DES MOINES UNIVERSITY
MEDICINE & HEALTH SCIENCES

Des Moines University Application for Continuing Education Credit

Activity Information

Date of application: October 12, 2020

Organization: National Alliance on Mental Illness (NAMI) Iowa

Series title: NAMI Provider Seminars

Date(s): Vary

Location: Vary

Time: Vary

Activity director: Ashley Parker, BSW

Phone: 515-771-0182

Email: ashley@namiiowa.org

Activity director: Ashley Parker

Phone:

Email:

Activity coordinator: N/A

Phone:

Email:

Format: *ACCME C5; CPME Standard 3.2, 9.0*

- ☒ Live
- ☐ Journal-based CME
- ☐ Online/Enduring materials
- ☒ Grand Rounds/Regularly scheduled series (RSS)
- ☒ Remote site teleconference
- ☐ Other:

Frequency of activity:

- ☐ Once
- ☐ Weekly
- ☐ Monthly
- ☐ Quarterly
- ☐ Annual
- ☒ Other: Vary

Type of credit requested: (additional requirements and fees may apply)

- ☒ American Osteopathic Association (AOA) credit
  - ☐ Category 1-A
  - ☐ Category 1-B
  - ☒ Category 2-A
  - ☐ Category 2-B
- ☒ Nursing credit (IBON)
- ☐ American Academy of Family Physicians (AAFP) Prescribed credit ***Additional fee
- ☒ *AMA PRA Category 1 Credit*™ through the Iowa Medical Society
- ☐ Podiatry credit (CPME)
- ☒ Certificates of participation
- ☐ Other:

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Planning Committee

Identify below members of the planning committee who have input into the planning process and selection of content. To comply with national CME standards, Des Moines University requires all planners and developers of content for an educational activity to complete and submit a financial conflict of interest form. It's the responsibility of the activity director to ensure that no conflicts of interest occur during the planning and content delivery process. If needed, attach separate documentation. *AOA Standards 2.2.4.2, 3.3, 3.5; ACCME C7, SCS 1.1, SCS 6.1-6.5, C9, SCS 2.1-2.3, SCS 4.2-4.5, C10, SCS 5.2; CPME Standard 1.3, 1.6, 5.2, 5.3*

The activity director(s), activity coordinator, and all planning committee members must complete a "Disclosure of Relevant Financial Relationships" form. The webform can be found online at https://cme.dmu.edu/disclosure.

Name, Credentials, Title	Phone	Email	COI
Ashley Parker *Provider Program Coordinator, NAMI Iowa*	515-771-0182	ashley@namiiowa.org	None

Target Audience

AOA Standards 2.1.8, 3.1.1, 3.1.2, 3.2; ACCME C3; CPME Standard 3.2

☒ Physicians
☒ Mid-level providers
☒ Nurses
☒ Ancillary Staff

☐ Residents
☐ Medical Students
☐ Non-Medical Students
☒ General Public

☒ Other: Licensed mental health counselors and social workers

Purpose and Mission

Describe the purpose and mission of this CME activity. Must be in harmony with the Des Moines University CME mission statement. *AOA Standard 2.2.2.1; CPME 1.1*

NAMI Provider aims to educate physicians, nurses, medical staff, mental health professionals, direct service workers and other allied professionals on the lived experiences of people living with mental illness navigating care and recovery.

This 4-hour seminar training utilizes evidence-based curriculum and storytelling from a teacher panel consisting of a mental health provider, a family member of someone living with a mental illness, and a person in recovery. The mental health provider is also either a family member of someone with a mental illness or and person in recovery as well.

With a severe shortage of psychiatrists and mental health providers in the state of Iowa, many primary care providers are tasked at providing mental health care in their communities without the enough training or experience working with the mentally ill population and their families. It is the goal of NAMI Iowa through the

NAMI Provider program to assist these providers in providing more competent, compassionate and person-centered care that integrates both the family and loved ones in the recovery and care process.

Educational Format

AOA Standard 2.1.7; ACCME C5; CPME Standard 3.2

☒	Case presentation	☐	Interactive response system
☐	Skills demonstration	☐	Simulated patient
☐	Lecture	☐	Laboratory session
☒	Panel discussion	☐	Mentoring/coaching
☐	Small group discussion	☒	Question and answer session
☒	Seminar	☐	Workshops
☐	Round table	☐	Other:

How was it determined that the format chosen was the best for delivery of activity?

Due to the COVID-19 pandemic, the NAMI Provider seminar is being taught virtually over Zoom. Due to the breadth of subject matter covered, the breakout workshop/seminar format allows for choice and interaction with all levels of attendees.

Identifying Professional Practice Gaps

The CME planning process begins with identifying professional practice gaps(s). The practice gap is the difference between what actually occurs and what the ideal or evidence-based practice should be. Describe below what practice gap(s) this CME activity will address. How do you know there is an educational need from the target audience? What clinical problems or opportunities for improvement will the activity address? What types of gaps in the target audience did you identify? (e.g., for clinical care: patient outcomes to improve, new methods of diagnosis or treatment to implement, better ways to deliver care) *ACCME C2, C3; AOA Standards 2.1.8, 2.2.3.3.1; CPME Standards 2.0, 3.0*

Silent epidemics often are insidious, eating away at society from within while the voices of victims go unheard and advocates are muted. Such is the case with mental illness. Because of the associated stigma, those afflicted rarely receive the required resources.

Their plight has been particularly precarious in Iowa, which ranks among the worst states in the nation for treatment — 47th in psychiatrists, 44th in mental health workforce availability and 51st (including the District of Columbia) in the ratio of state psychiatric beds to residents.

Yet serious mental illness is not an anomaly in Iowa. It afflicts 123,000.

According to the Cedar Valley Mental Health Planning Coalition, it is taking its toll in Black Hawk County:

- One in four — 29,000 adults — will experience a mental health issue.
- One in 17 — 18,000 adults — will develop a serious mental illness.
- One in five — 5,500 children — will experience a diagnosable mental health issue.
- One in 10 — 2,750 children — will have a serious emotional disturbance.

Due to the closure of state mental health hospitals and a shortage or mental health providers in Iowa, especially in rural health and child psychiatry, many individuals experiencing a mental health crisis seek help from the providers they have the most access to – primary care physicians and emergency departments. While these medical professionals are experts in their respective fields – family practice and emergency medical services – many of these providers have not received in-depth mental health training. After all, there is only so much that can be addressed in a short 10-15 minute appointment with a busy physician. As a result, many patients have reported receiving care that has lacked in understanding, breadth and compassion for the mental health crisis and struggles they are experiencing. These patients report that they have struggled to find the necessary services and care they seek, with many patients getting lost in the system.

The NAMI Provider professional development course aims to address these gaps in access and care by educating physicians and allied professionals of the real struggles of individuals and their families seeking mental health treatment utilizing an evidence-based curriculum centered around the recovery model of treatment and storytelling from a panel of NAMI-trained teachers. This teacher panel includes: a mental health provider (who is also a person in recovery from a mental illness or a family member of someone living with mental illness); a family member of someone living with a mental health condition; and a person in recovery from a mental illness. It is NAMI Iowa's hope that this training leads to better treatment outcomes and patient experiences so that all providers are equipped with working with working with this population to bridge the gaps in care, education and understanding.

Educational Need

Is the identified educational need of the target audience related to: (select all that apply) *ACCME C2, C3; CPME Standard 3.0, 3.1, 9.5*

☒ Knowledge (facts and information acquired by a person through experience or education)
☒ Competence (having the ability to apply knowledge, skills, or judgment in practice if called upon to do so)
☒ Performance (what the participant actually does in practice)
☒ Patient outcomes (actual outcomes in individual patients and/or patient populations)
☒ Community (change in population health status)

Barriers

What factors outside of the provider's control have been identified that would have an effect a change in patient outcomes. Include examples of identified factors outside of your organization's control that will have an impact on patient outcomes. *ACCME C18*

The barriers to mental healthcare access are significant issues facing many Americans. More than half of adults with mental illness in the U.S. do not receive mental healthcare treatment. That statistic alone is cause for concern. But mental health issues are far more common than most people realize. According to the U.S. Department of Health and Human Services, 1 in 5 American adults have experienced a mental health issue, and 1 in 25 Americans live with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression. Making sure that individuals have access to mental healthcare can improve lives and communities. For many, it can dramatically reduce or eliminate the risk of suicide, legal issues, family conflict, employment issues, substance abuse, and further mental and physical health problems. Barriers which prevent people from accessing mental healthcare services include:

- Financial barriers to mental health: Even after the Affordable Care Act required medical insurers to provide coverage for behavioral and mental healthcare, the cost of treatment often limits access to mental health services. For many individuals, a lack of financial resources prevents them from seeking help at all. For others, a lack of financial resources can lead to inconsistent or inadequate treatment. Even with insurance or financial assistance, mental healthcare services can be costly. Copays and deductibles add up quickly when a diagnosis requires regular therapy, complicated medication management, or intensive treatment programs.
- Mental Health Education and Awareness: Physical injuries and illnesses are typically obvious. They don't feel well, something hurts, or some clinical test shows an abnormality. Mental illnesses, however, are often hard to recognize. Often, symptoms are subtle and might be dismissed as "personality" or "attitude" issues. Clinical anxiety may be dismissed as "worrying too much," depression can often look like "laziness" or fatigue. Even serious conditions may not be obvious to the person suffering or those around them, if they don't share their inner thoughts and feelings. Other times, people assume that their emotional or mental status is normal, not realizing that they are suffering from disordered thinking or clinical symptoms. If a person doesn't know something is wrong, it's unlikely they will seek treatment.
- Social Stigma of Mental Health Conditions: Multiple studies have found that the stigma associated with mental illness often prevents people from accessing treatment. At one end of the spectrum, their own beliefs about mental illness can prevent them from acknowledging their illness or sticking with treatment. On the other end, the very real risk of facing discrimination in social and professional circles creates a huge barrier. People may fear that family and friends will avoid them or treat them negatively. They may also be concerned that the disclosure of a mental health condition can lead to negative treatment and perceptions at work.
- Racial/identity barriers to mental healthcare access: There are significant disparities in mental healthcare access among different minority groups. A recent study looked at how the Affordable Care Act has impacted mental healthcare access. The study found that white people are the only racial group in which a majority of people with severe psychological distress get treatment. More than half of people facing severe mental illness who are Black, Hispanic, or Asian don't get treatment. Jeanne Miranda, a professor of psychiatry and biobehavioral sciences at UCLA explains, "Minorities are often more likely to be poor, less likely to be treated by doctors of their same race and, in many cases, less likely to know they have a condition that requires professional care." Additionally, women, lesbian, gay, and transgender individuals can face additional stigma due to these intersecting identities/minority groups. Studies also suggest that doctors sometimes discriminate, declining to accept minority patients more often. At the same time, people are less likely to seek help if they think their doctor can't understand or empathize with their background or cultural differences and experiences.

What potential or real barriers are physicians faced with if this gap is to be addressed? Describe the educational strategies that have or are being implemented to remove, overcome or address these barriers to change? *ACCME C19*

NAMI: 9 Ways to Fight Mental Health Stigma

Lack of Mental Health Professionals: While the US is facing an overall shortage of doctors, the shortage of mental health professionals is steeper than any other category. According to the Health Resources and Services Administration, 89.3 million Americans live in federally designated Mental Health Professional Shortage Areas (in contrast, only 55.3 million Americans live in similarly designated primary-care shortage areas, and 44.6 million live in dental health shortage areas).

Policy Limitations: The World Health Organization cites a global lack of comprehensive mental health policies, which are crucial for implementing and coordinating mental health care services, as a key barrier to public access to mental health care. Nearly one-third of all countries, and almost half of all African nations, have no comprehensive mental health care policy or plan. Among countries with mental health care policies in place, approximately 40% have not been revised since 1990 and do not address recent developments in mental health care. Furthermore, 22% of countries do not have laws that offer legal protection of the human and civil rights of people with mental illnesses. In many low- and middle-income countries, the localization of mental health care resources in large cities has also been cited as a key barrier to providing mental health care to the entire population, and geographical decentralization has been recommended to improve accessibility to mental health care in non-urban communities.

Source: Ibid. Saraceno, B., van Ommeren, M, Batniji, R., Cohen, A., Gureje, O., Mahoney, J., Sridhar, D., Underhill, C. (2007). Barriers to improvement of mental health services in low-income and middle-income countries. Lancet, 370: 1164-74.

Collaboration with Stakeholders

If your organization is engaged in collaborative or cooperative relationships with other stakeholders, describe these relationships. *ACCME C20; CPME 1.6*

NAMI Iowa manages the Office of Consumer Affairs for Iowa DHS; NAMI Iowa is in partnership with Iowa Coalition Against Sexual Assault to develop mental health cross training for sexual assault survivor advocates and peer supporters through a grant from the US Department of Justice Office on Violence Against Women; NAMI Iowa is also a member of the University of Iowa Peer Support Training Collaborative; NAMI Iowa has partnered with Des Moines University to provide NAMI Provider training to all 3rd year medical students before they begin their internships in the field, and has worked with Des Moines University to adapt the NAMI Provider curriculum to cater advanced academic settings.

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Sources of Professional Practice Gaps

Check the procedures you will use to identify the CME needs of the intended target audience. AOA credit is requested, for a multi topic activity, each presentation must have an evidence based needs assessment source. *AOA Standards 2.1.2, 2.1.3, 2.2.3.1; ACCME C2, C21; CPME 2.1*

☐	OMT/OPP as part of the profession. No additional documentation necessary.
☒	Core competencies that are non-clinical (professionals, communications, system-based practice, etc.)
☐	Faculty development programs. No additional documentation necessary.
☐	Evaluation results from previous CME activities. Attach past evaluation summary with relevant suggestions highlighted.
☐	Request of medical staff or administration. Attach documentation or emails with relevant suggestions highlighted.
☐	Expert opinion from university or physician leaders. Attach meeting notes or survey results with relevant suggestions highlighted.
☐	Questionnaire (Learner Perceived Needs). Attach questionnaire summary with relevant suggestions highlighted.
☒	Literature reviews. Site the source or include a copy of the article. • Ibid. Saraceno, B., van Ommeren, M, Batniji, R., Cohen, A., Gureje, O., Mahoney, J., Sridhar, D., Underhill, C. (2007). Barriers to improvement of mental health services in low-income and middle-income countries. Lancet, 370: 1164-74.
☒	Public health priorities. • Responding to the need to provide professional development training through distance education during the COVID-19 pandemic. • Addressing the shortage of mental health providers across the state in a time when new depression and anxiety diagnoses are on the rise due to the effects of social isolation caused by COVID-19.
☐	New medical technology. Describe:
☐	Tests that determine learner competence (e.g., pre- and post- test results, self-assessment activities). Attached a copy of the test with relevant sections highlighted.
☐	Quality data or quality improvement initiative from organization. Attach reports or documentation with relevant sections highlighted.
☐	Data from local, statewide, regional, or national resources. Attach relevant reports or documentation. • Get national statistics from the NAMI national website. • Visit a fact sheet library for an extensive collection of graphs, statistics and easy to digest information on mental illness.
☐	Data from outside sources such as the National Institutes of Health or Public Health Service. Attach relevant reports or documentation.
☐	Results of evidence-based medicine studies. Attach studies.
☐	Legal or regulatory requirements (OSHA, JCAHO, etc.). Attach reports or documentation with relevant sections highlighted.
☐	Licensure or State mandate (ex: risk management). Attach reports or documentation with relevant sections highlighted.
☐	Change in national standard of practice. Attach reports or documentation with relevant sections highlighted.

☐	Board preparation courses based on pass rate/board scores. No additional documentation necessary.
☐	Quality resource website databases (e.g., ahrq.gov, guideline.gov)
☐	Other:

Learner Core Competencies

All activities must be developed in the context of desirable learner attributes as those designated by the Institution of Medicine (IOM) and American Board of Medical Specialties (ABMS), Accreditation Council of Continuing Graduate Medical Education (ACGME), and American Osteopathic Association (AOA) competencies.

Please check the appropriate attributes that apply to the development of and desired results for this educational activity or series. *AOA; ACCME C6*

☐	Osteopathic Philosophy/ Osteopathic Manipulative Medicine		Demonstrate and apply knowledge of accepted standards in osteopathic manipulative treatment appropriate to the specialty. Remain dedicated to life-long learning and to practice habits in osteopathic philosophy and OMM. (AOA)
☐	Medical Knowledge		Demonstrate and apply knowledge of accepted standards of clinical medicine in the respective area; remain current with new developments in medicine and participate in life-long learning activities. (AOA) Demonstrate 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. (ABMS, ACGME)
☒	Patient Care		Demonstrate the ability to effectively treat patients and provide medical care that incorporates the osteopathic philosophy, patient empathy, awareness of behavioral issues, the incorporation of preventive medicine and health promotion. (AOA) Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. (ABMS, ACGME)
☒	Provide Patient-Centered Care	☒	Identify, respect, and care about patients' differences, values, preferences, and expressed needs. (IOM)
		☒	Listen to, clearly inform, communicate with, and educate patients. (IOM)
		☒	Share decision making and management. (IOM)
		☒	Continuously advocate disease prevention, wellness, and promotion of healthy lifestyles, including a focus on population health. (IOM)
☒	Work in Interdisciplinary Teams		Cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable. (IOM)

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☐	Professionalism	☐	Uphold the Osteopathic Oath in the conduct of one's professional activities that promotes advocacy of patient welfare, adherence to ethical principles, and collaboration with health professionals, life-long learning, and sensitivity to a diverse patient population. (AOA)
		☐	Be cognizant of physical and mental health in order to effectively care for patients. (AOA)
		☐	Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. (ABMS, ACGME)
☐	Practice-Based Learning and Improvement	☐	Demonstrate the ability to critically evaluate methods of clinical practice. (AOA)
		☐	Integrate evidence-based medicine into patient care. (AOA)
		☐	Show an understanding of research methods. (AOA)
		☐	Improve patient care practices. (AOA, ABMS, ACGME)
		☐	Investigate and evaluate their patient care practices. (ABMS, ACGME)
		☐	Appraise and assimilate scientific evidence. (ABMS, ACGME)
☐	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. (IOM)	
☐	Apply Quality Improvement	☐	Identify errors and hazards in care. (IOM)
		☐	Understand and implement basic safety design principles, such as standardization and simplification. (IOM)
		☐	Continually understand and measure quality of care in terms of structure, process, and outcomes in relation to patient and community needs. (IOM)
		☐	Design and test interventions to change processes and systems of care, with the objective of improving quality. (IOM)
☒	Systems-Based Practice	☐	Demonstrate an understanding of health care delivery systems. (AOA)
		☐	Provide effective and qualitative patient care with the system. (AOA)
		☐	Practice cost effective medicine. (AOA)
		☐	Demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. (ABMS, ACGME)
☐	Interpersonal and Communication Skills	Demonstrate interpersonal and communication skills that enable a physician to establish and maintain professional relationships with patients, families, and other members of health care teams. (AOA)	

		Demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, patients' families, and professional associates. (ABMS, ACGME)
☒	Utilize Informatics	Communicate, manage knowledge, mitigate error, and support decision making using information technology. (IOM)

Learning Objectives

Define specific goals/objectives for the CME activity. What changes in knowledge, attitudes, or skills are expected as a result of this activity? What changes in patient care are expected? What will attendees know, or be able to do, as a result of participating in the activity*? AOA Standards 2.1.5, 2.2.3.2, 2.2.3.3.1; ACCME C7, SCS 1.1; CPME 3.0, 4.1, 7.1, 9.2*

Upon completion of this activity, participants will be able to:

1. Introduce health care staff to the emotional stages people affected by mental illness experience on the way to recovery.
2. Help staff gain a fresh understanding of and empathy for their patients'/clients' lived experience, especially during treatment.
3. Promote collaboration between clients, families, and providers to achieve the best level of recovery possible.

Activity Schedule

The accredited provider shall use the objectives developed for an educational activity to select the content, speakers, learning methods for the activity. If needed, attach separate documentation. *AOA Standard 2.2.3.3.1; CPME 7.1I*

Agenda times will vary.

NAMI Provider Seminar	CE Credit
Welcome and Introductions • Description of NAMI • Introduction of teaching team • Goals for the seminar • Polling and discussion: utilizing digital polls, evaluate and discuss attitudes around mental health and recovery prior to taking this training	**0.0**
Protective Agreements	**0.25**

Discuss protective or "community" agreements which is a shared agreement between participants about how we want to work together over the course of our time together. This can include guidelines for what it means to be respectful, expectations about turn-taking, or accessibility needs (camera on/off, bathroom breaks, eating in class, etc.), confidentiality and self-disclosure.	
Key Components of NAMI's Approach • No-fault approach • Bio-psycho-social dimensions of mental illness • Mental health conditions as traumatic experiences • Collaborative model of care	**0.50**
Impact of Mental Illness: Predictable Stages of Emotional Reactions • Family stages • Individual stages	**0.50**
Break	**0.0**
Secondary Prevention/Intervention • Misinterpretations of natural reactions to trauma • Secondary traumas for families • Secondary traumas for individuals	**0.50**
Empathy	**0.50**
Case Study Using the Collaborative Model of Care	**0.75**
Question and Answer Session	**0.25**
Adjourn	**0.0**
Total	**3.25**

Speaker Information

List speaker with pertinent credentials. Speakers who refuse to sign the financial conflict of interest form may not participate in the CME activity. For a multi topic activity, each presentation must have an evidence-based needs assessment source. A biographic sketch and/or CV is required for all speakers. If needed, attach separate documentation. *AOA Standards 2.2.4.2, 3.3, 3.5, ACCME C7, SCS 2.1-2.3, SCS 3.7, SCS 6.1-6.5, C8, SCS 3.7-3.10, SCS 4.2-4.5, C10, 5.1, 5.2; CPME Standard 5.0, 7.1*

All speakers, moderators, and panel members must complete a "Disclosure of Relevant Financial Relationships" form. The webform can be found online at https://cme.dmu.edu/disclosure.

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Name, Credentials, Title	Phone	Email	COI
Ashley Parker, BSW *Provider Program Coordinator, NAMI Iowa* (Moderator and Zoom technical assistance)	515-771-0182	ashley@namiiowa.org	None

☒ Not applicable. Activity is an RSS or journal club and is subject to change. Objectives will be submitted to the CME Department prior to the activity.

Level of Outcomes

Please indicate the level of outcomes this educational activity will address. Select one.

☐ Level 1 outcomes, or the "smile sheet," rate the CME activity's quality, usefulness, objectives, presentation, and/or speakers.
☐ Level 2 measures a change in participants' knowledge, skills, or attitude – an intention to change.
☒ Level 3 is a self-reported change in health professionals' behavior or practice.
☐ Level 4 is an objectively measured change in clinician behavior or practice.
☐ Level 5 is an objectively measured change in patient health status.

Evaluation

Describe how you will determine if your CME activity is effective in meeting the needs for which the activity was designed. The approved CME evaluation should be used along with other effective tools. *AOA Standards 2.1.6, 2.1.7, 2.1.9, 2.1.10, 2.1.11, 3.14; ACCME C11, C13, C22; CPME Standard 4.1*

☒ Post-activity evaluation*
☐ Use of audience polling device
☐ Pre-test
☐ Post-test
☐ 90-day follow-up assessment
☐ Verbal interview of participants summarized in writing
☐ Patient outcomes data
☒ Questionnaire
☐ Planning group review
☐ Other:

* DMU CME will provide a list of required CME evaluation questions.

Describe anticipated ways to evaluate short and long-term learning value of your activity.

Short-term: To assess the short-term learning value of this activity, an evaluation will be distributed to the learners on-site. The feedback provided is used to determine the effectiveness of the content presented and help plan for future activities. It will properly assess the learning and adaptation of the activity. Attendance and attendee satisfaction, per the evaluation, will assist the level of interest and understanding.

Long-term: NAMI Iowa will collect and store data from these evaluations and quarterly review the efficacy of our programming based on participant's feedback. Utilizing participants feedback, we will make appropriate adjustments to the course to better impact program outcomes and participant satisfaction.

Commercial Support

AOA Standards 2.2.3.3.2, 2.2.3.3.3.1-5, 2.2.4.1, ACCME C8, SCS 3.1-3.7, 3.11-3.13, C9, SCS 4.1, 4.2; CPME Standard 6.0

Independence of Activity Planning: When planning a CME activity, the activity director and members of the planning committee confirm that the following decisions will be made free of the control of commercial interests:

1. Identification of needs
2. Determination of education objectives
3. Selection and presentation of content
4. Selection of all personnel and organization that will be in a position to control the content
5. Selection of education methodology
6. Evaluation of the activity

☒ Check this box to indicate you have read, understand and comply with the independence of activity planning standards.

☐ This activity will not be requesting commercial support.

☒ This activity will be requesting commercial support (complete table below).

Company Name	Representative Name	Phone, Email	Requested Amount	Type
				☐ Grant ☐ Exhibit ☐ In Kind
				☐ Grant ☐ Exhibit ☐ In Kind

Content Validation

Applies to all those in control of content, including activity director, planning committee members and speakers. Des Moines University expects that all CME activities will adhere to the content validation statement.

1. 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.

2. 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 collections and analysis.
3. The content or format of CME activities and related materials will promote improvements or quality healthcare and not a specific proprietary business or commercial interest.
4. CME must give a balanced view of therapeutic options. Use of generic names will contribute to this impartiality.
5. If your CME educational materials include trade names, names from several companies should be used where available, not just trade names from a single company.
6. Feedback from learners will be collected to determine the effectiveness of this CME activity through questionnaires or other evaluation mechanisms.
7. Educational materials that are part of this activity, such as slides, abstracts, and handouts, cannot contain any advertising, trade names, or product-group messages.

☒ Check this box to indicate that you have read, understand, and will comply with the content validation statement.