healthcare processes and outcomes currently in practice and those potentially achievable. Put simply, it is actual practice (what learners currently know and/or do) vs. best practice (what they should know and/or do). These gaps are measured in terms of:
   • Knowledge – being aware of what to do
   • Competence – knowing how to do it
   • Performance – actually doing it

Describe the identified professional practice gap for this CME activity. (Criterion 2)
Professional practice gaps were found in the use and implementation of certain clinical practice guidelines in the free clinic setting, specifically the American Diabetes Association (ADA) Standards of Medical Care in Diabetes and The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC-7) from the US Department of Health and Human Services/National Institutes of Health/National Heart, Lung, and Blood Institute/National High Blood Pressure Education Program. As part of the NC Association of Free Clinics Annual Outcomes Survey, which all member organizations are required to complete, applicable clinics were asked to measure the health outcomes of patients diagnosed with diabetes and hypertension. (Annual Outcomes Survey, NC Association of Free Clinics, Blue Cross and Blue Shield of NC Foundation, 2010:12-14). The ADA Standards and the JNC-7 Guidelines were utilized as evidenced-based clinical practice guidelines for standards of care.

A total of 41 free clinics participated in measurements of diabetic patients for Hemoglobin A1C less than 7% at the end of 1st Qtr. 2010 and reported as follows: 7 clinics reported 60% or greater of their patients had a HgbA1C <7%; 17 clinics reported 31-59% of their patients had a HgbA1C <7%; and 17 clinics reported 30% or less of their patients had a HgbA1C <7%. A total of 40 free clinics participated in measurements of diabetic patients for Hemoglobin A1C greater than 9% at the end of 1st Qtr. 2010 and reported as follows: 30 clinics reported 30% or less of the patients had a HgbA1C >9%; 8 clinics reported 31-59% of their patients had a HgbA1C >9%; and 2 clinics reported 50% or more of their patients had a HgbA1C >9%. According to the published guidelines, "Lowering A1C to below or around 7% has been shown to reduce microvascular and neuropathic complications of type 1 and type 2 diabetes. Therefore, for microvascular disease
Revised July 1, 2008


prevention, the A1C goal for nonpregnant adults in general is <7%.” Most of the clinics were found to have patient populations outside the recommended guideline.  (ADA Standards of Medical Care in Diabetes - 2009. Diabetes Care. Volume 32, Supplement 1, January 2009.)

A total of 44 free clinics participated in measurements for patients diagnosed with hypertension and reported the following: 36 clinics reported by the end of 1st Qtr 2010 75% of their patients had received at least two blood pressure (BP) assessments; 5 clinics reported 50-74% of their patients had received at least two BP assessments; and 3 clinics reported less than 50% of their patients had received at least two BP assessments.  As recommended in the published guidelines, “The accurate measurement of BP is the sine qua non for successful management...At least two measurements should be made and the average recorded.”  (The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure.  August 2004.) A total of 15 clinics reported 75% or more of their patients had achieved BP control <140/90; 20 clinics reported 50-74% of their patients had achieved BP control <140/90; and 9 clinics reported 50% or less of their patients had achieved BP control <140/90.  The guidelines consider a BP ≥140/90 to show hypertension, which is associated with an increase in cardiovascular disease complications.  "Current control rates (SBP <140mmHg and DBP <90mmHg), though improved, are still far below the Healthy People goal of 50%, which was originally set as the year 2000 goal and has since been extended to 2010."  (The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure.  August 2004.)

Is the gap in (check all that apply):

☐ Knowledge
☐ Competence
► Performance

2.  CME activities incorporate the educational needs (knowledge, competence, or performance) that underlie the professional practice gaps.  Done prospectively, needs assessments look at gaps from various points of view, showing current practice vs. ideal practice.  Possible methods include: review of previous CME activity evaluations; identification by medical staff; requests from affiliated institutions, groups, or community organizations; referral data; expert opinion; legal, government, or regulatory requirements; institutional requirements or strategic plans; focus groups; interviews; survey results; national or specialty society guidelines; committee findings; literature reviews; library requests; Internet searches; community health needs assessments; practice/QI data; quality initiatives; patient chart audits; feedback from third party payers and regulators; P&T committees; Joint Commission standards; Maintenance of Certification (MOC) requirements; Institute of Medicine (IOM), Accreditation Council for Graduate Medical Education (ACGME), and/or American Board of Medical Specialties (ABMS) core competencies; research findings; Translational Science Institute (TSI) research; and/or new medical information.  [Note: For RSS, additional needs assessments can be performed for a specific session to further define a professional practice gap.  A need can be addressed in more than one session, and new needs can be incorporated over time into a series as long as they are appropriate to the target audience.]

Describe the needs assessments used for this CME activity.  How was the need brought to the attention of the planning committee?  (Criterion 2) In 2009, the NC Association of Free Clinics, along with member free clinic directors and providers, developed an Annual Outcomes Survey for evaluating direct services and health gains of free clinic patients.  The survey includes specific outcome measurements for free clinic patients diagnosed with diabetes and/or hypertension, two of the most common diagnoses among free clinics.  During the development of the outcomes measurement framework, professional practice gaps and educational needs were identified, therefore demonstrating an opportunity for improvement in how free clinics implement evidence-based clinical approaches in the treatment of diabetes and hypertension.

The following national practice guidelines were used to measure opportunities for improvement:


Based upon the identified professional practice gap and the needs assessments used, state the educational need.  What are and how to use the recommendations of the JNC-7 and ADA Standards in the free clinic setting
3. Based on the identified gap/need the CME activity is intended to address, what are the desired results? What is the activity designed to change? (Criterion 3)

This CME activity is designed to change (check all that apply with explanations and measurement plans for each):

- **X Competence** (give physicians new abilities/strategies/knowledge): **Improve the knowledge of practitioners in the free clinic setting on the recommended practice guidelines of the JNC-7 and ADA Standards**
  
  How do you intend to measure these changes? Possibilities include evaluation questions, audience response system, pre-tests, post-tests, surveys, etc. NC Association of Free Clinics Annual Outcomes Survey will require free clinics to assess and report current related performance measurements and assess and report targeted goals within specified timeframes. Also, will use Office of CME evaluation.

- **X Performance** (help physicians modify their practices): **Improve practitioners’ use of JNC-7 and ADA Standards as benchmarks of practice in the free clinic setting, while attempting to avoid possible barriers to their implementation**
  
  How do you intend to measure these changes? Possibilities include adherence to guidelines, interviews, focus groups, chart audits, peer review, direct observation, etc. NC Association of Free Clinics Annual Outcomes Survey will require free clinics to assess and report adherence to ADA Standards and JNC-7 Guidelines.

- **X Patient Outcomes** (help improve patient outcomes): **In free clinics, increase the number of nonpregnant adults with HgbA1C <7%; take at least two BP measurements with an average recorded for all patients; and decrease the number of patients with BP ≥140/90.**

  How do you intend to measure these changes? Possibilities include patient feedback, patient chart audits, hospital QI data, etc. NC Association of Free Clinics Annual Outcomes Survey will require free clinics to obtain and report related patient feedback and will require patient audits to assess and report related performance measurements.

4. Learner objectives should connect the identified need with the desired result and are framed in terms of the expected changes in competence, performance, and/or patient outcomes. Based on the desired, identified results, list the learner objectives for this CME activity. What should the attendees know or be better able to do as a result of participating? Be specific and use the attached list of action-oriented verbs. The number of objectives is not as important as being sure they adequately reflect what is to be achieved at the end of the CME activity.

At the conclusion of this CME activity, the learner should be better able to (list learner objectives):

1.) Describe criteria for the diagnosis of diabetes, the treatment goals for diabetes, and the diabetic management schedule per the American Diabetes Association (ADA) Standards of Medical Care; 2.) Describe and discuss barriers that impact diabetes management in the free clinic setting; 3.) Describe the evaluation and treatment guidelines per The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC-7); and 4.) Discuss barriers that affect clinical practice guidelines in the free clinic setting.

C.) Target Audience:
The content of a CME activity should be designed to match learners’ current or potential scope of professional activities. (Criterion 4)

5. Is this CME activity targeted to an internal, local/regional, national, and/or international audience? **Regional - NC Free Clinics and Community Health Centers**

6. List what types of practice settings will be represented in the target audience, e.g. academic, tertiary care, community hospital, private/group practice, managed care, non-profit organization, research, public health, mental health, education, government, veterans affairs, military, etc. **Non-profit organizations**

7. Indicate which specialties of medicine will be targeted (check all that apply):

- [ ] Anesthesiology
- [ ] Biochemistry
- [ ] Cancer Biology
- [ ] Cardiology
- [ ] Cardiothoracic Surgery
- [ ] Dermatology
- [ ] Emergency Medicine
- [ ] Endocrinology/Metabolism
X Family & Community  Gastroenterology  X General Internal Medicine  General Surgery
Gerontology & Geriatrics  Hematology & Oncology  Infectious Diseases  Microbiology/Immunology
Molecular Medicine  Nephrology  Neurobiology & Anatomy  Neurology
Neurosurgery  Obstetrics & Gynecology  Ophthalmology  Orthopaedic Surgery
Otolaryngology  Pathology  Pediatrics  Physiology & Pharmacology
Plastic & Reconstructive  Psychiatry & Behavioral  Public Health Sciences  Pulmonary/Critical Care/
Radiation Oncology  Radiology  Regenerative Medicine  Allergy/Immunologic Disease
Surgery  Urology  Others:  Rheumatology

8. Indicate the target audience’s level of experience (check all that apply).
☐ Beginner  ☑ Intermediate  ☑ Advanced  ☐ Expert

9. Will medical students, residents, and/or fellows be included?  ☑ Yes  ☐ No

10. Is the target audience multidisciplinary, e.g. targeted to both physicians and non-physicians?  ☑ Yes  ☐ No
   If yes, list other healthcare providers/practitioners that are part of the target audience.
   PAs, FNP’s, Nurses, Pharmacists and other allied health professionals that may volunteer or be employed by Free Clinics
   such as CMAs, EMTs and/or Paramedics

11. What is the estimated attendance size? 35-45

12. If additional types of continuing education credit, e.g. American Academy of Family Physicians (AAFP), American College of
    Obstetrics & Gynecology (ACOG), Accreditation Council for Pharmacy Education (ACPE), American Nurses Credentialing
    Center (ANCC) are needed, list them.  NA

D.) Core Competencies & Governor’s Task Force Health Issues:

13. A CME activity should be developed in the context of desirable physician attributes. (Criterion 6) Indicate which of the
    Institute of Medicine (IOM), Accreditation Council for Graduate Medical Education (ACGME), and/or American Board of
    Medical Specialties (ABMS) core competencies will be addressed by this CME activity (check all that apply). [Note: Post-
    activity evaluations will ask learners to identify which core competencies they felt were addressed.]
   ☐ Quality Improvement  ☐ Use of Informatics
   ☑ Evidence and Practice-Based Learning & Improvement  ☑ Working in Interdisciplinary Teams
   ☐ Patient-Centered Care  ☑ Interpersonal Communication Skills
   ☑ Medical Knowledge  ☑ Professionalism
   ☐ Systems-Based Practice

14. If this CME activity has a primary target audience from North Carolina, indicate which of the health issues from the
    Governor’s Task Force for Healthy Carolinians will be addressed (check all that apply):
   ☑ Access to Healthcare  ☑ Chronic Disease  ☑ Community Health  ☐ Complementary Med
   ☐ Cultural Competency  ☐ Disability  ☐ Environmental Health  ☐ Health Promotion
   ☐ Health Disparities  ☐ Infant Mortality  ☐ Infectious Disease  ☐ Info/Library Services
   ☐ Injury  ☐ Mental Health  ☐ Older Adult Health  ☐ Oral Health
   ☐ QI/Quality Assurance  ☐ Women’s Health  ☐ Leadership, Management, Education, & Communication

E.) Barriers to Change, Collaborations, & Non-Educational Strategies:
15. Often times, factors exist outside the control of the learner that can impact patient outcomes. List any potential or real barriers facing the learner for this need/gap to be addressed. Examples include lack of time; too few resources or administrative support; insurance/reimbursement issues; larger, healthcare system-type issues; patient compliance; costs; etc. (Criterion 18) Issues that could possibly affect free clinics include: too few resources, which could include funding to lack of adequate providers, patient compliance, and lack of local healthcare system infrastructure/support.

16. Describe the educational strategies that will be included in this CME activity to help remove, overcome, or address these barriers. (Criterion 19) Free clinic organizations from all over the state will be in attendance. Barriers affecting clinical practice guidelines in the free clinic setting will be addressed. Strategies for how individual free clinics have overcome identified barriers will be discussed and strategies for implementing clinical practice guidelines will be described.

17. List other stakeholders with whom collaboration or cooperation in the development or execution of the CME activity is possible in order to build bridges to quality. Could they help address any of the potential or real barriers listed? Examples include other institutional departments/sections; QI staff/committee; risk management staff; pharmacy and P&T committee; infection control staff/committee; library services; electronic health record staff; compliance office; billing office; office practice managers; managers of institutional initiatives; government agencies; local or national societies; community organizations; patient organizations; etc. (Criterion 20) Northwest AHEC, Blue Cross & Blue Shield of NC Foundation, and NC Community Health Centers

18. List any non-educational strategies to enhance/reinforce change as an adjunct to the CME activity. Examples include post-activity reminders to attendees; patient feedback or surveys; patient education materials; algorithms; flow sheets; personal patient outcomes data; display posters; newsletters; protocols; order sets; chart or electronic record reminders; forms; etc. (Criterion 17) NC Association of Free Clinics Annual Outcomes Survey (which relates to this activity) will be shared and compared with all member free clinics.

F.) Adult Learning Principles & Educational Methodology:

19. Adult learning is a complex, multistage process that incorporates the learner into the planning and evaluation process. Learning tends to be problem-centered rather than content-oriented, and experience provides the basis for learning, which is focused on material that has immediate relevance. Adults learn by solving genuine problems (reviewing their own issues and daily encounters); reflecting via analogy/comparison (comparing their own experiences to others); practicing and applying new knowledge and strategies; and developing a framework for application (creating plans for implementation). There are five stages of physician learning:

1. Recognizing a need for learning – when a physician becomes aware that something in his/her practice needs improvement
2. Searching for learning resources, which is driven by cognitive dissonance (the difference between what is and what should be)
3. Engaging in learning – when learning (formal or informal) becomes more intentional and focused on the problem at hand
4. Trying out what was learned – when a physician begins to use newly acquired knowledge or skills and looks to confirm the benefits
5. Incorporating what was learned – when a physician integrates the new knowledge or skills into daily practice

Describe how this CME activity will incorporate adult, more specifically physician, learning principles. This activity will allow attendees the opportunity for identifying needs for practice improvements and engagement in discussions for problem solving.

20. Educational formats should be appropriate for the setting, objectives, and desired results of the CME activity. (Criterion 5) Indicate what educational design/format will be used for this CME activity (check all that apply). Attach a schedule of events
(as applicable) and the teachers/authors of the content including name, degree, academic/professional title, and institutional/organizational affiliation.

X Lecture/Didactic
☐ Webcast/Webinar
☐ Simulated Patients
☐ Lab Exercises
☐ Roundtable Discussion
☐ Panel Discussion
☐ Case Studies
☐ Tumor Boards
☐ Hands-On Practicum
☐ Other (describe) Open Discussion
☐ Question & Answer
☐ Live Demonstration
☐ Journal Clubs
☐ Podcast
☐ Videoconference
☐ Interact. Workshop
☐ Pro/Con Debate
☐ Academic Detailing

G.) Evaluation:

21. The OCME requires use of its evaluation form, but Activity Directors may request questions to be added. Describe how the results of the evaluation will be used for this CME activity, including determining the effectiveness in meeting the educational need and creating changes in competence, performance, and/or patient outcomes. (Criterion 11) Identify topics for future CME activities and determine if objectives have been met.

H.) Funding Sources:

22. Indicate what funding sources will be used (check all that apply):

X Registration Fee (Amount: $25)
☐ Department/Institutional/Organization Funds
☐ Government Funds
☐ Foundation Grants
☐ Professional Society Funds
☐ Other (describe)
☐ Pharmaceutical/Medical Device Educational Grants (Criterion 8 and the Standards for Commercial Support)
☐ Exhibit Fees (Criterion 9 and the Standards for Commercial Support)

23. Will teachers/authors be paid an honorarium?  ☐ Yes* (Amount: $   )  X No

*WFUSM policy states honoraria higher than $1500 per day must be approved by the Associate Dean for Faculty Services. Planners, teachers, and authors may be reimbursed for out-of-pocket expenses consistent with WFUHS policies. If teachers or authors are listed on a CME activity agenda as facilitating or conducting a presentation or session, but participate in the remainder of the activity as a learner, their expenses can be reimbursed and honoraria can be paid for their teacher or author role. No other payment, apart from those paid by WFUHS, shall be given to the Activity Director, planning committee members, teachers, authors, joint sponsor, or others involved with the CME activity. (Criterion 8 and the Standards for Commercial Support)

I.) Required Attachments:

• Full Disclosure Statements for Activity Director, Staff, Additional Planning Committee Members, and Teachers/Authors
• Resolution of Conflict of Interest Forms Documenting How Conflicts Will Be Managed
• Signed CME Financial Agreement
• Organization’s mission statement/purpose/description (for those apart from WFIH/WFUSM, NCBH, or WFUBMC)
• Schedule of events (as appropriate) listing the teachers/authors of the content including name, degree, academic/professional title, and institutional/organizational affiliation

Application Fee Payment Options:

☐ Application fee will be mailed in the form of a check or money order (payable to Wake Forest University Health Sciences).
☐ Charge the following credit card: ☐ MasterCard ☐ Visa ☐ American Express
  Card #:       Expiration Date:
  Name of Credit Card Holder:
X Deduct application fee from the following WFUHS Chartfield: NW AHEC
☐ Deduct application fee from CME activity income managed by the OCME.
By submitting this Certification Request, the Activity Director and his/her staff understand that the proposed CME activity must be consistent with the overall CME mission and policies of WFUHS/WFUSM and follow all ACCME Essential Areas, Policies, and Updated Accreditation Criteria, including the 2004 ACCME Standards for Commercial Support.

Submitted by: Cindy Jones, NCAFC - Dir. of Training & Support          Date: Feb. 9, 2010