Application Review Process:

1. Complete the following program application.

2. Include the required application materials (samples accepted):
   - Appropriate program/representative materials
   - Marketing materials, and
   - Documentation of CME accreditation (*if applicable*)

3. Include payment with signed and dated form.

4. Provide other information that may be pertinent to a fair review of this program (e.g., needs assessment documentation, learner-centered objectives, course syllabus, faculty listing, etc.)

5. If you wish to submit participant completion data, check the 'Electronic Submission' option. ABPN will provide your organization with a formatted Excel spreadsheet so the information can be uploaded into the ABPN Physician Folios accounts. Organizations must agree to email ABPN the data file within 30 days of program completion.

6. Submit the materials, including the applicable fee, to the following address:

Attn: Patti Vondrak, Director of MOC
MOC Program Review
American Board of Psychiatry and Neurology, Inc.
2150 E. Lake Cook Road, Suite 900
Buffalo Grove, IL 60089
Or email to pvondrak@abpn.com

Note: Only programs that have successfully undergone this process may use the following wording in publicizing or advertising the program. Variations of this wording should not be used without permission.

THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY HAS REVIEWED THE

(_____*NAME OF PROGRAM*_____) AND HAS APPROVED THIS PROGRAM AS PART OF A

COMPREHENSIVE_____PROGRAM, WHICH IS MANDATED

BY THE ABMS AS A NECESSARY COMPONENT OF MAINTENANCE OF CERTIFICATION.

Please allow four weeks for program review.

American Board of Psychiatry and Neurology, Inc.

Educational Program Review for Maintenance of Certification: Improvement in Medical Practice (PIP)

1. Please provide the following information for the organization submitting this educational program for review. If this program review should be sent to a different individual, please provide the necessary information.

Organization Name _____

Contact Name _____ Title _____
(to whom questions should be directed)

Address _____ City _____ State __ Zip _____

Email _____ Telephone _____ Fax _____

2. What is the title of the program to be reviewed?

3. Indicate published best practices, practice guidelines or peer-based standards of care (e.g. hospital quality improvement programs, standard practice guidelines, etc.) used in comparison :

4. Quality measure to be reviewed (minimum of 4):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

5. Application Approval Type:

☐ New

☐ Renewal

☐ Revision (activity currently approved)

6. Indicate date(s) of activity:

   One-time approval: _____

   3-year approval: _____

7. Indicate format of activity (check all that apply):

   ☐ Online

   ☐ Live (meeting or conference)

   ☐ Audio (mp3, CD)

   ☐ Print (journal or book)

   ☐ DVD

8. This program fulfills the following ABPN PIP module(s):

   ☐Clinical Module (Chart Review)

   ☐Feedback Module -- *Optional requirement for the physicians as of 1/1/2016*

9. *If applicable,* what is the number of Category 1 CME credits awarded for this program?

   _____ Number of Category 1 CME credits

10. Verify that your program meets the following ABPN PIP requirements:

☐Clinical Module (Chart Review)

☐Step A: Initial Assessment

Each diplomate is required to collect data from at least five of their own patient charts in a specific category (e.g., diagnosis, type of treatment, or treatment setting) obtained from the diplomate's personal practice over the previous 3-year period.

☐Step B: Identify and Implement Improvement

Each diplomate must then compare data from the five of their own patient charts with published best practices, practice guidelines, or peer-based standards of care (e.g. hospital quality improvement programs, standard practice guidelines, etc.), and develop and carry out a plan to improve effectiveness and/or efficiency of his/her medical practice.

☐Step C: Reassessment

Within 24 months of initial assessment, each diplomate must collect the same data from at least another five of their own patient charts (may use same or different patients) in the same specific category, to see if improvements in practice have occurred.

☐**Feedback Module -- *Optional requirement for the physicians as of 1/1/2016***

☐**Step A: Initial Assessment**

Each diplomate must solicit personal performance feedback from at least five peers* or five of their own patients** concerning the diplomate's clinical activity over the previous three years.

☐**Step B: Identify and Implement Improvement**

Each diplomate must then identify opportunities for improvement in the effectiveness and/or efficiency in their practice as related to the general competencies and take steps to implement suggested improvements.

☐**Step C: Reassessment**

Within 24 months of initial assessment, each diplomate must collect the same data from another set of the same or different five peers* or five patients to see if improvements in practice have occurred. Feedback may be obtained from the same patients or peers as in the original and follow-up feedback.

** Peers may include other professional healthcare staff such as psychologists, social workers, counselors, and nurses.*
***Patients can include those for which the diplomate supervises the care from another provider (e.g., resident).*

11. Description of your program:

12. What is the basis of the proposed PIP unit (e.g., specific practice guidelines, quality improvement committee decision, literature review, etc.)

13. Which specialty/ties or subspecialty/ties is the program intended for (*see www.abpn.com for listing of specialties/subspecialties)*? List all that apply:

14. Which ABPN general competencies does this program address? (Note: The latest version of the ABPN general competencies is available at **www.abpn.com**.)

Check all that apply:

- ☐ Interpersonal and communication skills
- ☐ Medical Knowledge
- ☐ Patient care
- ☐ Practice-based learning and improvement
- ☐ Professionalism
- ☐ Systems-based practice

15. Provide the URL link to your program (i.e., www.abpn.com):

16. Please indicate any supporting partners (i.e., other organizations involved in providing this program):

☐Software/registry partner(s): _____

☐Education partner(s): _____

☐Other (describe): _____

17. Source of funding for this program (check all that apply):

☐Commercial Support (as defined by ACCME) Describe process for ensuring compliance with the ACCME Standards for Commercial Support℠:

List Commercial Supporters/funders:

☐Fee-based (enter participant fee): $_____

☐Foundation grant/other non-profit funding

☐Government grant (HRSA, etc.)

☐Institutional support

☐Other, describe:

_____

18. Will your organization verify/audit successful completion of the program for each participant?

☐Yes ☐No If so, how?

19. Include a copy of the following along with the application:

☐Program/representative sample materials

☐Marketing materials *(ABPN must approve marketing materials prior to distribution)*

☐Documentation of CME accreditation (*if applicable*)

☐Signed and dated credit card form or payment

20. ☐Check if you wish to submit **electronic participant completion data** to the ABPN's Physician Folios accounts. Organizations must agree to submit the data files within 30 days of the completed program.

American Board of Psychiatry and Neurology, Inc.

Educational Program Review for Maintenance of Certification: Improvement in Medical Practice (PIP)

Fee Enclosure - indicate the amount enclosed for this review:

☐$100 for a one-time only program

Indicate date of program: _____

☐$250 for a program seeking approval for up to 3 years.

Indicate 3-year period: _____

A discount will be provided for programs submitted at the same time. After the initial fee of $250 for the first program, each subsequent program review fee will be $100.

If paying by check, make checks payable to the American Board of Psychiatry and Neurology, Inc.

If you wish to pay by credit card, please fill in all requested information below.

☐ American Express ☐ Discover ☐ Mastercard ☐ Visa Credit Card No._____

Amount Authorized for payment: $_____Expiration Date (mm/yy) _____

Name as shown on Credit Card: _____

Organization name _____

Billing Address _____

City, State, Zip _____

Billing Phone _____

To complete and submit the forms electronically:

- Fill in the information on this page, including the credit card payment form.
- Save the full pdf document to your computer, naming it with your organization name.
- Attach the application, as well as the product sample and marketing materials and email to pvondrak@abpn.com.

* Signature_____ Date _____

* **Credit Card form must be signed by cardholder**.

The ABPN accepts no liability for misdirected or inaccurate information. If for any reason your credit card company fails to authorize this transaction, the ABPN will charge you whatever fees, costs or expenses it incurs for such a rejection.