Reviewed:

SCCME Director signature Date

Stanford Center for Continuing Medical Education (SCCME) Online CME Planning Documentation Worksheet & Application

Stanford University's Center for Continuing Medical Education (SCCME) is responsible for ensuring compliance with the accreditation criteria, policies and standards of the Accreditation Council for Continuing Medical Education (ACCME).

Basic Requirements for CME Certification by SCCME:

- Course Director (who must be Stanford faculty) accepts accountability for ensuring compliance with SCCME policies and ACCME policies and criteria.
- **Course director and planners must complete disclosures, attestations, and resolution of any conflicts of interest prior to beginning activity planning.**
- Content:
  - **meets** ACCME/American Medical Association (AMA) definition of CME (see below);
  - **conforms** to the ACCME Content Validation Policy (see below); and,
  - is **compatible with** SCCME's Mission Statement (*http://cme.stanford.edu/about.html)*.
- The activity is HIPAA compliant (responsibility of the Course Director).
- The activity is prospectively reviewed and approved by SCCME's Associate Dean of Postgraduate Medical Education.

Definition of Continuing Medical Education (CME)

Continuing medical education consists of educational activities, which serve to maintain, develop, or increase the knowledge, skills, professional performance, and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is that 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 health care to the public. (Sources: ACCME and AMA).

ACCME Content Validation Policy

- All the recommendations involving clinical medicine in a CME activity 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.
- All scientific research referred to, reported or used in CME in support or justification of a patient care recommendation must conform to the generally accepted standards of experimental design, data collection and analysis.
- Providers are not eligible for ACCME accreditation or reaccreditation if they present activities that promote recommendations, treatment or manners of practicing medicine that are not within the definition of CME, or known to have risks or dangers that outweigh the benefits or are known to be ineffective in the treatment of patients.

An Important Note

SCCME retains the right to withdraw credit at any time, should it determine that ACCME Criteria, Policies, and/or SCCME Policies and Procedures have been violated.

Stanford Center for Continuing Medical Education
1070 Arastradero, Suite 230, Mail Code: 5753, Palo Alto, CA 94304
Phone: 650.497.8554 / Fax: 650.497.8585

Stanford has developed a planning process that meets the ACCME Criteria, including the Standards for Commercial Support. Planning of CME activities is based not only on need, but also on thoughtful consideration of Adult Learning Principles. Submit an electronic version, including the following attachments: **1) Project Description that addresses the specifics of the delivery format, potential impact, an outline of the content to be delivered, and proposed faculty**, 2) Course Director/Planner Financial Disclosure and Attestation forms for the Course Director and any Co-Course Directors, 3) Resolution of Conflict of Interest forms for all conflicted course directors, 4) any supportive documentation of "professional practice gaps", and 5) a budget, to **seolim@stanford.edu**.

Section 1: General Information

Activity Title:	Screening and Assessing Depression in Primary Care Settings: Clinical and Ethical Considerations
Stanford Department/Division:	Psychiatry and Behavioral Sciences
Who will be responsible for backstopping the course?	☐ Hospital ✓ Department ☐ Center
Estimated length:	2 hours
Course Director:	**Name:** Sue Smith, MD **Title:** Clinical Professor, Psychiatry and Behavioral Sciences **Phone:** (650) XXX-XXXX **Fax:** (650) XXX--XXXX **E-mail:** ssmith@stanford.edu
Co-Course Director (if applicable):	**Name:** John Doe, PhD **Title:** Assistant Professor of Psychiatry and Behavioral Sciences **Phone:** (650) XXX-XXXX **Fax:** (650) XXX-XXXX **E-mail:** jdoe@stanford.edu

PTA/Cost Center for certification fee: A PTA cost center will be opened for this activity by the Center for CME. All course expenses and revenue will be managed by the Center and will flow through the assigned PTA. The course director's department/division/institute must provide a guarantee account to cover any activity deficits.

Departmental Financial Account: 1000000-100-EXXXX for guarantee backstop.

Please list the financial contact for your department/division/institute: Marcia Jackson, DFA

CME PTA (*assigned and completed by SCCME*): _____

Section 2: Target Audience (C-4)

Provider Type	*Specialty*	
☒ Physician (MD/DO) ☒ Other (Specify): Clinical Psychology, Social Work, Marriage and Family Therapy	☐ All Specialties ☐ Cardiology ☒ Family Practice ☒ Primary Care ☐ General Surgery ☒ Internal Medicine ☐ Neurology	☐ Oncology ☐ Pediatrics ☒ Psychiatry ☐ Radiology ☐ Urology ☒ Other (specify): OB/GYN

Section 3: Planners Disclosure/Attestation (C-7)

INSTRUCTIONS: SCCME/ACCME encourages more than one planner. List all planners/course directors and complete disclosure/attestation forms for Course Directors. If there are relevant financial relationships with commercial interests they must be resolved and documented using the "Resolution of Conflict of Interest" form. **All planners must complete and sign the attestation and disclosure forms prior to the start of the planning process.** If the activity receives an award, the Course Director must also sign the Course Director Responsibility Agreement.

Name	*Role in Activity*	*Attach with Application*	*Attach (if applicable)*
Sue Smith, MD	Course Director	☒ Disclosure ☒ Attestation	☐ Resolution of Conflict of Interest
John Doe, PhD	Co-Course Director	☒ Disclosure ☒ Attestation	☐ Resolution of Conflict of Interest
Terrance Johnson, PhD	Planner	☒ Disclosure ☒ Attestation	Not needed at this time. If the proposed activity is selected to receive an award resolution will be required if applicable.
Nancy Garcia, MD	Planner	☒ Disclosure ☒ Attestation	Not needed at this time. If the proposed activity is selected to receive an award resolution will be required if applicable.

Section 4: Gap Analysis and Needs Documentation (C-2, C-3)

Identifying Gaps in Knowledge, Competence and/or Performance-in-Practice

In accordance with Stanford's CME Mission, this educational activity must be designed to improve (1) physician competence, and/or (2) physician performance-in-practice, and/or 3) patient outcomes.

ACCME Definitions:

- **Competence:** ability to apply knowledge plus a strategy in practice when the opportunity presents
- **Performance in Practice:** the application of new strategies or skills in the practice setting
- **Gap:** the difference between what physicians are currently doing in practice and what is considered best or ideal practice
- **Patient Outcomes:** self-reported or data supported improvements in patient outcomes as a result of physician performance improvement

Note: Gaps may be based upon problems faced in practice, expert opinion, quality issues, hospital mandates, regulatory requirements, published literature, MOC, previous evaluation data from learners, department surveys or other identified sources.

The key to planning this CME activity is that you have clearly identified the 'gap'. The gap is based on the difference between what the learners **do now** in practice **versus what you want them to do based on best evidence** (also known as 'Best Practice').

Practice gaps are based on underlying causes, such as a need for ***knowledge*** about a particular topic, a need to improve ***competence*** (know when and how to apply new strategies in practice) and/or improved ***performance*** (such as adoption of new skills or behaviors).

In the table below, answer the following questions to help identify the purpose of this CME activity.

1. What are the clinical problems or issues you want to address in this activity?	Currently, patients in primary care are not consistently screened for depression. In addition, many patients presenting to primary care physicians (PCPs) are depressed, but they frequently are not assessed for depression. Furthermore, depression can masquerade as a medical illness as well as complicate the course of medical diseases and subsequent treatment. Therefore, patient outcomes can be greatly improved if primary care physicians screen and assess depression symptoms as well as link patients to appropriate psychiatric care.

2. Why do these issues exist? Is there a lack of knowledge, or competence, or an issue with performance? It can be more than one or a combination of all.	Primary care physicians lack knowledge and competence with regards to screening and assessing for depression or suicide risk, because this was generally not part of their training and currently there is no standard practice for PCPs to do so. PCPs lack the knowledge and competence to make diagnoses using the new DSM-5 criteria for depressive disorders, which were recently released. Lastly, PCPs lack the knowledge and competence to effectively refer depressed patients to psychiatric treatment and to interface with mental health providers and systems.
3. What do you want to change?	1) Increase competence to screen for depression and suicide risk in the primary care setting; 2) Increase competence to assess depression and suicide risk, within the time limits of a primary care visit, and performance in the use of the new DSM-5 criteria for depressive disorders; 3) Increase competence in referring depressed patients in primary care settings to psychiatric care and interfacing with mental health providers and systems.

Using the table below, state the current practice, the best practice that you intend for the learner to achieve as a result of this activity, and the resulting gap which is the difference between the two. Please include references to support your statements. State the underlying cause of the gap and the learning objectives.

Current Practice (i.e. what physicians are currently doing in practice)	***Best Practice*** ***(i.e. what physicians should be doing based on best available evidence)***	***Resulting Gap*** ***(i.e. Learner needs)***	***Cause of Gap*** ***(i.e. lack of knowledge, competence or performance)***	***Learning Objectives*** ***(What the learners should be able to achieve as a result of the activity) See Addendum A.***
EXAMPLE: *Many Stanford physicians do not utilize protocols in the administration and monitoring of heparin* ***Source:*** *Stanford Hospital and Clinics quality data (attached)*	***EXAMPLE:*** *Physicians adhere to the National Patient Safety Goal on Anticoagulation and follow Stanford Hospital and Clinics protocols for administering heparin and monitoring heparin levels.* ***Source:*** *National Patient Safety Goal on Anticoagulation NPSG.03.05.01* *Stanford Heparin protocol* *Stanford Warfarin protocol*	*Stanford physicians need to have a strategy to ensure the safety of patients receiving anticoagulants and to follow the Stanford protocols.*	☐ Knowledge ☒ Competence (Knowledge + Strategy) ☒ Performance-in-Practice	*Evaluate the various heparin protocols and apply the appropriate anticoagulation protocol to reduce the risks of adverse drug events and to ensure patient safety.*
1. ***Current Practice:*** Approximately two-thirds of depressed patients receive care in a primary care setting (1), and among individuals who committed suicide 40% visited their primary care physician in the month preceding their death (2,3). Despite the incidence of depression found among primary care patients, research studies indicate that primary care physicians who provide usual care do not identify depressive symptoms in 30%-50% of their patients with depression (4,5).	1.***Best Practice:*** In 2002, the US Preventive Services Task Force recommends routine screening for depression in primary care settings (4,6,7). The Patient Health Questionnaire (PHQ-9) has been tested and validated for use in primary care settings; however, the use of the PHQ-9 in conjunction with lab tests to assess depression has not been developed. Based on the best available evidence, physicians will screen patients using age appropriate screening instruments for depression and suicide risk in primary care settings. ***Source:*** ☒ National Guidelines or Consensus Statements	***Resulting Gap:*** Physicians need to increase their knowledge of techniques to screen for depression and suicide risk and become capable of applying them (i.e., gain competence) in the primary care setting.	☒ Knowledge ☒ Competence (Knowledge + Strategy) ☐ Performance-in-Practice	***Learning objective for this gap:*** 1. Describe the clinical diagnosis of depression and impact of misdiagnosis or missed diagnosis. 2. Recognize identifying signs and symptoms of the range of patient presentation of depression in the primary care setting. 3. Screen patients for depression and suicide risk in a primary care setting.

Current Practice (i.e. what physicians are currently doing in practice)	***Best Practice (i.e. what physicians should be doing based on best available evidence)***	***Resulting Gap (i.e. Learner needs)***	***Cause of Gap (i.e. lack of knowledge, competence or performance)***	***Learning Objectives (What the learners should be able to achieve as a result of the activity) See Addendum A.***
Source: (site references): ☐ Evaluation data or survey data from learners ☒ Peer Reviewed Literature ☐ Other 1. Luoma JB, Martin CE, Person JL. Contact with mental health and primary care providers before suicide: a review of the evidence. Am J Psychiatry. 2002; 159:909-916. 2. Pirkis J, Burgess P. Suicide and recency of health care contacts: a systematic review: Br J Psychiatry. 1998; 173:462-474. 3. Hegarty K, Gunn J, Blashki G, Griffiths F, Dowell T, Kendrick T. How could depression guidelines be made more relevant and applicable to primary care? A quantitative and qualitative review of national guidelines. Br J Gen Pract. 2009 May;59(562):e149-56.	☐ Hospital Mandates or regulatory requirements ☐ Quality and Patient Safety Indicators (hospital, National, Department) ☐ Other 4. Pignone MP, Gaynes BN, Rushton JL, et al. Screening for depression in adults: a summary of the evidence for the US Preventive Services Task Force. Ann Intern Med. 2002; 136:765-776. 5. Mitchell J, Trangle M, Degnan B, et al. Institute for Clinical Systems Improvement. Adult Depression in Primary Care. 16th Ed, September 2013. Retrieved on 10/30/2014 from https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_behavioral_health_guidelines/depression/ 6. American College of Physicians. Depression care guide: team-based practices for screening, diagnosis, and management in primary care settings. Kravitz RL, Franks P, Feldman MD, Tancredi DJ, Slee, CA, Epstein RM, et al. 7. Patient Engagement Programs for Recognition and Initial Treatment of Depression in Primary Care: A Randomized Trial JAMA. 2013;310(17):1818-1828.			

Current Practice (i.e. what physicians are currently doing in practice)	***Best Practice*** ***(i.e. what physicians should be doing based on best available evidence)***	***Resulting Gap*** ***(i.e. Learner needs)***	***Cause of Gap*** ***(i.e. lack of knowledge, competence or performance)***	***Learning Objectives*** ***(What the learners should be able to achieve as a result of the activity) See Addendum A.***
2. ***Current Practice:*** DSM-5 diagnostic criteria for depressive disorders have not been widely applied, because they were just recently released. ***Source:*** (site references): ☐ Evaluation data or survey data from learners ☒ Peer Reviewed Literature ☐ Other Same references as the ones in #1	2.***Best Practice:*** In 2002, the US Preventive Services Task Force recommends routine screening for depression in primary care settings (4,6,7). In May 2013, the most recent edition, DSM-5, was published. Physicians need to use the current guidelines in order to assess the severity of depression and suicide risk in their patients. ***Source:*** ☒ National Guidelines or Consensus Statements ☐ Hospital Mandates or regulatory requirements ☐ Quality and Patient Safety Indicators (hospital, National, Department) ☐ Other Same references as the ones in #1	***Resulting Gap:*** Physicians need to learn how to make diagnoses using the new DSM-5 criteria for depressive disorders and become capable of applying them (i.e., gain competence) in the primary care setting.	☒ Knowledge ☒ Competence (Knowledge + Strategy) ☒ Performance-in-Practice	***Learning objective for this gap:*** 4. Assess the severity of depression and suicide risk, in the time limits of a primary care visit, using the DSM-5 criteria for depressive disorder.
3. ***Current Practice:*** Since physicians inadequately screen and assess depression in primary care settings, they are not referring patients with depression to psychiatric treatment and gaining experience in the most effective ways to refer these patients. ***Source:***	3.***Best Practice:*** After screening and assessing depression in primary care patients, physicians should refer appropriate patients to mental health providers. ***Source:*** ☒ National Guidelines or Consensus Statements ☐ Hospital Mandates or regulatory	***Resulting Gap:*** Physicians need to learn about (i.e., gain knowledge) effective ways to refer depressed patients to psychiatric treatment and to interface with mental health providers and systems, and become capable of	☒ Knowledge ☒ Competence (Knowledge + Strategy) ☐ Performance-in-Practice	***Learning objective for this gap:*** 5. Implement an effective referral process of depressed and/or suicidal patients to psychiatric treatment 6. Manage long-term treatment for depressed

Current Practice (i.e. what physicians are currently doing in practice)	***Best Practice*** ***(i.e. what physicians should be doing based on best available evidence)***	***Resulting Gap*** ***(i.e. Learner needs)***	***Cause of Gap*** ***(i.e. lack of knowledge, competence or performance)***	***Learning Objectives*** ***(What the learners should be able to achieve as a result of the activity) See Addendum A.***
(site references): ☐ Evaluation data or survey data from learners ☒ Peer Reviewed Literature ☐ Other Same references as the ones in #1	requirements ☐ Quality and Patient Safety Indicators (hospital, National, Department) ☐ Other Same references as the ones in #1	applying them (i.e., gain competence) in the primary care setting.		patients through coordinated care with mental health providers and systems. 7. Examine the ethical considerations in medical decision making as it relates to managing patients with depression and co-morbidity with other psychiatric disorders.

Section 5: Expected Result for This Activity (C-3)

INSTRUCTION AND BACKGROUND: The ACCME and Stanford's CME Mission require that every CME activity focus on improvement in (1) competence and/or (2) performance-in-practice and/or (3) patient outcomes. You must designate the type of outcome this activity is intended to achieve. Once designated, outcomes measurement tools will be selected that match this designation. Please note that patient outcomes may be self-reported and anecdotal. **This activity is designated to change: (check all that you will measure post activity):**

☒ Competence (Knowledge + Strategy) ☒ Performance-in-Practice ☐ Patient Outcomes

Section 6: Measuring Educational Outcomes (C-11)

Stanford must measure for changes in learner competence, performance-in-practice or patient outcomes, as required by the ACCME.

Educational Outcome Measures (EOM) are used to assess changes in learners, based on the desired results of the CME activity. Based on your designation for the activity as stated in Section 5 above (change in competence, performance in practice or patient outcomes), please indicate the evaluation tool you wish to use to measure changes in your learners.

Competence – *measured at conclusion of activity*	
☒ **Competence –** knowledge plus a strategy to use it in practice	*Changes in competence will be assessed through a post activity survey that accompanies all online CME activities*
☒ Pre and post-tests ☐ Case Study questions	*We will assess baseline knowledge and competence regarding assessing and screening depression and suicide and then again after didactics and video role plays.*

Performance- *measured 2 months post activity*	
☒ **Performance –** new strategies or skills *adopted* in practice	*A post activity survey can be emailed to participants approximately 2 months after their participation in the activity that will address what changes they have implemented in their practices* "Have you made diagnoses using the new DSM-5 criteria for depressive disorders, since participating in the CME training?"
☐ Other form of performance measurement: Please describe	

Patient Outcomes - *measured 9-12 months post activity*
☐ Observed improvements in patient care as a result of the educational activity.
☐ Analysis of QI/QA data collected before and after the educational activity

Section 7: Format and Design Related to Desired Results (C-5)

Format and design of each educational activity should be based on the designation for the activity (designed to change competence, performance-in-practice or patient outcomes). Educational design should include the appropriate method to engage the learners in the educational process.

Mode of Educational Activity	
Internet Enduring Material	Self-directed learning at a time convenient for learners
Rationale for Mode of Instruction *Please explain how the formats will engage the learners in the educational activity, facilitating the achievement of the learning objectives and desired results.*	**This section must be completed by planners:** Videos by leading experts in the field will provide up to date scientific information, role plays will demonstrate to learners how they can engage in ideal behaviors, and case studies with self-assessment will engage learners in the educational process. Quizzes will facilitate better integration of the information into strategies to apply in practice.

Check all that apply for your activity:

Methods to Engage Learners	
☒ Didactic Video Lectures	Conveys to learners the course content in an engaging and succinct format.
☐ Video Interviews	Enriches course materials with opinions and views on the topic(s) by content experts.
☒ Case studies with Self-Assessments ☐ Self-Assessments	Provides an actual problem or situation learners have experienced. Followed by set of questions on how to approach these situations. These allows for learners to self-assess their level of understanding the course content.
☐ Discussion Board	Provides an opportunity for faculty to answer specific participant questions.
☒ Quizzes	Tests learners' level of comprehensions of course content.
☒ Additional Readings	Provides an opportunity for further learning.
☒ Other (please indicate below): Videos of role-play demonstration of patients and primary care physicians.	*RATIONALE:* Provides role modeling of behaviors described in didactic videos lectures. This is important because often physicians report that they do not know what to say or how to respond to psychologically distressed patients. Observing best practices in realistic scenarios will augment the didactic video lectures by illustrating complex doctor-patient interactions.

Section 8: Processes or Tools to Reinforce and Sustain Learning Goals (Supplemental Educational Tool/Non-educational Intervention) (C-17)

☐ Patient information packet/Patient handout material available ☐ System interventions (i.e. reminder to wash hands in patient rooms) ☐ Algorithm worksheet ☐ Email reminders to learners (i.e., new staging guidelines, summary points from session) ✓ Online resources or guidelines available to reinforce learning ☐ Educational take-away points sent to physicians to sustain learning ✓ Physician handout material to aid in diagnosis, management or treatment ☐ Pocket reference card ☐ Other, specify: ☐ No plans at this time for adjunct tools	Involves the use of ancillary tools or processes that are not actually part of the CME activity but support learners changes in practice. Example: Email reminders may be used to remind learners of changes they reported they would make in practice. CONTENT: Online resources or guidelines will be provided with the course to ensure that learners stay informed on changes /updates and provide opportunities for advanced learning. Depression screening tool (PHQ-9) will be provided to ensure that physicians have the necessary resources to screen for depression. SOURCE: 1.Mitchell J, Trangle M, Degnan B, et al. Institute for Clinical Systems Improvement. Adult Depression in Primary Care. 16th Ed, September 2013. Retrieved on 10/30/2014 from: https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_behavioral_health_guidelines/depression/ 2. Patient Health Questionnaire 9 (PHQ-9). Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute. 3. American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.

Section 9: Desirable Physician Attributes Must Be Applied To CME Content (C-6)

INSTRUCTION AND BACKGROUND: CME activities should be developed in the context of "desirable physician attributes" that are related to specialty board Maintenance of Certification (MOC). Identify 1-3 competencies from the IOM/ABMS/ACGME (see below) that will be addressed in this CME activity. Place an 'X' in the appropriate checkbox.

National Priorities for Physician Attributes

Institute of Medicine Competencies	*ABMS (MOC)/ACGME Competencies*
☐ **Provide patient-centered care** – identify, respect, and care about patients' differences, values, preferences, and expressed needs; relieve pain and suffering; coordinate continuous care; listen to, clearly inform, communicate with, and educated patients; share decision making and management; and continuously advocate disease prevention, wellness, and promotion of health lifestyles, including a focus on population health. ☐ **Work in interdisciplinary teams –** cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable. ☐ **Employ evidence-based practice –** integrate best research with clinical expertise and patient values for optimum care, and participate in learning and research activities to the extent feasible. ☐ **Apply quality improvement –** identify errors and hazards in care; understand and implement basic safety design principles, such as standardization and simplification; continually understand and measure quality of care in terms of structure, process, and outcomes in relation to patient and community needs; and design and test interventions to change processes and systems of care, with the objective of improving quality. ☐ **Utilize informatics –** communicate, manage, knowledge, mitigate error, and support decision making using information technology.	☒ **Patient care that is** compassionate, appropriate, and effective for the treatment of health problems and the promotion of health ☒ **Medical knowledge** about established and evolving biomedical, clinical, and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care ☐ **Practice-based learning and improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care ☒ **Interpersonal and communication skills** that result in effective information exchange and teaming with patients, their families, and other health professional ☐ **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population ☐ **Systems-based practice,** as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system for health care and the ability to effectively call on system resources to provide care that is of optimal value.

For more information on these physician attributes, visit: http://www.iom.edu/CMS/3809/4634/5914.aspx, www.acgme.org, www.abms.org

Section 10: Identified Factors/Barriers and Strategies to Address or Overcome Factors/Barriers (C18, C19)

INSTRUCTIONS: Planners are encouraged to identify factors/barriers that could prevent implementation of changes in practice that will impact on patient outcomes (see potential barriers listed below). Explain how your activity will address these factors/barriers so that physicians may overcome them and make changes in practice that will impact on patient care.

Identified Factors/Barriers	***Please describe how you will address the identified factors/barriers in the activity:*** ***Example: If the identified barrier is cost, you would attempt to address the barrier by stating "The content will address cost effectiveness and new billing practices."***
☒ Lack of time to assess or counsel patients	The content will address how a physician may be efficient and use less time in screening and assessing depressed patients
☐ Lack of administrative support/resources	
☐ Insurance/reimbursement issues	
☒ Patient compliance issues	The content will address how to increase the chances that a depressed patient will follow-up on a physician's referral to psychiatric care.
☐ Lack of consensus on professional guidelines	
☐ Cost	
☐ No perceived barriers	
☐ Other, specify:	

Section 11: Collaboration with Other Stakeholders (C-20)

INSTRUCTIONS: The ACCME recognizes that CME provides many opportunities for planners to collaborate with other stakeholders, such as quality departments, other medical departments within the system, specialty medical societies, risk management, etc. to participate in the planning process in order to enhance the education for the learners. Please list collaborations you plan to engage in to enhance this activity.

☒ No, I do not intend to collaborate with other stakeholders	
☐ Yes, I intend to collaborate with the stakeholders listed below:	
Collaborator	***How Will Collaboration Enhance The Activity Results?***

Section 12: Institutional or Systems Framework for Quality/Patient Safety (C-21)

INSTRUCTIONS: All CME activities should focus on integrating and contributing to healthcare quality improvements. Indicate below any quality connections you intend to address within your CME activity that will improve patient safety or outcomes.

- ☐ Hospital goals/Initiatives
- ☐ Hospital QI
- ☒ Departmental quality goals
- ☐ Maintenance of Certification (MOC) requirements
- ☐ National quality initiatives
- ☐ Other, specify:

Please describe the contributions this activity will make to quality improvement and/or patient safety:

Appropriate assessment of suicide risk is a major goal of our Department of Psychiatry and Behavioral Sciences. This CME activity aims to improve competence in preventing suicide in adults presenting to primary care settings.

Please indicate how this CME activity will comply with AB1195.

Cultural and Linguistic Competency - AB1195 - California Assembly Bill 1195 requires continuing medical education activities with patient care components to include cultural and linguistic competency curriculum. It is the intent of the bill, which went into effect July 1, 2006, to encourage physicians and surgeons, CME providers in the State of California, and the ACCME to meet the cultural and linguistic concerns of a diverse patient population through appropriate professional development. The Stanford University School of Medicine Multicultural Health Portal contains many useful cultural and linguistic competency tools including culture guides, language access information and pertinent state and federal laws. Found at: **http://lane.stanford.edu/portals/cultural.html**

☒ Provide learners with resources on cultural and linguistic competency
☒ Guide CME faculty presenters to address relevant cultural issues
☐ Other (please specify):

Marketing Materials

The SCCME must review and approve all marketing materials (including advertisements, web postings, etc. prior to distribution).

Please provide a statement of need that will be included in the marketing materials and course description section of this activity:
Example: This CME activity provides a practical approach to the management of atopic dermatitis by the primary care provider. The main signs and symptoms of the disease (xerosis, inflammation, pruritus, infection) and their corresponding treatment will be reviewed. Case scenarios will be used to put these principles into practice with a treatment algorithm. The role of patient and family counseling and support is also discussed.
This CME activity focuses on depression in the primary care setting – the screening, assessment, and referral of depressed patients. Special emphasis is given to the risk of suicide and ethical issues with depressed patients, particularly among geriatric patients. Guidance is given for effective referral of depressed patients to psychiatry treatment and interfacing with mental health providers and systems. Online learners are engaged by short modules with role-play demonstrations of patients and physicians, case studies and self-assessment, and interactive quizzes.

FACULTY SELECTION

Please list all individuals who will be presenting content in this activity. Faculty that you select should have a demonstrated expertise in the therapeutic field, strong presentation and communication skills, and ability to address the gaps and learning objectives expressed in this planning document. You should select faculty with expertise and teaching ability. Faculty chosen to achieve the objectives of this activity and their qualifications are (add more lines as necessary):

Faculty Name	***Title and Affiliation***	***Qualifications (i.e. content expert)***
Sue Smith, MD	Clinical Professor, Psychiatry and Behavioral Sciences, Stanford	Expert in assessment and medication management of depression
John Doe, PhD	Assistant Professor of Psychiatry and Behavioral Sciences, Stanford	Expert in depression screening, assessment and treatment
Maria Robinson, PsyD	Adjunct Clinical Faculty Stanford	Expert in depression screening, assessment and treatment
Victor Lee, MD	Professor and Chair, Psychiatry and Behavioral Sciences, Stanford	Expert in assessment and medication management of depression

Signatures

Please read and check boxes below.

☒	I attest that the information entered into this CME Application form is true and accurate to the best of my knowledge.
☒	I agree to be responsible for timely communication with the CME and Ed Tech teams and continuous effort to complete this activity in the timeframe outlined.
☒	I agree to abide by the Stanford Center for CME policies and procedures.
☒	By affixing my signature below, I am approving the transfer of fees to the Stanford Center for CME for this activity.

Course Director

Sue Smith, MD

Print Name of Course Director

Sue Smith — 3-28-15

Signature of Course Director — Date

Departmental Approval

Victor Lee, MD

Print Name of Department Chair

Victor Lee — 4-1-15

Signature of Department Chair — Date

CME Certification Approval (for SCCME use only)

This application has been reviewed and the CME activity has been approved for

_____ ***AMA PRA Category 1 Credit(s)™.***

Date Range:_____

_____ — _____

Griffith Harsh, MD — Date
Associate Dean for Postgraduate Medical Education
Stanford University School of Medicine

(Note: This activity is not certified for CME credit until Application has been signed by Associate Dean and approval letter has been issued by SCCME.)

DOCUMENTATION REQUIREMENTS

The following attachments must be included with the submission of this CME Application:

- Disclosure forms for all course directors; current within previous 12 months of planning. (dated and signed)
- Attestation forms for all course directors. (dated and signed)
- Resolution of Conflict of Interest (COI) forms for all conflicted course directors. (dated and signed)
- **Project Description: Description of the project (with specifics of the delivery format), potential impact, an outline of the content to be delivered, and proposed faculty.**
- Supportive documentation of "professional practice gaps" (i.e., citation for literature, survey results, evaluation analysis, planning meeting notes, etc.)
- Budget detailing projected expenses. SCCME form required, including backstop signature.

Checklist for Application Submission

1. ✓ **Project Description (with specifics of the delivery format), potential impact, an outline of the content to be delivered, and proposed faculty.**
2. ✓ **Disclosure/Attestation forms** for course directors and planners (dated & signed).
3. ☐ **Resolution of Conflict of Interest forms** for those course directors who identified relevant financial relationships (dated and signed). – **Not Applicable**
4. ✓ **Signatures of both the course director and the department chair must be on the application form.**
5. ✓ **Examples of non-educational tools, if developed.**
6. ✓ **Budget detailing expenses reviewed by course director and department chair.**
7. ✓ **Signature of DFA or appropriate financial authority on the budget to approve backstop for the course**

Include attachments with submission of application.

Addendum A

GUIDELINES FOR DEVELOPING CME LEARNER-CENTERED OBJECTIVES

CME providers are now expected to design CME activities with the intent of **changing physician competence, performance and/or patient outcomes**, *as opposed to merely increasing knowledge*. Objectives must be *behavioral* rather than *instructional.*

- competence (knowing how to do something; having the knowledge/ability to apply knowledge, skills and judgment in practice; new strategies one might consider putting into practice)
- performance (what one actually puts into practice)
- patient outcomes (patient health status)

Tips for Writing Good Objectives:

- Objectives should address these questions:
  - What should the result of the educational activity be for participants?
  - What should the participant be able to do after attending the activity?
- Make sure that objectives are measureable and relate directly to reducing the identified practice gap
- State what the *learner might do differently* (behavioral change) because of what has been learned
- Use verbs which allow measureable outcome and thus can then be used in the evaluation process

VERBS that can used to measure changes in COMPETENCE:					
Differentiate	Analyze	Compare	Contrast	Plan	Recommend
Distinguish	Evaluate	Assess	Develop	Design	Formulate

VERBS that can used to measure changes in PERFORMANCE:					
Apply	Manage	Perform	Integrate	Interpret	Diagnose
Examine	Prescribe	Incorporate	Employ	Counsel	Utilize

Avoid words or phrases such as think, understand, know, appreciate, learn, comprehend, be aware of, be familiar with, etc.
These are <u>not measureable</u> actions.

Examples of Well Written Objectives:

- Critically review and analyze cases to improve quality and safety of patient care in management of hyperglycemia *(competence)*
- Manage patients diagnosed with ovarian cancer incorporating stage grouping, evidence-based evaluation management guidelines and clinical trial data *(performance)*
- Differentiate the clinical presentations of acute rhinosinusitis vs acute bacterial rhinosinusitis to develop treatment plans *(competence)*
- Diagnose possible life-threatening arrhythmias in adolescent athletes based on patient/family history, physical exam and ECG *(performance)*