

## GAP ANALYSIS WORKSHEET

**Instructions:** Type directly into blank cells of the tables. Save the completed form to your computer.

EDUCATIONAL ACTIVITY TITLE: \_\_\_\_\_

### PROFESSIONAL PRACTICE GAP(S)

CURRENT STATE	DESIRED STATE	IDENTIFIED GAP	TYPE OF GAP	LEARNING OUTCOME(S)
Describe the current state of practice including the problem, if known.	Describe the desired state that the educational activity is designed to promote.	Difference between current state and desired state.	Check which type of gap has been identified.	List learning outcome(s) in behavioral term using a single measurable verb for each. Learning outcomes should fit into one of Miller's zones <sup>1</sup> :
<i>EXAMPLE: Nurses in Intensive Care Units are unfamiliar with new protocol for hypothermia</i>	<i>ICU nurses can effectively manage patients with ordered hypothermia protocol</i>	<i>Education needed regarding how to implement and manage hypothermia protocol</i>	<input checked="" type="checkbox"/> Knowledge <input type="checkbox"/> Skills <input type="checkbox"/> Practice	<i>1. Learners will self-report an increase in knowledge about the goals and process of the hypothermia protocol.            2. Learners will self-report an increase in confidence when managing a patient with ordered hypothermia protocol.</i>
			<input type="checkbox"/> Knowledge <input type="checkbox"/> Skills <input type="checkbox"/> Practice	

<sup>1</sup> Examples of learning outcomes for each zone: **Knows** (knowledge gained) – Learners will self-report an increase in knowledge about XYZ **Knows how** (knows how to apply the knowledge) – Learners will describe how they will integrate XYZ into their practice **Shows** (demonstrates how to apply knowledge) – Learners will demonstrate the correct procedure for XYZ during the learning activity **Does** (applies knowledge in practice) – Learners will integrate knowledge into practice as validated by an decrease in the incidence of XYZ measure.

# Approved Provider Nurse Planner Biographical Data Form

Approved Provider: \_\_\_\_\_

Date completed: \_\_\_\_\_

Individual's role(s) in the Approved Provider Unit: *(Check all that apply)*

- Primary Nurse Planner     Nurse Planner     Content Expert

**Directions:** Type information directly into the space provided or type an 'X' in the appropriate box to indicate your response. Save the completed form to your computer. Do **not** attach any additional materials (no CV or resume). **Note:** Nurse Planners may complete one *Biographical Data Form* for the year, then a separate COI form for each activity they plan.

## Section 1: Demographic Data

Name and credentials: \_\_\_\_\_

If RN, Nursing Degree(s):  AD    Diploma    BSN    Masters    Doctorate

Present Position: \_\_\_\_\_  
*(job title, employer, city, state)*

Mailing Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Licensure as a Registered Nurse: *(must be current)*

RN license number: \_\_\_\_\_ State: \_\_\_\_\_ Expiration mm/yy: \_\_\_\_\_

## Section 2: Orientation & Expertise

A. Indicate the ways(s) you were oriented to the current ANCC/MW MSD accreditation standards and criteria for planning, implementing and evaluating continuing nursing education (CNE) activities, as well as the policies, procedures and forms specific to your Approved Provider Unit:

\_\_\_\_\_

B. Briefly describe your education/experience in **planning** educational programs, including any experience with the Nurse Planner role:

\_\_\_\_\_

**NOTE:** Please summarize information from the curriculum vitae (CV) in lieu of attaching the entire document. If description does not provide adequate information, additional documentation may be requested.

## Section 3: Statement of Understanding

An "X" in the box below serves as the electronic signature of the individual completing this Biographical Data form and attests to the accuracy of the information given above.

**Name and Credentials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Approved Provider Nurse Planner Conflict of Interest Form

**DIRECTIONS:** Type information directly into the space provided or type an 'X' in the appropriate box to indicate your response. Save the completed form to your computer.

## Section 1: Demographic Data

Name and **credentials:** \_\_\_\_\_  
Present Position: \_\_\_\_\_  
(job title, employer, city, state)  
Mailing Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**NOTE:** The Midwest MSD reserves the right to ask for information on how the presenter's qualifications were validated.

## Section 2: Educational Activity

Educational Activity Title: \_\_\_\_\_  
Individual Session Title (if different): \_\_\_\_\_  
Education Activity Date(s): \_\_\_\_\_  
Individual's role(s) in this Educational Activity: (Check all that apply)  
 Nurse Planner       Presenter/Faculty/Author       Content Expert

## Section 3: Actual, Potential & Perceived Conflict of Interest

The potential for **Conflict of Interest (COI)** exists when an individual has the ability to control or influence the content of an educational activity **and** has a financial relationship with a commercial interest, the products or services of which are pertinent to the content of the educational activity. Actions must be taken to resolve any potential or actual COI for planners, presenters/faculty/authors or content reviewers prior to the start of the educational activity.

Each individual who is in a position to control or influence the content of an education activity must disclose all **relevant relationships** with any **commercial interest**, including but not limited to members of the planning committee, speakers, presenters, faculty, authors, and/or content reviewers.

**Relevant Relationships**, as defined by ANCC, are relationships that are expected to result in financial benefit from a commercial interest organization, the products or services of which are related to the content of the educational activity.

Relationships with any commercial interest of the individual's spouse/partner may be relevant relationships and must be reported, evaluated and resolved. Evidence of a relevant relationship with a commercial interest may include but is not limited to receiving a salary, royalty, intellectual property rights, consulting fee, honoraria, ownership interest (stock and stock options), grants, contracts, or other financial benefit directly or indirectly from the commercial interest. Financial benefits may be associated with **employment, management positions, stockholder, independent contractor relationships (including contracted research), other contractual relationships, consulting, speaking, teaching, membership on an advisory committee or review panel, board membership**, and other activities from which remuneration is received or expected. Relevant relationships can also include 'contracted research' where the institution receives a grant and manages the grant funds and the individual is the principal or a named investigator on the grant.

**Commercial Interest**, as defined by ANCC, is any entity producing, marketing, re-selling, or distributing healthcare goods or services consumed by or used on patients, or an entity that is owned or controlled by an entity that produces, markets, re-sells or distributes healthcare goods or services consumed by, or used on, patients. Nonprofit or government organizations, non-healthcare-related companies, healthcare facilities, and group medical practices are **not** considered commercial interests.

Individuals found to have a COI are not eligible to serve as a/the Nurse Planner, but may be able to serve on the planning committee or as a presenter/author if measures are taken to resolve the COI. Employees or representatives of a commercial interest **may not** serve as a Planner of an educational activity, although they may be eligible to serve as faculty if measures are taken to resolve any potential conflict of interest.

1. Over the past 12 months, have you or your spouse/partner had a financial relationship with a commercial interest whose products or services may be relevant to the educational content that you will plan/present for this activity?

NO     YES – Provide details of relationship(s) below:

Check all that apply	CATEGORY	DESCRIPTION – Provide Names of Organizations & Relationship
<input type="checkbox"/>	Employee	<i>e.g. salesperson, marketing, or education</i>
<input type="checkbox"/>	Royalty	
<input type="checkbox"/>	Stockholder	
<input type="checkbox"/>	Research Support	
<input type="checkbox"/>	Speakers Bureau	
<input type="checkbox"/>	Consultant	
<input type="checkbox"/>	Other	

#### Section 4: Statement of Understanding

I have taken every precaution to ensure that the presentation identified above will be evidence-based or based on the best available evidence and free from bias and promotion. Completion of the name and date below serves as the electronic signature of the individual completing this Conflict of Interest Form and attests to the accuracy of the information given above.

Name and Credentials: \_\_\_\_\_ Date: \_\_\_\_\_

#### Section 5: Planning Committee Member Review

The Primary Nurse Planner or member of the planning committee is responsible for ensuring completion and review of the Nurse Planner Conflict of Interest form, to document evaluation of actual or potential bias and conflict of interest.

**TO BE COMPLETED BY THE PRIMARY NURSE PLANNER OR MEMBER OF THE PLANNING COMMITTEE:**

This form must be reviewed by the Primary Nurse Planner or member of the Planning Committee for this educational activity ***other than the RN completing it*** to verify the RN meets the following requirements to serve as a Nurse Planner:

1. Is currently licensed as a Registered Nurse
2. Holds a baccalaureate or graduate degree in nursing
3. Is not employed by and does not represent any commercial interest organization
4. Has no COI (relevant relationship with a commercial interest as defined above)
5. Is willing to work to ensure the content integrity of this educational activity

**Resolution of potential Conflicts of Interest – check all that apply:**

- Not Applicable - No relationship(s) with a commercial interest were disclosed
- Not Applicable - Relationship(s) disclosed were found not to be 'relevant relationship(s)' (*explain in NOTES below*)

**Relevant relationship(s) with a commercial interest were identified (COI exists):**

**RN not eligible to serve as the Nurse Planner**

NOTES:

**Additional concern(s) for potential for bias that were not self-reported on this form AND resolution – if applicable:**

**Electronic Signature:** An 'X' in the box below serves as the electronic signature of the Primary Nurse Planner or Planning Committee member reviewing the content of this form and attests to the accuracy of the information given above.

Name and Credentials: \_\_\_\_\_ Date: \_\_\_\_\_



# Planner/Faculty Conflict of Interest Form

**DIRECTIONS:** Type information directly into the space provided or type an 'X' in the appropriate box to indicate your response. Save the completed form to your computer.

## Section 1: Demographic Data

Name and **credentials:** \_\_\_\_\_  
Present Position: \_\_\_\_\_  
(job title, employer, city, state)  
Mailing Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**NOTE:** The Midwest MSD reserves the right to ask for information on how the presenter's qualifications were validated.

## Section 2: Educational Activity

Educational Activity Title: \_\_\_\_\_  
Individual Session Title (if different): \_\_\_\_\_  
Education Activity Date(s): \_\_\_\_\_  
Individual's role(s) in this Educational Activity: (Check all that apply)  
 Planning Committee  Presenter/Faculty/Author  Content Expert  Content Reviewer *if applicable*

## Section 3: Actual, Potential & Perceived Conflict of Interest

The potential for **Conflict of Interest (COI)** exists when an individual has the ability to control or influence the content of an educational activity **and** has a financial relationship with a commercial interest, the products or services of which are pertinent to the content of the educational activity. Actions must be taken to resolve any potential or actual COI for planners, presenters/faculty/authors or content reviewers prior to the start of the educational activity.

Each individual who is in a position to control or influence the content of an education activity must disclose all **relevant relationships** with any **commercial interest**, including but not limited to members of the planning committee, speakers, presenters, faculty, authors, and/or content reviewers.

**Relevant Relationships**, as defined by ANCC, are relationships that are expected to result in financial benefit from a commercial interest organization, the products or services of which are related to the content of the educational activity.

Relationships with any commercial interest of the individual's spouse/partner may be relevant relationships and must be reported, evaluated and resolved. Evidence of a relevant relationship with a commercial interest may include but is not limited to receiving a salary, royalty, intellectual property rights, consulting fee, honoraria, ownership interest (stock and stock options), grants, contracts, or other financial benefit directly or indirectly from the commercial interest. Financial benefits may be associated with **employment, management positions, stockholder, independent contractor relationships (including contracted research), other contractual relationships, consulting, speaking, teaching, membership on an advisory committee or review panel, board membership**, and other activities from which remuneration is received or expected. Relevant relationships can also include 'contracted research' where the institution receives a grant and manages the grant funds and the individual is the principal or a named investigator on the grant.

**Commercial Interest**, as defined by ANCC, is any entity producing, marketing, re-selling, or distributing healthcare goods or services consumed by or used on patients, or an entity that is owned or controlled by an entity that produces, markets, re-sells or distributes healthcare goods or services consumed by, or used on, patients. Nonprofit or government organizations, non-healthcare-related companies, healthcare facilities, and group medical practices are **not** considered commercial interests.

Individuals found to have a COI are not eligible to serve as a/the Nurse Planner, but may be able to serve on the planning committee or as a presenter/author if measures are taken to resolve the COI. Employees or representatives of a commercial interest **may not** serve as a Planner of an educational activity, although they may be eligible to serve as faculty if measures are taken to resolve any potential conflict of interest.

1. Over the past 12 months, have you or your spouse/partner had a financial relationship with a commercial interest whose products or services may be relevant to the educational content that you will plan/present for this activity?

NO     YES – Provide details of relationship(s) below:

Check all that apply	CATEGORY	DESCRIPTION – Provide Names of Organizations & Relationship
<input type="checkbox"/>	Employee	<i>e.g. salesperson, marketing, or education</i>
<input type="checkbox"/>	Royalty	
<input type="checkbox"/>	Stockholder	
<input type="checkbox"/>	Research Support	
<input type="checkbox"/>	Speakers Bureau	
<input type="checkbox"/>	Consultant	
<input type="checkbox"/>	Other	

#### Section 4: Statement of Understanding

I have taken every precaution to ensure that the presentation identified above will be evidence-based or based on the best available evidence and free from bias and promotion. Completion of the name and date below serves as the electronic signature of the individual completing this Conflict of Interest Form and attests to the accuracy of the information given above.

**Name and Credentials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

#### Section 5: Nurse Planner Review

The Nurse Planner is responsible for ensuring completion and review of Conflict of Interest forms completed by each planner, presenter/faculty/author, and content reviewer, to document evaluation of actual or potential bias and conflict of interest.

<b>TO BE COMPLETED BY THE NURSE PLANNER:</b>	
<b>Resolution of potential Conflicts of Interest – check all that apply:</b>	
<input type="checkbox"/>	Not Applicable - No relationship(s) with a commercial interest were disclosed
<input type="checkbox"/>	Not Applicable - Relationship(s) disclosed were found not to be 'relevant relationship(s)' ( <i>explain in NOTES below</i> )
<b>Relevant relationship(s) with a commercial interest were identified (COI exists) – ACTIONS TO RESOLVE COI:</b>	
<input type="checkbox"/>	Removed individual from participating in all parts of this educational activity
<input type="checkbox"/>	Revised individual's role in activity so the financial relationship was no longer relevant
<input type="checkbox"/>	Not awarding contact hours for a portion or all of the educational activity
<input type="checkbox"/>	Review of educational activity for evidence of integrity/absence of bias by (name) _____ <b>AND:</b>
<input type="checkbox"/>	Presentation will be monitored to evaluate for commercial bias ( <i>document outcome in NOTES</i> )
<input type="checkbox"/>	Participant feedback will be reviewed to evaluate for commercial bias in the activity ( <i>document results in NOTES</i> )
<input type="checkbox"/>	Other procedure: _____
NOTES:	
<b>Additional concern(s) for potential for bias that were not self-reported on this form <u>AND</u> resolution – if applicable:</b>	
<b>Electronic Signature:</b> An 'X' in the box below serves as the electronic signature of the Nurse Planner reviewing the content of this form and attests to the accuracy of the information given above.	
<input style="width: 100%; height: 20px;" type="text"/>	<b>Name and Credentials:</b> _____ <b>Date:</b> _____

# MIDWEST MULTISTATE DIVISION EDUCATIONAL PLANNING FORM

**Instructions:** For educational activities with multiple sessions, please complete a planning form for each individual session for which contact hours will be awarded. Type directly into blank cells of the tables. Save the completed form to your computer.

**EDUCATIONAL ACTIVITY TITLE:** \_\_\_\_\_

**INDIVIDUAL SESSION TITLE: (IF DIFFERENT THAN ACTIVITY TITLE)** \_\_\_\_\_

LEARNING OUTCOME(S)			
List learning outcome(s) in behavioral terms using a single measurable verb for each. Outcomes are evaluated to determine the impact of educational activities on patient care and professional development of the learner. Learning outcomes should fit into one of Miller's zones <sup>1</sup> :			
CONTENT	TIME FRAME	PRESENTER/FACULTY /AUTHOR	LEARNER ENGAGEMENT STRATEGIES
Provide an outline of the content to be presented, related to each learning outcome, in sufficient detail to determine consistency with learning outcomes, selected learner engagement strategies and appropriate time allotted. <i>(Restatement of learning outcomes does not meet the criteria)</i>	List the number of minutes <sup>2</sup> for each topic/ content area and/ or active learner engagement strategies <sup>3</sup> .	List the presenter, faculty person or author for each content area.	List the engagement strategies used by each presenter for each content area. <sup>4</sup>
			<input type="checkbox"/> Question/Answer <input type="checkbox"/> Self-check or self-assessment <input type="checkbox"/> Audience response system <input type="checkbox"/> Return skill demonstration* <input type="checkbox"/> Role play* <input type="checkbox"/> Small group discussion* <input type="checkbox"/> Assignments/testing/practice* <input type="checkbox"/> Engaging learners in dialogue <input type="checkbox"/> Analyzing case studies*
			<input type="checkbox"/> Question/Answer <input type="checkbox"/> Self-check or self-assessment <input type="checkbox"/> Audience response system <input type="checkbox"/> Return skill demonstration* <input type="checkbox"/> Role play* <input type="checkbox"/> Small group discussion* <input type="checkbox"/> Assignments/testing/practice* <input type="checkbox"/> Engaging learners in dialogue <input type="checkbox"/> Analyzing case studies*

<sup>1</sup> Examples of learning outcomes for each zone: **Knows** (*knowledge gained*) – Learners will self-report an increase in knowledge about XYZ **Knows how** (*knows how to apply the knowledge*) – Learners will describe how they will integrate XYZ into their practice **Shows** (*demonstrates how to apply knowledge*) – Learners will demonstrate the correct procedure for XYZ during the learning activity **Does** (*applies knowledge in practice*) – Learners will integrate knowledge into practice as validated by an decrease in the incidence of XYZ measure. **NOTE** that evaluation questions should reflect the learning outcomes.

<sup>2</sup> Total number of minutes should match the total number of hours used to calculate the contact hours awarded.



<sup>3</sup> Time spent on learner feedback and/or evaluation is acceptable to include in calculation of contact hours.

<sup>4</sup> Engagement strategies marked with an asterisk (\*) are active strategies that require time to complete. These strategies should be detailed in the Content column outline and the time frames for each indicated in the time frame column.

**Total minutes for this activity/session (including time spent on evaluation) = \_\_\_\_\_**

**List full citations for the evidence-based reference(s) used to develop the content of this educational activity/session next to the appropriate category:**

<b>Information from organization/website:</b> (current available evidence within past 5-7 years; may be published or unpublished content. Examples –Agency for Healthcare Research and Quality, Centers for Disease Control, National Institutes of Health). Provide full web page citations for material referenced, not “CDC.org”.	
<b>Peer –reviewed journal/resource:</b> (reference should be within past 5-7 years)	
<b>Clinical guidelines:</b> (published or online. Example -www.guidelines.gov)	
<b>Expert resource:</b> (individual, organization, or educational institution - book, article, website)	
<b>Textbook reference:</b>	
<b>Other:</b>	

# APPROVED PROVIDER CNE ACTIVITY PLANNING GUIDE

Criterion 1-10, with corresponding requirements below, refers to procedures relative to the planning and implementation of specific activities. Approved Providers must demonstrate adherence to the following criteria requested in narrative and/or checklist format. **All criteria listed below must be documented for each activity provided within the Approved Provider Unit.** This Approved Provider CNE Activity Planning Guide (or an equivalent form/narrative that includes all elements below) is required to be completed for each educational activity to meet the recordkeeping requirements for each activity provided.

<b>Approved Provider Unit:</b>	
<b>Provider Approval #:</b>	<b>Activity #:</b> <i>(if applicable)</i>
<b>Activity Title:</b>	
<b>Individual Session Title (if different):</b>	
<b>Activity Date(s):</b>	
<b>Location(s) of Activity:</b>	
<b>Contact Hours:</b>	
<b>Other credits issued:</b>	<input type="checkbox"/> CME <input type="checkbox"/> Pharmacy <input type="checkbox"/> Social Work <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> RT <input type="checkbox"/> Mental Health <input type="checkbox"/> Other: _____
<b>Activity Type:</b> <i>(please select one)</i>	<input type="checkbox"/> Live <input type="checkbox"/> Enduring <input type="checkbox"/> Blended
<b>If enduring or blended activity, date content was/or needs to be reviewed:</b>	mm/dd/yy
<b>Activity Format:</b>	
<input type="checkbox"/> Conference/Symposium <input type="checkbox"/> Podcast <input type="checkbox"/> CD/DVD <input type="checkbox"/> Journal/Article <input type="checkbox"/> Webinar/Webcast <input type="checkbox"/> Satellite Symposium <input type="checkbox"/> Audioconference <input type="checkbox"/> Case Study <input type="checkbox"/> Meeting Series/Journal Club <input type="checkbox"/> Computer based <input type="checkbox"/> Other: _____	
<b>Will this activity be repeated?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>Nurse Planner:</b>	
<b>If System Provider, identify organization within the system providing the activity:</b> _____	
<b>This planning document was completed by:</b> <u>Name, Credentials on Date</u>	

## EDUCATIONAL DESIGN CRITERIA

### 1. Jointly Provided Activities

**Jointly provided?**    Yes    No

**If yes, provide Organization(s) Name(s):** \_\_\_\_\_  
 \_\_\_\_\_

**If yes, joint-provider agreement attached**    Yes

*The joint provider agreement must be signed by representatives legally authorized to enter into contracts on behalf of each organization involved in the activity and must identify the responsibilities of each organization.*

**If yes, the provider and joint provider organization names prominently displayed on the promotional**

materials  Yes

If yes, joint-provider organization names disclosed to learners  Yes

## 2. Effective Design Principles

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Continuing education activities are developed in response to, and with consideration for, the unique educational needs of the target audience. At a minimum for CNE the target audience must include Registered Nurses. The educational design process incorporates identified gap(s), measurable outcomes, best available evidence, and appropriate learner engagement strategies.

**Professional Practice Gap(s)** – *Identify the gap(s) (difference between current state and desired state) in knowledge, skills or practice revealed by the needs assessment, which the activity addressed (e.g. change in practice, problem in practice, opportunity for improvement).*

**Completed Gap Analysis Worksheet Attached** – *Use of the Gap Analysis Worksheet is required*

**Evidence to Validate Professional Practice Gap(s)** – *Check all that apply*

- Written needs assessment or survey of stakeholders, target audience members, subject matter experts
- Individual input from stakeholders such as learners, managers, or subject matter experts
- Requested by nursing management, based on internal quality measures or identified need
- Quality studies/performance improvement activities
- Evaluation data from previous educational activities
- Trends in literature, law and/or healthcare
- Trends in practice, treatment modalities, and/or technology
- Other – (Describe): \_\_\_\_\_

**Sources of Supporting Evidence** – *Check all that apply*

- Annual needs assessment or survey
- Literature review
- Requests (phone, in-person, email)
- Activity evaluation summary requests
- Surveys from stakeholders or learners
- Outcome/Quality data (i.e. Regulatory)
- Research findings
- Content expert
- Other – (Describe): \_\_\_\_\_

**Supporting Evidence is Located:**  On file  Attached  Other – (Describe): \_\_\_\_\_

**Brief Summary of Data Supporting the Need for the Activity:**

\_\_\_\_\_

**Target Audience** – *Check all that apply*

- Registered Nurses – RNs
- Advanced Practice Registered Nurses – APRNs
- Registered Nurses in a Specialty Area – (Identify specialty): \_\_\_\_\_
- Inter-professional e.g., Physicians, Pharmacists, Social Workers – (Describe): \_\_\_\_\_
- Other – (Describe): \_\_\_\_\_

**Desired Learning Outcome(s)** – Outcomes are evaluated to determine the impact of educational activities on patient care and professional development of the learner.

**Learning Outcome(s) listed on Educational Planning Form:**  Yes

**Educational Planning Form(s)** – learner outcomes, related content outline and learner engagement strategies for each session/presentation during this educational activity. Note: Use of the Educational Planning Form is required

**Completed Form(s) Attached**

**Learner Engagement Strategies** – Strategies utilized during the educational activity to engage learners

**Learner Engagement Strategies listed on Educational Planning Form:**  Yes

### 3. Qualified Planners

Planning for each educational activity must include one Nurse Planner and one other planner. One of the planners must have appropriate subject matter expertise for the educational activity (*this individual is identified as the content expert*). List the names and credentials of the Nurse Planner and all other persons involved in planning the educational activity. ***Please note: Only one individual may serve as the Nurse Planner. Other nurses involved in the planning should be listed as Planning Committee Members below.***

Nurse Planner Name and Credentials	Disclosure/COI Form Attached?	Was COI found?	Bio form
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Attached <input type="checkbox"/> On file

Is the Nurse Planner also the Content Expert?  Yes  No

If no, please provide the name of the individual who served on the committee as the Content Expert below:

Content Expert(s) Name and Credentials	Disclosure/COI Form Attached?	Was COI found?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

How were qualifications verified?  Review of resume/CV/bio  Certification in content area  
 Current position/title/certification  Other – (Describe): \_\_\_\_\_

Qualifications of Content Expert verified by: Name, Credentials on Date

Other Planning Committee Member(s) Name and Credentials:	Disclosure/COI Form Attached?	Was COI found?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**REMINDER:** Strategies utilized by the Nurse Planner to resolve COI must be documented on the individual’s Conflict of Interest Form.

#### **4. Qualified Faculty**

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List the names and titles of the activity presenters/faculty/ speakers/authors, and/or content reviewers who participated in the planning of the educational activity.

Name and Credentials of Presenter(s)/Faculty/ Speaker(s)/Author(s):	Disclosure/ COI Form Attached?	Was COI found?	How did the planning committee assure the qualifications of this individual are appropriate and adequate? <i>(Check all that apply)</i>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Review of resume/CV <input type="checkbox"/> Current position/title/ certification <input type="checkbox"/> Recommendation by colleagues <input type="checkbox"/> Review of literature written by faculty <input type="checkbox"/> Observation of previous presentation <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Review of resume/CV <input type="checkbox"/> Current position/title/ certification <input type="checkbox"/> Recommendation by colleagues <input type="checkbox"/> Review of literature written by faculty <input type="checkbox"/> Observation of previous presentation <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Review of resume/CV <input type="checkbox"/> Current position/title/ certification <input type="checkbox"/> Recommendation by colleagues <input type="checkbox"/> Review of literature written by faculty <input type="checkbox"/> Observation of previous presentation <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Review of resume/CV <input type="checkbox"/> Current position/title/ certification <input type="checkbox"/> Recommendation by colleagues <input type="checkbox"/> Review of literature written by faculty <input type="checkbox"/> Observation of previous presentation <input type="checkbox"/> Other: _____

The Approved Provider Unit must take precautions to prevent bias and ensure content integrity during the educational activity, whether or not commercial support was received or exhibits were present.

**The following precautions taken to prevent bias in the educational content:** *(Check all that apply)*

- Each Faculty/Presenter/Author has agreed that s/he will present information fairly and without bias.
- The potential for bias was discussed/reviewed with each presenter *(trade names, relationships with commercial entities and any commercial support received, etc.)*.
- In conjunction with the above, the session will be monitored for potential violation(s) and any violations will be addressed.
- Other (Describe): \_\_\_\_\_

Name <u>and</u> Credentials of Content Reviewer(s): <i>(if applicable)</i>	Disclosure/COI Form Attached?	Was COI found?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## 5. Contact Hour Calculation

Contact hours are determined in a logical and defensible manner, and awarded to participants for those portions of the educational activity devoted to learning and evaluation. One contact hour = 60 minutes. Activities must be a minimum of 30 minutes. After the first contact hour, fractions or portions of the 60-minute hour should be calculated e.g. 150 minutes of learning experience equals 2.5 contact hours. Contact hours can be awarded in the hundredths (i.e., two digits past the decimal point) or you may round down. Do not round up. Time allowed for registration, introductions, announcements, breaks, meals, business meetings and viewing of exhibits should be excluded from the calculation of contact hours.

### Full Agenda/Schedule for the Educational Activity

- Copy of Full Agenda Attached** – *from registration to closing, including breaks*

*REMINDER: The agenda must include a breakdown of contact hour calculations for all sessions awarding nursing contact hours. The full agenda/schedule should be compared to the timeframes listed on the Educational Planning Form to verify calculation of contact hours. No agenda/schedule is required for activities of one hour or less.*

### Method Used to Calculate Contact Hours

- Total number of eligible minutes for the entire activity/event divided by 60
- Total number of eligible minutes for each session attended, divided by 60
- Pilot study – average time for completion of activity by testers
- Historical data – compared this activity to a similar existing enduring material activity
- Professional opinion based on complexity of content and delivery method
- Other (Describe): \_\_\_\_\_

**Successful Completion Requirements** – *Check all that apply*

- |  |  |
|--|--|
| <input type="checkbox"/> Attendance at entire activity – <i>as determined by planning committee’s selected methodology or Board of Nursing requirement</i> | <input type="checkbox"/> Completion/submission of evaluation form  |
| <input type="checkbox"/> Attendance at 1 or more sessions  | <input type="checkbox"/> Completion of self-study packet   |
| <input type="checkbox"/> Participation in key interview(s)   | <input checked="" type="checkbox"/> Participation in self-evaluation &/or pre- posttest  |
| <input type="checkbox"/> Participation in case study analysis  | <input type="checkbox"/> Achieving passing score on posttest – <i>attach a copy of the posttest and indicate scoring methodology</i> |
| <input type="checkbox"/> Return skill demonstration  | <input type="checkbox"/> Small group work/exercises  |
| <input type="checkbox"/> Submission of required assignment(s)  | <input type="checkbox"/> Observation of practice implementation  |
| <input type="checkbox"/> Other – (Describe): _____   | <input type="checkbox"/> Participation in audience response system   |

**REMINDER:** Successful completion requirements must be shared with learners prior to the start of the learning activity, e.g. brochure, announcement, flyer, email, website, etc. Ensure that the method of communicating this with learners is documented.

**How was learner participation/attendance verified?**

Live activity:

- Pre-registration/check-in/sign-in sheet/scanning system/participation verification at event
- Other – (Describe): \_\_\_\_\_

Blended activity:

- Pre-registration/check-in/sign-in sheet/scanning system/participation verification for live portion of event
- Log-in or electronic verification for reading assignments or mixed media viewing
- Submission of required assignments
- Other – (Describe): \_\_\_\_\_

Enduring activity:

- Log-in or electronic verification of receipt of or access to enduring materials (*printed materials, mixed media, etc.*)
- Collection of participation verification via computer log
- Collection of completed posttest
- Other – (Describe): \_\_\_\_\_

**6. Certificate of Completion**

Participants receive written verification of their successful completion of an activity that contains the following: (a) participant name, (b) title and date (*or completion date*) of activity, (c) name and address of Approved Provider (*Web address acceptable*), (d) number of contact hours awarded/received, (e) Midwest MSD Provider Approval number, and (f) the official Midwest MSD Provider Approval statement.

**Provider Approval Statement** [*Insert Name of Approved Provider*] is an approved provider of continuing nursing education by the Midwest Multistate Division, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.

The official approval statement must be provided to learners prior to the start of every educational activity and on each certificate of attendance. The approval statement must be displayed clearly to the learner and be written exactly as indicated by the Midwest MSD.



**Certificate of Completion Attached**  Yes

**Process for issuing certificates to participants:**

- Receipt of evaluation form at the end of the activity/or thereafter
- Copy of document listing sessions attended/contact hours awarded collected at the event
- Individual certificates generated after the activity based on evaluation/sessions attended or completion of posttest
- Certificates generated by online evaluation program
- Other – (Describe): \_\_\_\_\_

**7. Activity Evaluation**

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A clearly defined method that includes learner input is used to evaluate the effectiveness of each educational activity. Results from the activity evaluation are used to guide future activities. The evaluation components and method of evaluation should be relative to the desired learning outcome of the educational activity.

**Method(s) of Evaluation Used – Check all that apply**

*Short Term Methods:*

- Evaluation form
- Self-reported intention to integrate knowledge learned into practice
- Pre- and/or Post-test
- Return skill demonstration
- Other – (Describe): \_\_\_\_\_

*Long Term Methods: (check only if a long-term measure will be completed)*

- Self-reported actual change in practice
- Data collection related to change in patient metrics
- Observation of performance in practice
- Return on investment (ROI)
- Other – (Describe): \_\_\_\_\_

**Evaluation Online**  No  Yes – URL/Website/Intranet: \_\_\_\_\_; Log-in: \_\_\_\_\_;

**Evaluation Summary Attached**  Yes

**How will the evaluation results be used to guide the development of future activities?**

- Revisions to subsequent offerings (*repeat activities*)
- Shared with presenters/faculty/authors
- Provide feedback to participants
- Shared with planning committee
- Future planning of educational activities
- Shared with administration/QI staff
- Other – (Describe): \_\_\_\_\_

**8. Promotional Materials**

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**Method(s) used to promote the activity – check all that apply**

- Flyer/brochure
- Email notification
- Memo/Letter
- Website/Intranet – *please provide PDF screen shot*
- Meeting notice
- Social media/Blog – *please provide PDF screen shot*
- Other – (Describe): \_\_\_\_\_

**All Types/Forms of Promotional Materials Attached**  Yes

**Event Website?**  Yes  No

URL/Website: \_\_\_\_\_

**Online Registration?**  Yes  No

If no promotional materials developed, describe how the target audience was made aware of the educational activity: \_\_\_\_\_

### 9. Commercial Support and Exhibits

The Approved Provider Unit must adhere to the [ANCC Content Integrity Standards for Industry Support in Continuing Nursing Educational Activities](#) at all times. The Approved Provider Unit must have a written policy or procedure that includes a signed, written agreement when commercial support is received. They must also take precautions to prevent bias and ensure content integrity when exhibits/vendors are present.

Did this activity receive commercial support  Yes  No

NAME OF COMMERCIAL INTEREST ORGANIZATION	TYPE OF SUPPORT	
	FUNDING AMOUNT	IN-KIND DONATION

Commercial Support Agreements Attached (if applicable)  Yes  No  N/A

Content Integrity will be/has been maintained by: (check all that apply)

- Commercial supporter(s) did not participate in the planning of this activity in any way.
- The commercial support policy/procedure was discussed with those providing the support.
- The commercial support policy/procedure was shared in writing with those providing the support.
- Support agreement terms and conditions was discussed and clarified prior to signing
- Presenters/faculty/authors were informed of and agreed not to promote the products or the company providing financial or in-kind services
- Presence of commercial support and need to avoid bias was discussed with each presenter/faculty/author
- Advertising/company logos were removed from any educational content (slides, handouts)
- Educational materials were not packaged in items bearing logos of a commercial interest
- Commercial supporter(s) were not referenced during the activity except for required disclosure
- In conjunction with above, the session(s) were monitored and violators of policy are not asked to present again.
- Other – (Describe): \_\_\_\_\_

Were exhibits/vendors present at this educational activity?  Yes  No

The following strategies/precautions have been taken to prevent bias/ensure content integrity with the presence of exhibits/vendors: (Check all that apply)

- Exhibiting, promoting or selling products will not take place during scheduled educational time
- Exhibit area will be physically separated from area where educational content will be delivered
- Marketing/advertising will not be included within educational content (slides, handouts, etc.)
- ‘Giveaways’ will be kept separate from educational materials/delivery
- Learner contact information will not be shared without written permission from the learner
- Commercial interest organizations are not allowed to influence the audience during the educational activity for any reason
- Other – (Describe): \_\_\_\_\_

## 10. Disclosure Responsibilities

All required disclosures and any other applicable disclosures must be provided to learners *prior to the start* of an educational activity. Evidence of disclosures to the learner must be retained in the activity file.

For *live* activities, disclosures must be made prior to the initiation of educational content. In *enduring* activities (print, electronic, or web-based activities), disclosures must be visible to the learner prior to the start of educational content. Required disclosures may not occur or be located at the end of the educational activity.

Use an 'X' to identify the disclosures that are applicable for this educational activity, and the place(s) where learners will receive each applicable disclosure in writing prior to the start of the educational activity.

DISCLOSURE	APPLICABLE?		WHERE IS THIS ITEM DISCLOSED?			
	NO	YES	Promotional/ Advertising Materials	Participant Handout/ Packet	On Screen/ Disclosure Slide	Sign at Check-In Area
Provider Approval Statement		X				
Successful Completion Requirements		X				
Presence/Absence of COI for Planners and Presenters/Authors/ Content Reviewers		X				
Commercial Support <i>(if applicable)</i>						
Joint Providers Identified <i>(if applicable)</i>						
Expiration Date for Awarding Contact Hours <i>(Enduring Material activities only)</i>						

\* Providers must specify method and provide written documentation. Note that verbal-only disclosures are not permitted.

**Copies of all methods noted above to deliver required disclosures to learners attached** *(promotional materials, letters, program schedules, presentation materials, announcements, etc. as identified above)*

Yes

### Required Attachments

- Joint-Provider agreement (if applicable)
- Gap Analysis Worksheet
- Sources of evidence to support the professional practice gap(s) the activity will address
- Complete Educational Planning Form(s)
- Full agenda/schedule for the educational activity – *from registration to closing, including breaks*
- Signed biographical data and conflict of interest form for the Nurse Planner involved in the activity
- Signed conflict of interest forms for all members of the planning committee and presenters/authors/content reviewers involved in the activity.
- Certificate of completion including all required elements
- Evaluation method used including a summary of evaluation data
- Commercial Support agreement (if applicable)
- Promotional materials (all resources used to market the activity to the target audience)

- Required disclosure delivery mechanisms (all mechanisms to deliver disclosures)
- List of participant names
- Record of the number of contact hours earned by each participant

(INSERT NAME OF APPROVED PROVIDER)  
**COMMERCIAL SUPPORT AGREEMENT**

**Commercial support** is defined as financial, or in-kind, contributions given by a commercial interest, which is used to pay all or part of the costs of a CNE activity. A commercial interest is defined by the American Nurse's Credentialing Center (ANCC) and the Midwest Multistate Division (Midwest MSD), as any entity producing, marketing, reselling, or distributing healthcare goods or services consumed by or used on patients, or an entity that is owned or controlled by an entity that produces, markets, resells, or distributes healthcare goods or services consumed by or used on patients. Nonprofit or government organizations, non-healthcare related companies, healthcare facilities, and group medical practices are not considered commercial interests.

Commercial support is categorized as either financial or in-kind. **In-Kind** support is materials, space or other non-monetary resources or services used by an Approved Provider to conduct an educational activity; which may include but is not limited to human resources, marketing services, physical space, equipment such as audio-visual materials and teaching tools. **Financial** support can be restricted or unrestricted and must be explained. **Unrestricted** support is support given freely and without constraint by the Commercial Interest Organization. The Approved Provider has sole discretion to administer commercial support as appropriate for planning, developing, implementing or evaluating the educational activity. **Restricted** support is given toward a specific aspect of an educational activity such as meals, breakout sessions or speaker honoraria.

Activity Title: \_\_\_\_\_

Activity Date: \_\_\_\_\_ Activity Format:  Live  Enduring  Blended

Name of Commercial Interest/Supporter: \_\_\_\_\_

Commercial Interest Representative: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Amount of Support: \$ \_\_\_\_\_

Type of Support:  In-Kind Support – Describe: \_\_\_\_\_

Financial:  Unrestricted

Restricted:  Speaker honorarium  Speaker travel expenses

Meal function  Other – Describe: \_\_\_\_\_

TERMS & CONDITIONS – please check each box below to indicate your understanding and agreement to terms	
<input type="checkbox"/>	All organizations must comply with the ANCC <i>Content Integrity Standards for Industry Support in Continuing Education Activities</i> which is available on the Midwest MSD website at <a href="http://www.midwestnurses.org">www.midwestnurses.org</a>
<input type="checkbox"/>	Organizations providing commercial support for an educational activity may not influence the planning, implementation or evaluation of the educational activity, including: <ul style="list-style-type: none"> <li>• Assessment of learning needs/gap analysis</li> <li>• Determination of learning outcomes</li> <li>• Selection or development of content</li> <li>• Selection of planners, presenters, authors and/or content reviewers</li> <li>• Selection of learner engagement strategies</li> <li>• Evaluation methods</li> </ul>

<input type="checkbox"/>	A Commercial Interest Organization may not jointly provide educational activities
<input type="checkbox"/>	The Approved Provider will make all decisions regarding the disposition and disbursement of commercial support in accordance with the ANCC/Midwest MSD Accreditation criteria.
<input type="checkbox"/>	Commercial support will be disclosed to the learners participating in the educational activity
<input type="checkbox"/>	A Commercial Interest Organization may not exhibit, sell or promote its goods or services in relation to the content of an educational activity at any time during which the educational activity takes place including the introduction and conclusion of the activity, regardless of the format of the educational activity
<input type="checkbox"/>	Advertisements promoting the products or services of a Commercial Interest Organization in relation to the content of an educational activity must be physically separated from the educational activity, regardless of the format of the educational activity
<input type="checkbox"/>	Commercial Interest Organizations may provide giveaways for learners, as long as there is physical separation between accessing the giveaway and learner engagement in the educational activity

By signature below, the representatives 1) acknowledge they are duly authorized to enter into binding contracts on behalf of the Commercial Interest and Approved Provider Organizations and 2) agree to comply with the terms and conditions outlined above.

### APPROVED PROVIDER

Organization Name: \_\_\_\_\_

Organization Representative: \_\_\_\_\_

Representative Title/Position: \_\_\_\_\_

**Electronic Signature:** An 'X' below serves as the electronic signature of the individual, with authority to sign agreements on behalf of the organization, agreeing to the terms and attesting to the accuracy of the information given above.

**Name and Credentials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### COMMERCIAL INTEREST ORGANIZATION

Organization Name: \_\_\_\_\_

Organization Representative: \_\_\_\_\_

Representative Title/Position: \_\_\_\_\_

**Electronic Signature:** An 'X' below serves as the electronic signature of the individual, with authority to sign agreements on behalf of the organization, agreeing to the terms and attesting to the accuracy of the information given above.

**Name and Credentials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(INSERT NAME OF APPROVED PROVIDER)  
**JOINT PROVIDER AGREEMENT**

This activity is being jointly provided by (Insert Approved Provider Name) and (Insert Joint Provider Organization Name).

Activity Title: \_\_\_\_\_

Activity Date: \_\_\_\_\_ Activity Format:  Live  Enduring  Blended

Approved Provider Nurse Planner: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

(Insert Approved Provider Name) will ensure the educational activity has a strong educational design and meets the ANCC/Midwest Multistate Division (Midwest MSD) Accreditation Program educational design criteria. Below is a listing of the specific activity planning duties related to this educational activity and the organization responsible for completion. Please check the responsible party related to each task. *Those items indicated as "Required" are the responsibility of the Approved Provider as stipulated by the ANCC/Midwest MSD Accreditation criteria. The Joint Provider may assist with these items, but the final responsibility lies with the Approved Provider.*

PLANNING RESPONSIBILITIES:	APPROVED PROVIDER:	(INSERT JOINT PROVIDER NAME):
• Determining learning outcomes	Required	
• Selecting planners, presenters, faculty, authors, and content reviewers	Required	
• Awarding contact hours	Required	
• Developing evaluation method(s)	Required	
• Managing commercial support	Required	
• Recordkeeping procedures	Required	
• Ensuring the Provider's name is prominently displayed on all promotional materials developed for the activity	Required	
Insert additional duties to outline below: <i>(suggestions provided)</i>		
• Develop marketing materials		
• Process registrations		
• Handouts		
• On-Site staff support		
• Budget reconciliation		
• Evaluation summary		
• Thank Yous		

**NOTE:** Financial details are often not outlined in joint provider agreements between organizations. However, in the event an exchange of money is included as part of the agreement, it is recommended that the financial arrangements be stipulated in the joint provider agreement. Jointly providing an education activity is a collaborative venture between two or more organizations that requires the direct involvement of the Approved Provider's Nurse Planner. Contact Hours may not be purchased.

By signature below, the representatives (1) acknowledge they are duly authorized to enter into binding contracts on behalf of the Approved Provider and Joint Provider Organizations and (2) agree to the duties and responsibilities outlined above.

**APPROVED PROVIDER**

Organization Name: \_\_\_\_\_

Organization Representative: \_\_\_\_\_

Representative Title/Position: \_\_\_\_\_

**Electronic Signature:** An 'X' below serves as the electronic signature of the individual, with authority to sign agreements on behalf of the organization, agreeing to the terms and attesting to the accuracy of the information given above.

**Name and Credentials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**JOINT PROVIDER**

Organization Name: \_\_\_\_\_

Organization Representative: \_\_\_\_\_

Representative Title/Position: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Electronic Signature:** An 'X' below serves as the electronic signature of the individual, with authority to sign agreements on behalf of the organization, agreeing to the terms and attesting to the accuracy of the information given above.

**Name and Credentials:** \_\_\_\_\_ **Date:** \_\_\_\_\_