

Designated Provider of Continuing Education Application – Checklist for Submission for Review



Thank you for your interest in becoming a Designated Provider of Continuing Education for DMH Professional Credentials (CE Designated Provider). DMH asks that you utilize this checklist in order to ensure that the required information is submitted for review. Please submit this checklist with your application.

Submission Checklist

- ☐ Completed application with signature
- ☐ Response to organizational requirement 1 – educational objectives
- ☐ Response to organizational requirement 2 – qualified instructors
- ☐ Response to organizational requirement 3 – planning and evaluation of CE offering
- ☐ Response to organizational requirement 4 – maintenance of documentation

Thank you for your interest in becoming a CE Designated Provider. This checklist, application and attachments should be submitted electronically to Stephanie Foster with DMH's Division of Professional Licensure and Certification for processing. Please submit directly to place@dmh.ms.gov.

Incomplete applications (inclusive of attachments) will not be presented to the PLACE Board for review and determination.

Introduction

The Mississippi State Board of Mental Health, through the Mississippi Department of Mental Health (DMH), is statutorily authorized to certify/license case managers [i.e., community support specialists], mental health therapists, intellectual and developmental disabilities therapists, and others as deemed appropriate by the Mississippi State Board of Mental Health. Additionally, DMH is statutorily authorized to certify /license mental health/intellectual and developmental disabilities program administrators and addiction therapists.

DMH professional credentials are designed primarily for individuals who are not already professionally credentialed and who are employed in Mississippi's state mental health system. DMH professional credentials are designed to promote the provision of quality services in Mississippi's "state mental health system." Employment in Mississippi's "state mental health system," as defined by the rules and regulations of the credentialing programs, is a mandatory requirement to apply for and hold a DMH professional credential. Full certification/licensure attests to an individual's: educational background; relevant work experience; demonstration of mastery of basic knowledge, respective to professional credentialing program, pertinent to state mental health system service provision; continued participation in relevant educational activities, through the continuing education (CE) renewal requirement; and, agreement to adhere to the *DMH Principles of Ethical and Professional Conduct*.

DMH administers the professional credentialing programs through its Division of Professional Licensure and Certification (PLACE) and the Professional Licensure and Certification Review Board (PLACE Board). Additionally, the Peer Support Specialist credential is managed through DMH's Division of Recovery and Resiliency. In order to ensure the availability of continuing education offerings for people credentialed through PLACE, a Designated Provider of Continuing Education model has been established. The requirements for becoming a Designated Provider of Continuing Education for DMH Professional Credentials (Designated Provider) and for the approval of continuing education offerings are outlined in this document.

Designated Provider Status

Through the application process, the PLACE Board determines an agency's status as a Designated Provider. Endorsement as a Designated Provider allows an agency to approve continuing education hours (CE hrs.) for all of the DMH credentialing programs.

In order to become a Designated Provider an agency must 1) be identified by DMH as a part of the state mental health system; 2) meet all the guidelines set forth in this document; and 3) have the capacity to offer approval for all of the DMH credentialing programs. Designated Providers are approved for up to a two (2) year period of time, during which they must consistently comply with all requirements. Designated Providers will be randomly audited by the PLACE Board and/or DMH. Complaints and/or the results of random audits may result in the removal of the Designated Provider status. *See Appendix A for the application for endorsement as a Designated Provider.*

Organizational Requirements of Designated Providers

It is important that Designated Providers have the systems and processes in place to ensure the integrity of the continuing education offerings that they approve for (CE hrs.). Organizations must have the following systems/processes in place to confirm:

1. educational objectives approved by the agency as a Designated Provider are met;
2. qualified instructors/presenters/speakers are utilized;
3. credentialed individuals for which credit is received participate in the planning and evaluation of the continuing education offering (e.g. If continuing education hours are approved for the Mental Health Therapist Program, a CMHT/LCMHT must participate in the planning and evaluation components of the offering.); and,
4. records for each individual continuing education offering (inclusive of training content, instructor qualifications, participant sign-in sheets, participant evaluations, and continuing education certificates) are maintained for a minimum of three (3) years from the date of the CE offering. For example, if Applied Suicide Intervention Skills Training (ASIST) is offered 3 times during a 12 month period then the Designated Provider would maintain the required documentation for each of the 3 continued education offerings.

Organizations seeking to become a Designated Provider should submit their responses to these items as a part of the application process.

Continuing Education Requirements

Acceptable Formats of Continuing Education Offerings

Continuing Education Offerings primarily include conferences, seminars, and workshops in which the participant is face to face with the qualified instructor with the opportunity for interaction.

Calculation of Continuing Education Hours

In order to be approved for continuing education hours, an offering must be at least 60 minutes in length. **1 CE hr. is equivalent to 60 minutes spent face to face with the qualified instructor with the opportunity for interaction (i.e. instructional time).**

Time devoted to registration, welcoming participants, organizational business, meals, or other refreshments should not be counted as instructional time. In the event that there is a speaker during a meal time, only the time of the actual presentation may be calculated for continuing education hours. Designated Providers must review the final agenda for each conference/seminar/workshop as a part of the preapproval process.

Participants should only be awarded CE hrs. for the time the Designated Provider can verify that he/she actually spent in instruction. For example, a participant only submits an evaluation for two of three workshop sessions that had approval for CE hrs. In that example, the participant would only be awarded 2 CE hrs based on the evaluations submitted.

Content of Continuing Education Offerings

In order to be approved for CE hours for each specific DMH Credentialing Program (i.e. Mental Health Therapist, IDD Therapist, Addictions Therapist, Licensed Administrator, Community Support Specialist, Peer Support Specialist), the instructional content must be applicable to each respective scope of practice as outlined in the DMH Credentialing Program's Rules and Regulations.

Priorities for approved CE hours should include topics such as: evidence-based practices, promising practices with the evidence/research to support them, cultural diversity, and ethics.

Content that should not be approved for CE hours includes the following:

- computer related training;
- time management;
- office, agency, or employer training geared to management policies and procedures;
- personal growth and enrichment;
- business meetings;
- supervisory sessions; and,
- "staffing", Treatment plan review, Service Plan review, or Plan of Services and Supports review.

Qualified Instructors

Utilization of qualified instructors is critical to the value of the continuing education offering. In order for a Designated Provider to approve CE hours, a qualified instructor must be utilized. A

qualified instructor must demonstrate authority through formal education, experience, or training in the particular area or topic for which they are providing instruction.

Length of Approval of CE Hrs.

A Designated Provider may approve a continuing education offering for CE hrs. for a twelve month period in the event that there are no changes to the content, instructional time, or qualified instructors. Any changes to those items will require a new review.

Documentation Requirements (see Appendix B for the required document templates)

The following documentation must be maintained by the Designated Provider for each continuing education offering that is approved for CE hrs.

- Content objectives
- Instructor qualifications
- Participant sign-in sheets
- Participant evaluations
- Copies of participant certificates

Participant certificates should be issued to the participants within ninety (90) days of the approved continuing education offering.

Appendix A
Application

Designated Provider of Continuing Education Application



Agency Information

Organization Name	
Street Address	
City ST ZIP Code	
Work Phone	
E-Mail Address	
Fax	

Type of Application

- ☐ New Application
☐ Renewal (DP # _____)

Agency Contact Person

Please indicate the agency/organization representative responsible for submission of the application and the review/approval of continuing education applications.

Name	
Street Address	
City ST ZIP Code	
Work Phone	
E-Mail Address	
Fax	

Organizational Requirements

In the attachments provided with this application (see pages 3-6), please provide a response to the following. Describe the systems/processes in place that the agency has to confirm that:

1. educational objectives approved by the agency as a Designated Provider are met;
2. qualified instructors/presenters/speakers are utilized;
3. credentialed individuals for which credit is received participate in the planning and evaluation of the continuing education offering; and,
4. records for each individual continuing education offering (inclusive of training content, instructor qualifications, participant sign-in sheets, participant evaluations, and continuing education certificates) are maintained for a minimum of three (3) years from the date of the continuing education offering.

Agency Verification

By submitting this application and supplementary documents, I affirm that the facts set forth in it are true and complete. I attest that the agency will abide by the Guide for Becoming a Designated Provider for Continuing Education for Credentials Offered through the Department of Mental Health's Professional Licensure and Certification (PLACE) Board, as well as the rules of regulations set forth for each of the DMH Professional Credentialing Programs.

Name (printed)	
Signature	
Date of Submission	

Thank you for completing this application form and for your interest in becoming a Designated Provider of Continuing Education. **This application and attachments should be submitted electronically to Stephanie Foster with DMH's Division of Professional Licensure and Certification for processing. Please submit directly to place@dmh.ms.gov.**

Incomplete applications (inclusive of attachments) will not be presented to the PLACE Board for review and determination.

Organization Requirement 1 – Educational Objectives

Organizational Requirement 2 – Qualified Instructors

Organizational Requirement 3 – Planning and Evaluation of CE Offering

Organizational Requirement 4 – Maintenance of Documentation

Appendix B
Required Documentation

PLANNER/ PRESENTER A-1**SECTION A. IDENTIFYING INFORMATION**

Name:	Title of Presentation:
Title of Conference:	Date of Presentation:
Select the option that best describes your role:	Lead Planner Presenter

SECTION B. VESTED INTEREST

1. Have you received anything of value from a commercial supporter, which may have been perceived as direct or indirect interest in the subject(s) you are addressing in this educational activity?

If yes to (1), please list the commercial supporter:

If yes to (1), please describe your relationship: (select all that apply)

Speaker's Bureau	Shareholder
Consultant	Grant/Research Support
Major Stockholder	No relationship
Large Gift(s)	Other, please describe

If yes to (1), How will conflict of interest be resolved?

2. Describe professional experience and/or areas of expertise (including publications) related to the involvement in continuing education.

3. Identify how you took part in the planning and evaluation of this activity:

Planned objectives/content	Reviewed evaluation summary
Planned time frame	Will utilize evaluation to revise presentation as needed
Planned teaching strategies	Other, please describe
Attended committee meetings	

SECTION C. PRESENTER QUESTIONS (VESTED INTEREST)

4. **Presenter:** During your presentation, will you include discussion of an unlabeled or the investigational use of a produce, device, or drug that has not been approved by the FDA? For the use being presented in this educational activity?

If yes to (4) Please explain:

If yes to (4) you must disclose this information during your presentation. Select the method of disclosure:

Handouts	Verbally, during presentation
Audiovisuals	Other, please describe

If yes to (4), How will conflict of interest be resolved?

5. **Presenter:** How will your presentation practice cultural awareness?

BIOGRAPHICAL DATA. (PRESENTER ALSO ATTACH CURRICULUM VITAE)

Name:	Home Address:
Employer:	Employer Address:
Phone:	E-Mail Address:
Present Position: (Title and Description)	

EDUCATION.

DEGREE	INSTITUTION	MAJOR AREA OF STUDY	YEAR DEGREE AWARDED

PLEASE SIGN AND DATE BELOW. IF PROVIDING ELECTRONIC SIGNATURE, A STATEMENT **MUST BE INCLUDED (NEXT TO SIGNATURE) VERIFYING THAT YOUR ELECTRONIC SIGNATURE IS THE EQUIVALENT OF YOUR ACKNOWLEDGEMENT AND VERIFICATION OF THE INFORMATION PROVIDED.**

Signature: _____

Date: _____

PRESENTATION ABSTRACT & REFERENCES

Name:
Title of Conference:
Title of Presentation:
Date of Presentation:
ABSTRACT. (3-5 SENTENCES EXPLAINING YOUR PRESENTATION)
CITATIONS/ REFERENCES. (MINIMUM OF 3 SCHOLARLY REFERENCES: APA FORMAT)

PRESENTER A-2: PRESENTATION OUTLINE

Title of Conference:				
Title of Presentation:				
Duration of Presentation: (All sessions must be at least 60 minutes; thereafter, credit is awarded in increments of 30 minutes)				
Evaluation Tool: (Select the evaluation method to be used to evaluate this activity.)				
Post Test	Structured Interview	Attitude Scale	Direct Observation of Skill Performance	Other, please list
Evaluation Category: (Select the most appropriate evaluation category for this activity.)				
Learner Satisfaction	Knowledge	Skill and Attitude Change	Change in Practice	Other, please specify
Objectives: Must provide 3 objectives. Please be specific and begin objectives with action verbs such as: Discuss, Explain, Define, List, Demonstrate, etc.			Presenter(s): List for each objective.	Time Frame: List for each objective.
Objective 1:				
Objective 1 Supporting Information:				
Objective 2:				
Objective 2 Supporting Information:				
Objective 3:				
Objective 3 Supporting Information:				

Conference Title:
Location:
Date:

Insert Designated Provider Agency
Logo Here

Please Print Name	Please Sign-In	Email Address	Phone #	DMH Credential

CONTINUING EDUCATION EVALUATION
(INSERT DESIGNATED PROVIDER AGENCY NAME HERE)
(INSERT NAME OF CE OFFERING HERE)

Please circle the discipline(s) for which you would like to receive continuing education credit:

DMH Mental Health Therapist

DMH Addictions Therapist

Licensed DMH Administrator

DMH IDD Therapist

DMH Community Support Specialist

DMH Certified Peer Support Specialist

Attendance Certificate

Session: Session Name

Presenter: Presenter Name

Date: Date

Time: Time

Overall Goal of Session: List the Goal of the session

Objectives: (By completion of this activity, the participant will be able to)

1. Objective 1
2. Objective 2
3. Objective 3

Please circle one response per question below.	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
I was able to achieve the educational objectives for this activity: Objective 1	5	4	3	2	1
I was able to achieve the educational objectives for this activity: Objective 2	5	4	3	2	1
I was able to achieve the educational objectives for this activity: Objective 3	5	4	3	2	1
The educational objectives were related to the overall purpose.	5	4	3	2	1
The presenter(s) demonstrated expertise in the subject matter.	5	4	3	2	1
The instructional process (teaching strategy) was effective.	5	4	3	2	1
The physical facilities were appropriate.	5	4	3	2	1

Additional Presentation Questions:

1. Did you detect commercial bias in this presentation? **No** **Yes**
 - a. If yes, please explain what made you feel bias. By whom?
2. Was there discussion of an unlabeled or the investigational use of a product, device, or drug that has not been approved by the FDA for the use being presented? **No** **Yes**
 - a. If yes, please explain.
3. How will you use the information to assist you in your practice?

4. How much did you learn as a result of this continuing education opportunity? (1 being very little- 5 being a great deal)

1 2 3 4 5

5. Please list any additional comments and/or program improvements below.

6. I would like the Mississippi Department of Mental Health, Division of Professional Development to provide conferences or workshops on the following topics:

General Questions:

1. Do you prefer: ☐ Half-Day Workshops ☐ Full-Day Workshops ☐ Multi-Day Workshops

2. Do you prefer workshops in: ☐ Hotels ☐ Hospital ☐ No preference

3. How much time do you need to respond to a program announcement?

☐ Less than 1 month ☐ 4-6 weeks ☐ More than 6 weeks

4. How did you learn about this program?

☐ Brochure ☐ Supervisor ☐ College ☐ Other

5. How far did you travel to attend this program?

☐ 0-25 miles ☐ 25-50 miles ☐ 50-100 miles ☐ over 100 miles

If you have any comments or concerns regarding this training session, please contact (*insert name of Designated Provider Agency*) within 90 days of activity completion.

Thank you for your participation in this evaluation!

Signature of Participant

Email Address (required)

Printed Name of Participant

Mailing Address (optional)

Insert Designated Provider Agency
Logo Here

Participant's Name:

Participant's Email Address:

INSERT DESIGNATED PROVIDER AGENCY NAME

Insert Designated Provider Agency Address

CERTIFICATE OF CONTINUING EDUCATION

Title of CE Offering:

Location (City, State):

Date(s):

This signed Certificate of Continuing Education Hours affirms that the individual name above attended this continuing education activity endorsed by *(Insert Designated Provider Agency Name Here)*.

This activity, for *(insert number of CE hours received by the participant)* hour(s) of CE hours for full attendance/successful completion, has been awarded by *(insert agency name)* which is a designated provider of continuing education for the DMH *(insert name of credentialing program)*.

The CE evaluation form for each session was handed out at the end of the session. All signed and submitted participant evaluation forms have been cross-referenced against the certificate of continuing education issued. Participant evaluations must be received in order to receive credit. This is a certified form confirming the number of CE hours earned by the participant.

*Signature of Designated Provider Agency
Representative with title*

Date of Approval

Any dispute regarding CE hours must be made to the Designated Provider Agency within 90 days of the CE offering.