The Alliance for Continuing Education in the Health Professions

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Almanac

VOLUME 36
NUMBER 5
JULY/AUGUST 2014

2

Surviving the Comet Headed Our Way

Over the past decade, numerous industries have been profoundly affected by the dramatic changes that have come about because of advances in technology and information systems. Two illustrative examples include print journalism and the music recording industry . . .

[READ THE FULL ARTICLE ON PAGE 2]

THE WORLD OF EDUCATION IS CHANGING RAPIDLY—SOME PEOPLE PREDICT UNIVERSITIES WON'T EVEN EXIST IN 10 YEARS. GEORGE MEJICANO, MD, FACEHP, SPECULATES ON SEVERAL FUTURE SCENARIOS IN THE WORLD OF EDUCATION.

INSIDE THIS ISSUE

The *Almanac* is published by the Alliance for Continuing Education in the Health Professions, 4720 Montgomery Lane, Suite 900, Bethesda, MD 20814-3451; Phone: 301-683-8130; Fax: 301-683-8131; email: acehp@acehp.org; ISSN#1076-3899. The views expressed in the *Almanac* are those of the authors and are not intended to represent the views of the Alliance or its membership.

Surviving the Comet Headed Our Way

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Over the past decade, numerous industries have been profoundly affected by the dramatic changes that have come about because of advances in technology and information systems. Two illustrative examples include print journalism and the music recording industry. In these two cases, the groups who controlled product distribution struggled to adapt to rapid changes in format, development, digital dissemination, and consumption of content. Business models and standard operating procedures were turned on their heads as (1) a commodity that was thought to be relatively scarce proliferated at astounding rates, and (2) consumers were able to access that commodity anytime and in virtually any format. Most thought leaders in both print journalism and the music recording industry did not heed the warning signs. They saw the proverbial comet light up the evening sky but could not imagine that it was headed directly towards them. As a result, many newspapers have gone out of business and the record labels have lost millions of dollars over the past decade. What does this have to do with continuing education in the health professions? It turns out that the same disruptive innovations that sent shock waves through journalism and the music recording industry are also putting stress on the medical education industrial complex. And there are many signs that suggest that we are not in an ideal position to survive the impact headed our way. The proverbial night sky is revealing a threatening celestial body heading towards us. Will we survive?

Each year, enormous resources are poured into the coffers of our educational systems. Tuition in the USA has risen at a faster rate than healthcare expenditures. However, the outcomes from this enormous investment are distressingly poor. Whether it is K–12 education or continuing professional development in the health professions, it is very difficult to justify the collective return on investment over the past few decades. We continue to focus on time spent learning instead of application, performance and health outcomes. We enroll learners in short, episodic continuing education (CE) activities instead of insisting on longitudinal experiences that are more likely to close practice gaps. We persist in utilizing passive teaching methods in the face of mounting evidence that active learning formats produce better results. And we continue to use a "one size fits all" philosophy that assumes individuals have the same educational needs, learn in the same way, and progress at the same rate as individuals who work in vastly different systems.

The comet headed our way is bearing down on us! New ideas and new methods have taken hold in higher education. Companies like Coursera and Udacity use the web to deliver vast amounts of content—for free—to people all over the world. These companies scale educational delivery to unprecedented heights, allowing a professor teaching in a Massive Open Online Course (MOOC) to reach literally tens of thousands of learners in one fell swoop. More importantly, they threaten to completely upend the time-honored business model of higher education because they allow unfettered access to content. Indeed, some top notch universities are giving away content and only bill enrolled students for assessment of what they may have learned. In many CE circles, this would equate to charging health professionals only for taking a post-activity quiz. The paradigm may have changed before our very eyes and perhaps we need to change our taxonomy to reflect this new, emerging reality: assessment of skills and a focus on what someone does is far more important than what one has learned. It's not continuing education that matters but periodic assessment that has the most value.

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Another disruptive organization is the Kahn Academy which incorporates evaluation tools that embrace adaptive learning concepts. Based loosely upon game theory, the design of their educational modules incorporates rapid feedback, systems that provide hints "on demand," and nested levels of content that become available only after a learner achieves predetermined mastery by solving specific problems or completing a series of tasks. In essence, these systems generate individualized learning plans in real time. Similar to the examples describe above, the Kahn Academy content is available at no charge.

As a result, institutions of higher learning are under great stress. State support is drying up and the cost of education continues to rise. Faculty members at academic medical centers are under duress because federal research funding is so hard to obtain. In addition, the average age that an investigator obtains independent funding continues to increase. Further, the value of a graduate degree has arguably decreased because the nation's universities are awarding too many degrees (i.e., there is now more supply than demand). The pressure on clinical faculty is no less problematic as departments demand ever increasing productivity in the clinic, the wards and the operating room. The end result is that the educational mission suffers as resources dwindle and faculty time is eaten up by other needs.

At a time when simulation, blended learning techniques, faculty development and more sophisticated assessment approaches should be proliferating, many academic programs are making cuts and planning for a reduction in student support services. Some of this is due to the rising cost in administration but some of it is also fueled by the increasing demand for clinical sites and educational attention brought forth by expansion in class size, new health professions schools coming on line, and the added number of advanced learners that require supervision across the professions.

Despite these challenges, however, there is hope that we will not go the way of the dinosaurs. After all, education is a force for positive change. Information continues to exponentially grow and society will continue to need people who can solve problems. By using technology to extend the work of faculty (e.g., a digitally captured lecture can be accessed multiple times in an asynchronous fashion); shifting more responsibility to the learners so they can access learning resources by themselves; using learning resources across institutions and adopting standardized curricula across the nation; and most importantly, embracing a competency-based educational system; we can overcome these challenges and survive the comet's impact.

What is meant by a competency-based educational (CBE) system? At a fundamental level, CBE focuses on what a learner does and not what a learner knows. Our traditional system produces variable outcomes while keeping time on task constant (e.g., four years for the MD degree, three years for a residency in internal medicine, sixteen credits for a classic two day CME conference). In CBE, the outcomes are fixed while time is variable. Further, CBE replaces the power hierarchy of traditional education with a learner-instructor partnership that allows individuals to enter the educational arena at different places, advance at different speeds and focus on problems faced in real life situations. CBE has transformed the world of graduate medical education and is rapidly being accepted in other arenas. It has the potential to destabilize the world of continuing education because it emphasizes assessment and learner progression across milestones, competencies and entrustable professional activities.

The typical Alliance for Continuing Education in the Health Professions member is well versed in activity planning, accreditation requirements, adult learning principles and the operational aspects of modern day continuing education. The knowledge, skills and attitudes that underpin the Alliance competencies together with the high stakes examination created by the National Commission for Certification of CME Professionals have raised the bar for individuals who work in our field. However, most of us are poorly prepared to navigate through the new universe of psychometrics, performance measures, educational badges, game theory, simulation, electronic portfolios, and interprofessional collaborative practice.

One small example of how CE professionals might need to change is the incorporation of something known as the triple jump assessment in CE activities. In a triple jump assessment, learners are first given a minimal amount of information, followed by a phase that allows them to obtain enough information to determine what other resources might be needed to solve a particular problem. The second phase involves a search of learning resources and the active process of tapping into those resources, followed by the last phase whereby learners synthesize what they have learned, apply it into practice and seek feedback. Such complex activities take time, resources, and skills that many of us simply don't have at this time. But that is exactly the type of skill that we will need to survive the sunless sky that follows a major collision of celestial bodies. The technology and information comet is headed our way. Are we prepared—either as individuals or as an organization—prepared for the dark days ahead?

Call for Alliance Board Nominations Open

NOW THROUGH AUGUST 28

On behalf of the Governance Committee, all members are invited to participate in the call for nominations for the Board for Directors. The Alliance's Board members are the stewards of the association, providing leadership, a shared vision, a sense of mission and ensuring fiscal health of the organization. If you or someone you know would be a great addition to the Board, visit the Alliance website to download information on the nomination/election process and the nomination form. Nominations must be received no later than September 12, 2014. Questions? Contact us at board@acehp.org.

Update on the Physician Payments Sunshine Act

Thomas Sullivan, President, Rockpointe; Editor, Policy and Medicine
Matthew Chandler, JD, Research Director, Policy and Medicine

Pharmaceutical and device manufacturers have been busy working through the first reporting year under the Physician Payments Sunshine Act. June 30, 2014 marked the deadline for companies to submit detailed reports to the Centers for Medicare and Medicaid Services (CMS) regarding payments and items of value given to physicians and teachings hospitals during 2013. On September 30, 2014, CMS will publish the majority of the information contained in these reports on a searchable website.

This article discusses a number of aspects of the Physician Payments Sunshine Act, including recent proposed changes to the CME exemption of the Sunshine Act, the data submission and dispute resolution process, state-accredited CME programs, and recent answers to frequently asked questions (FAQs) from CMS.

Recent Proposed Changes to the CME-Exemption in the Sunshine Act

The original Final Rule of the Sunshine Act provided manufacturers a specific reporting exemption for speaker payments if (1) the CME event at which the healthcare professional speaks meets the accreditation or certification requirements of the ACCME, AAFP, ADA, AMA, or the AOA; (2) the manufacturer does not pay the covered recipient speaker directly, and (3) the manufacturer does not select the speaker or provide the third party (such as a continuing education vendor) with a distinct, special rule for payments related to CME programs.

On July 3, 2014, CMS proposed to remove this CME exemption, §403.904(g) of the Final Rule, "in its entirety." [http://thornrun.com/action-center/?vvsrc=%2fcampaigns%2f36776%2frespond] CMS notes that since the Final Rule, other accrediting organizations had requested that payments made to speakers at their events also be exempted from reporting. "These organizations have stated that they follow the same accreditation standards as the [five] organizations specified in the Final Rule." CMS states that their "apparent endorsement or support to organizations sponsoring continuing education events was an unintended consequence of the final rule."

Furthermore, other stakeholders have recommended removing the exclusion because removal would "allow for consistent reporting for compensation provided to physician speakers at all continuing education events, as well as transparency regarding compensation paid to physician speakers."

Based on the surrounding language in their new proposal, CMS continues to recognize the firewalls in place at accredited CME. Most notably, CMS states that they will consider speaker payments to be excluded from Sunshine reporting "when an applicable manufacturer or applicable GPO provides funding to a continuing education provider, but does not either:

1. select or pay the covered recipient speaker directly, or
2. provide the continuing education provider with a distinct, identifiable set of covered recipients to be considered as speakers for the continuing education program."

Notice these are the exact same requirements as (2) and (3) in the original rule. In other words, the proposal seems to be essentially the same as the current speaker/faculty policy, except CMS isn't specifically mandating that education events must be accredited by one of the specific five bodies. In explaining its rationale for the change, CMS states: "This approach is consistent with our discussion in the preamble to the final rule, in which we explained that if an applicable manufacturer conveys 'full discretion' to the continuing education provider, those payments are outside the scope of the rule."

CMS stated that part of its motivation in proposing to remove the CME exclusion is to avoid the "redundancy in another section of the Final Rule. CMS is essentially proposing to replace the well-defined CME language with §403.904(i)(1) of the Final Rule, which excludes **indirect payments** or other transfers of value where the applicable manufacturer is **"unaware"** of the identity of the covered recipient during the reporting year or by the end of the second quarter of the following reporting year.

The key issue is that CMS has not yet offered a specific definition of "indirect payments" or "awareness." CMS' classification of "awareness" could lead to a case where a manufacturer supporting an accredited program finds out that about a physician attendee at a sponsored event a full year after the event itself. Would they have to report this because now they are "aware" of the physician's identity?

This proposed change to the Sunshine Act impacts planning that has occurred over the past 18 months since the Final Rule. While much of the Sunshine Act remains mired in confusion, CMS' continuing education exemption specifically stated the accrediting criteria for companies looking to develop well-defined policies surrounding CME programs. This actually offered companies and physicians certainty that many other Sunshine Act provisions could use.

There are concerns that CMS' proposed policy, instead of encouraging CME programs, will have the opposite effect. Manufacturers may be inclined to over-report in the face of ambiguity; this could chill physician participation in important educational activities.

CMS is accepting comments on this new policy, but only through September 2, 2014. This is an important issue for CME stakeholders, so providers should look closely at CMS' proposal and comment accordingly.

Troubles with Data Submission

In the weeks leading up to the June 30 reporting deadline, many companies struggled with registration and uploading data to Open Payments.

CMS' timeline for data submission did not leave much room for error. From June 9 to June 30—16 business days—companies were required to finish the second step of Phase 2, which included submitting detailed data reports and attesting to the information's accuracy. However, glitches in the Open Payments system set companies back during the process.

Due to the difficulties, many stakeholders petitioned CMS to extend the time period for manufacturers to complete the data submission process. CMS ended up offering companies an extra week: "In order to help ensure the accuracy and completeness of final data submission and attestation in the Open Payments system," they stated, "CMS will not enforce penalties for reporting non-compliance until after July 7." [http://policymed.typepad.com/files/cms-open-payments-email--penalty-delay.pdf]

Review and Dispute By Doctors

Before the public has access to the database, healthcare professionals have a 45-day window to review their reports and challenge payments they believe to be inaccurate or misleading. The start date of this period continues to be a mystery. As of July 8, CMS continues to state that physicians will have access to the Sunshine data within CMS' Open Payments website starting in "mid-July."[http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/Physicians.html]

Prior to being able to check their data, physicians must register with CMS' Enterprise Portal, EIDM. Physicians can register with EIDM now, and the process can take several weeks to complete. EIDM matches information entered by users to information provided by Experian. "Out of Wallet" questions are also used to verify identity—these ask for private data and contain information pulled from your credit report such as: mortgage lender name, previous employer name, auto lender name.

Communicating with Physicians

We encourage companies to let physician clients know that they can register with CMS' EIDM[1] system. Physicians should also be encouraged to check the NPPES database to make sure their information is correct. Manufacturers' reporting obligations are based on National Provider Identifiers (NPIs), so accuracy is of upmost importance. CMS has just clarified that applicable manufacturers may rely on NPI information in NPPES as of **90 days** before the beginning of the reporting year. While it is not possible to keep past "versions" of NPPES due to the continual updates, each provider entry is date-stamped to include the date the entry was created, as well as the date of each update, which establishes the information available at any given time. [https://questions.cms.gov/faq.php?id=5005&faqId=10094]

Physicians working at universities must also be aware that because manufacturers will be disclosing their payments on a public website, there is now a possibility of discrepancies in self-reporting forms. A strong emphasis must be placed on accurate conflict of interest disclosure forms to ensure that physician faculty are properly disclosing all relationships. In the future, the Sunshine Act will provide CME companies the ability to check payment information submitted from CME speakers as well.

Accredited CME Exemption From Sunshine Reporting—State Medical Societies Included

The revisions to the CME exemption have created uncertainty surrounding how companies will handle reporting for accredited education. However, as noted above, the current Final Rule of the Sunshine Act includes an exemption for activities produced by CME providers accredited by the Accreditation Council for Continuing Medical Education (ACCME), which adhere to ACCME's Standards for Commercial Support. ACCME accredits organizations that offer CME primarily to national or international audiences, and also recognizes state and territory medical societies (SMS) as accreditors for organizations that offer CME primarily to learners from their state or contiguous states.

In order to dispel some confusion about whether state accreditors were also exempt under the Sunshine Act Final Rule, ACCME published in their Executive Summary of the March 2014 Meetings of the ACCME Board of Directors an article entitled *"CMS Open Payments: Communicating the Equivalency of the ACCME and SMS Systems."*[http://www.accme.org/sites/default/files/2014_03_Executive_Summary.pdf]

ACCME states: "Within the ACCME system, all accredited providers meet one set of standards and are accredited using an ACCME-determined process. All the accredited CME generated by a provider within the ACCME system (i.e., ACCME-accredited CME) meets the same requirements and standards." According to the statement, "[o]perationally, within the ACCME system, there is a distribution of responsibility for accreditation between the ACCME and its recognized state and territorial accreditors, based on the target audience of the providers (i.e., the ACCME conducts the accreditation of providers that have a national audience and the state medical societies conduct the accreditation of providers of CME for their state or contiguous states)."

ACCME clearly states: "The accreditor is the only difference between ACCME-accredited providers and state medical society accredited providers. **All the accredited CME events/activities presented by these providers are ACCME-accredited CME, and all ACCME-accredited CME is required to meet the same ACCME requirements. The ACCME has processes in place to ensure this identity and has data that verifies this identity.**"

Notably, while speaker payments—including lodging, travel, and meals—from national and state accredited providers are exempt from reporting requirements, other aspects of the Sunshine Act are less clear. For example, meals for attendees at CME programs are generally not exempt unless the CME provider serves only buffet style meals at a communal table. Reporting is also not required if

the CME provider segregates physician-paid attendance fees to cover the cost of food and beverages, whereby the physicians are essentially purchasing their own meals. Additionally, meals under $10 per person also do not require reporting. However, even if the payment for a meal is exempt (under $10), it still should be tracked in case the aggregate amount for the year exceeds the $100 limit.

Frequently Asked Questions

With just one week left for submission, CMS offered a long list of answers to Frequently Asked Questions (FAQs) to assist companies with the process. Many of the answers dealt with technical operations involved in the data submission process.

The following list represents only a few of the 27 FAQs, but they highlight some important aspects of the law going forward.

If an applicable manufacturer or applicable GPO later determines an error across all payments or other transfers of value for meals provided to a specific physician, could an applicable manufacturer or applicable GPO submit a negative value record to offset the error for all payment records regarding meals for the specific physician?

No, the Open Payments system **will not accept a negative value** for a payment or other transfer of value amount. Applicable manufacturers and applicable GPOs are responsible for submitting corrected information regarding their annual report in accordance with 42 C.F.R. § 403.908(h)(1). [https://questions.cms.gov/faq.php?id=5005&faqId=10054]

How does CMS plan to handle the dispute process from an IT perspective?

Physicians and teaching hospitals will be able to initiate data reviews and disputes through the Open Payments system during the review and dispute period, which follows the data submission period (and will begin in **mid-July, 2014**). Applicable manufacturers and applicable GPOs will be able to review disputed records and take action to correct the records and resolve any issues directly with physicians and teaching hospitals.

Any discussions pertaining to the resolution of a disputed record must take place outside of the Open Payments system between the applicable manufacturer/applicable GPO and physician/teaching hospital. For more information on the review and dispute process and timing, review the Open Payments website. [https://questions.cms.gov/faq.php?id=5005&faqId=10130]

Are attestations required as part of corrected record resubmissions?

If any records are resubmitted, the **entirety of the data for the program year** must be attested to again. [https://questions.cms.gov/faq.php?id=5005&faqId=10124]

Is an applicable manufacturer company that dissolves or is purchased by another company responsible for reporting in Open Payments?

If a company meeting the definition of an applicable manufacturer dissolves, it is still responsible for reporting in Open Payments for the period when it was an applicable manufacturer.

For example, if Company A meets the definition of an applicable manufacturer and is purchased by Company B, then Company A is responsible for reporting in Open Payments for the period prior to the purchase. However, if Company B meets the definition of an applicable manufacturer upon the purchase of Company A, it too is responsible for reporting in Open Payments beginning with the date of the purchase. [https://questions.cms.gov/faq.php?id=5005&faqId=10076]

Can a physician reimburse an applicable manufacturer for payments so that no information is reported about them in Open Payments?

Some payments or other transfers of value are excluded from reporting; however, **no exclusion exists for payments or transfers of value that are later reimbursed**. Review 42 C.F.R. §403.904(i)(1) for information on possible exclusions. [https://questions.cms.gov/faq.php?id=5005&faqId=10084]

Since NPPES data may be updated by physicians on an ongoing basis, at what point in time may applicable manufacturers rely on the data?

Applicable manufacturers may rely on NPI information in NPPES as of **90 days before the beginning of the reporting year**. While it is not possible to keep past "versions" of NPPES due to the continual updates, each provider entry is date-stamped to include the date the entry was created, as well as the date of each update, which establishes the information available at any given time. [https://questions.cms.gov/faq.php?id=5005&faqId=10094]

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[1] EIDM is the acronym for CMS' Enterprise Identity Management system which includes Identity Management, Access Management, Authorization Assistance Workflow Tools, and Identity Lifecycle Management functions

[2] According to CMS FAQ8390, the meals exception in 42 CFR 403.904(h)(2) only applies to situations where an applicable manufacturer provides a large buffet meal, snacks or coffee that are made available to all conference attendees and where it would be difficult to establish the identity of the physicians, who partook in the meal or snack. This exception does not apply to meals provided to select attendees at a conference where the sponsoring applicable manufacturer can establish the identity of the attendees.

Reality CPD
Your Guide to Which Way is Up!

Derek Dietze, MA, FACEHP, CCMEP
Associate Editor

Q: What are some pointers on writing better multiple choice questions for assessing knowledge change from CME/CE activities?

A: An essential component of knowledge outcomes assessment is the development of high-quality multiple choice knowledge questions for use pre, during and after CME/CE activities. In my search for evidence-based guidance on optimal multiple choice knowledge question design, I have come across several articles and resources, but few have been specifically focused on application within the CME/CE setting. The two most practical resources I trust are "AAFP Guidelines for Assessment Writing" from the American Academy of Family Physicians (AAFP)[1] (a brief summary designed to help AAFP faculty write multiple-choice tests for CME activities), and "Multiple-Choice Item-Writing Guidelines/Rules/Suggestions/Advice as Derived from 46 Authoritative Textbooks"[2].

Below is a summary of what I consider the top 10 do's and don'ts of multiple choice knowledge question writing. They are derived from the two previously-mentioned resources and informed by common problems I have found when reviewing (and seeing outcomes results from) thousands of pre/post questions from CME/CE activities.

Top 10 Do's and Don'ts of Multiple Choice Knowledge Question Writing for CME/CE Activities

1. Base each question on a specific learning objective and related activity content (ensure strong linkage).
2. Write short questions to minimize respondent reading time. This is especially important for questions administered through ARS (Audience Response System).
3. Avoid testing knowledge of medical trivia—keep the questions relevant to practice.
4. Avoid trick questions meant to mislead the respondent to answer incorrectly. The focus is knowledge assessment, not trickery.
5. Use either the "one best answer" or "one correct answer" format—avoid using "select the wrong answer" type questions or negative/double negative phrasing. Questions using negative phrasing can be confusing to respondents.
6. Avoid True/False and Yes/No questions (to avoid respondents getting the answer correct by chance half of the time).
7. Use four or five response options—no more, no less.
8. Use response options that follow grammatically from the question, are related, and are similar in grammar, length, and complexity. Breaking this rule can provide correct answer cues to the respondent.
9. Avoid the more complex response option formats (i.e., A and D, A and C, All of the above, None of the above, A, B and C). These formats can be very confusing and time-consuming.
10. Use incorrect answer options (distractors) that are accurate but do not fully meet the requirements of the question; options should never be implausible, trivial, or nonsensical.

While this list is a good start, I highly recommend review of the two resources in greater detail for more in-depth direction and insights.

If you have found any additional evidence-based rules and resources to be of help with your question-writing, please let me know at derek.dietze@improvecme.com so they can be shared with Alliance members.

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[1] American Academy of Family Physicians. AAFP Guidelines for Assessment Writing. 2013. http://www.aafp.org/dam/AAFP/documents/cme/faculty_development/assessments-writing.pdf Last accessed 8/4/2014.

[2] Multiple-Choice Item-Writing Guidelines/Rules/Suggestions/Advice as Derived from 46 Authoritative Textbooks. Source: Haladyna, T.M. and Downing, S.M. (1989). At taxonomy of multiple-choice item-writing rules. Applied Measurement in Education, pages 37–50. http://www.nova.edu/hpdtesting/ctl/forms/multiple_choice.pdf Last accessed 8/4/2014.

MOOCs: Professional Development Tools for CEHP Professionals

Wendy Turell, DrPH, CCMEP
PlatformQ Health

What's a MOOC?

Massive open online courses (MOOCs) and other forms of online open courseware have become tremendously popular in recent years and have created quite a stir in the world of higher education. Through these online educational platforms, non-profit and for-profit organizations, as well as universities, offer free education on various topics.

The vast majority of the courses do not offer university credit, although some do offer certificates of completion. Some of these courses are available for participation on demand at any time, while others require participants to enroll along with a cohort of students, within a specific timeframe. MOOCs deliver information in various ways including video, graphic presentations, documents and powerpoint style presentations. Many classes involve homework and other interactive elements such as peer grading, chat features, and question and answer opportunities with faculty. Synchronous (non-archived) courses are typically led by "live" faculty and can mimic a university course feel. Open courseware and other university-based offerings are more likely to include text-only material repurposed from university courses. While a potentially good resource, these types of offerings do require more self-pacing and independence from learners who may need to cull through material on their own, without guidance or thorough explanation (e.g.: PPT slides without audio or talking points may not give a learner the "full picture" of a lecture).

How Can You Benefit from a MOOC?

MOOCs may have many students—even tens of thousands—in one cohort, so don't expect individualized attention from a professor. However, if you are a CEHP professional who is looking to hone scientific, business, or data analysis skills, MOOCs and Open Courseware may be tools to help you on your journey. Learner retention has been reported to be a challenge for MOOCs (see *MOOCs: The evidence base, the implications, and the evolution,* this issue), however for motivated learners, these courses can be a great professional development resource.

Alliance members have already begun taking advantage of free online courses. Linda Coogle of Scitent Inc. informed the Almanac that she took part in two 6-week courses offered by the University of Virginia Darden School of Business through Coursera. One business strategy course, which included over 50,000 students in her cohort, delivered education through videos, slides, case studies, and recommended readings (all of which were available at no cost via online links). Linda reported that she has passed on information learned through the courses to colleagues via in-house trainings, and has otherwise applied skills acquired through the courses in her professional life.

Greselda Butler, who works in Professional Education at Otsuka America Pharmaceutical, desired to learn more about the clinical trial process in order to better understand her work environment and processes. She completed the course Design and Interpretation of Clinical Trials which was offered by the John Hopkins Bloomberg School of Public Health on Coursera. She stated she was motivated by her curiosity for the topic area, which she has held for some time, and for a desire to perform well at her job. Although she found the lack of structure inherent in the MOOC less desirable than traditional university style courses, she learned to adjust to the self-paced model by setting aside regular time prior to her workday to dedicate for the 2–3 hours per week needed to complete the course material. She reported that

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Ready to join a Special Interest Group?

Recently launched on the Alliance's Online Community, Special Interest Groups are designed to provide you with an opportunity get expert advice, provide support among your peers and contribute thought leadership on five key topics areas: Research, Technology, Advocacy, Quality Improvement, and Interprofessional Education. SIGs are a vehicle to advance your professional development and connect with your colleagues on mutual interests!

Learn more and join the conversations . . .

- RESEARCH http://community.ACEhp.org/ResearchSIG
- TECHNOLOGY http://community.ACEhp.org/TechnologySIG
- ADVOCACY http://community.ACEhp.org/AdvocacySIG
- QIS http://community.ACEhp.org/QISIG
- IPE http://community.ACEhp.org/IPESIG

You may join as many as you like!

taking the MOOC was "an excellent experience," and that she is already registered for another MOOC.

Shari Dermer of Med-IQ also took part in two Coursera offerings: Major Depression in the Population, and Instructional Methods in Health Professions Education, which were administered in conjunction with the John Hopkins Bloomberg School of Public Health and the University of Michigan, respectively. She was interested in her own professional growth in these topic areas, and (as a CME professional) was curious to see how the MOOC presented coursework and managed students. Although Shari's courses were offered within a specific timeframe, during each week of the courses she was able to choose when to view lectures, complete assignments, and access resources. She reported that this semi on-demand model was a good fit for her lifestyle.

Table 1 provides a list of recent and upcoming MOOC topics that may be of interest to Alliance members interested in professional development. You may wish to further explore the linked websites to discover other topics that may align with your professional interests. Happy learning!

TABLE 1: RECENT AND UPCOMING COURSE EXAMPLES

HOST	COURSE TITLE
Coursera	Instructional Methods in Health Professions Education
Coursera	Mathematical Biostatistics Boot Camp 1
EdX	Health in Numbers: Quantitative Methods in Clinical & Public Health Research
Coursera	Community Change in Public Health
Coursera	Diabetes: A Global Challenge
JHSPH Open CourseWare	Issues in Survey Research Design
JHSPH Open CourseWare	Introduction to Methods for Health Services Research and Evaluation
JHSPH Open CourseWare	Entertainment Education for Behavior Change
Udacity	Elementary Statistics
MIT OpenCourseWare	Qualitative Research Design: Design and Methods
Khan Academy	Influenza
EdX	An Introduction to Global Health
Khan Academy	Medicare Overview
NovoED	Mobile Health Without Borders

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THE ALLIANCE for CEhp AWARDS 2014 RECIPIENTS

Ensuring Appropriate Management of Associated Commercial Promotion with Live Activities

Michelle Montgomery, MA, CCMEP, Director of Continuing Education, Dannemiller, Inc.

The Accreditation Council for Continuing Medical Education's (ACCME) Standards for Commercial Support, Standard 4: Appropriate Management of Associated Commercial Promotion has been in place many years. According to the ACCME's 2013 Annual Report, CME Providers' income from advertising and exhibits grew more than 30 million dollars from 2011, so perhaps this topic should receive more attention in our professional conversation. Let's start with some definitions. The ACCME defines commercial support as financial, or in-kind, contributions given by a commercial interest, which is used to pay all or part of the costs of a CME activity. The ACCME also says that commercial exhibits and advertisements are promotional activities and not continuing medical education. Therefore, monies paid by commercial interests to providers for these promotional activities or items are not considered to be commercial support.

In short, commercial support helps offset the costs of conducting a CME activity. This may include items such as faculty honorarium and travel, meeting room rental, AV support, food and beverage, and development of marketing material. Even though all of the suggestions below are not specifically ACCME requirements, here are some best practice examples of ways that providers are ensuring compliance in keeping commercial promotion separate from education.

Internal Policies

Develop clear policies that can be provided to your staff, joint providers and partners that specify what is and what is not allowed.

Exhibitor/Advertising Agreements

Institute formal exhibitor and advertising agreements, similar to a commercial support letter of agreement. This will further address SCS 4.1 in that exhibits or advertising cannot be a condition of the provision of commercial support.

Commercial Interest Representative Agreements

Have all commercial interest representatives read, sign and agree to your onsite policies and requirements. This way there is no question as to what is permitted and what is not permitted.

Commercial Interest Monitoring

In addition to the agreement discussed above, you can also provide joint provider representatives and staff with a "cheat sheet" of what to look for onsite to stay in compliance should a CME provider representative not be able to attend the live activity. Make sure they understand the requirements beforehand, have them sign the form after the activity and include it in your activity file for documentation. Be prepared to handle if a commercial interest representative doesn't follow the guidelines and have a clear process for resolving any issues of non-compliance.

Advertising restrictions

Make certain that advertising in an activity program book or on a website does not contain any CME content, such as slides or abstracts. Review all of the material in conjunction with jointly provided activities including meeting marketing or registration websites, which are often overlooked.

No competition

Be vigilant that promotional activities don't compete with your CME activity. Exhibits should ideally be in a separate room or area and not part of the registration space or more importantly, the education space. Make sure your other promotional activities, such as product theatres conform to the specifications of ACCME SCS 4.2 so that they are kept separate from the accredited CME.

Proper signage

Provide clear notification to learners through posters and displays when there is a promotional activity that is not part of the CME activity as with corporate showcases and exhibits. Even further, if a non-CME satellite is included in your marketing brochure, include an obvious note that CME is not provided.

Clear definitions and acknowledgments

Call it what it is. Commercial support is received in the form of an educational grant from a commercial interest and requires disclosure to learners. Other support is a much broader category, which can include financial support from advertising, exhibits and non-commercial interest defined organizations. Although not required, disclosure to learners is still acceptable.

In conclusion, as some organizations allow promotional activities associated with accredited CME activities, we need to keep our policies and procedures in line with these practices. Continue to review internally what can be updated to bring your Program into better compliance. We want to thank the ACCME for reviewing this article for accuracy.

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E-Learning Made Easy: Content Authoring Applications for CE Professionals

Jeremy C. Lundberg, MSSW, CEO, EthosCE Learning Management System and DLC Solutions

The rapid evolution of content authoring software has dramatically changed the landscape of e-learning for the better. Gone are the days of spending months (and lots of money) to plan, design, and "hard code" a single elearning module. Today, applications, such as Articulate.com and Adobe Captivate, enable non-technical CE educators to create rich, highly interactive e-learning modules in hours right on their personal computers. Essentially, if you can use PowerPoint, you can build interactive courseware including simulations, virtual patient case studies, and much more.

Considerations When Selecting a Content Authoring Application

- What is the level of technical knowledge required by the author?
- Are the application features aligned to our overall educational strategy?
- What is the pricing model and type of licensing? Per administrator or learner?
- Does the vendor provide training and Help Desk (e.g., user community, video tutorials, FAQs)?
- Are incremental updates and product upgrades included?
- What course export formats are available? (e.g, SCORM, HTML5)
- Are courses displayed in a "mobile friendly" format?
- Can the courses be hosted in a learning management system (LMS)?

Keys to e-Learning Success

Regardless of the software application you choose, here are some recommended e-learning best practices to help guide your development efforts:

- **Education Plan**—As with every CE initiative, develop a formal education plan that defines learning objectives, needs assessment, course elements, etc. This document will serve to inform the rest of your elearning course creation process.
- **Storyboard**—Use PowerPoint or a similar application to create a complete storyboard of your course content, elements, and interactions. Have each slide represent a single screen and have some type of interaction at least every five screens to keep the learner engaged. In addition, you may also want to create a separate whiteboard flowchart to illuminate key content connections and interactions to your course development team.
- **Editorial**—Have content in final, "approved" format before you begin any software design and production efforts. You will save everyone a lot of time and money in minimizing the number of rounds required for revisions and review.
- **Production**—Once you have completed the above three steps, consider the content "locked" during your course production. Changing content while simultaneously programming will unnecessarily lengthen the production cycle and compromise version control.
- **Testing**—Have your stakeholders (e.g., learners, faculty, staff) "kick the tires" on the e-learning module in a test server environment and record and itemize issues within a system (e.g., Basecamp.com) to be addressed. There is nothing more frustrating for learners than to have course elements not work properly or staff not receiving the data points they were expecting from the courseware.
- **Implementation**—NEVER launch on a Friday or as you are heading home for the day. Murphy's Law dictates the something will go absolutely wrong and you don't want a buggy module out there for all the world to see. Set a formal launch date for the middle of the week, design and execute your marketing plan, and enjoy the success of your new, rapidly produced e-learning module.

E-learning opportunities are an expectation among healthcare professionals. Yet, the creation of such courseware, had historically been a challenge for many non-technical CE professionals. However, significant improvements within content authoring software industry (e.g., Articulate Storyline) have reduced these barriers and the CE community should leverage these new applications to create low-cost, high-impact courseware designed to advance patient care.

Accreditation Council for CME Publishes 2013 Annual Report

ACCREDITED CONTINUING MEDICAL EDUCATION PROVIDERS OFFER A DIVERSE RANGE OF EDUCATIONAL ACTIVITIES TO 24 MILLION PARTICIPANTS

The Accreditation Council for Continuing Medical Education (ACCME®) has released their 2013 Annual Report. The report shows a robust, stable system with 1,950 accredited continuing medical education (CME) providers. Accredited providers offered more than 138,000 educational activities in 2013, comprising more than one million hours of instruction. These CME activities educated more than 24 million learners, including physicians and other healthcare professionals.

For More Information

» ACCME Full Press Release

» ACCME 2013 Annual Report

» ACCME 2013 Annual Report Audio Commentary by Murray Kopelow, MD, ACCME President and CEO

» ACCME Annual Reports 1998–2012

MOOCs: The Evidence Base, the Implications, and the Evolution

Brian S. McGowan, PhD
ArcheMedX, Inc.

If you are like me, when it comes to innovation in educational models you might agree that substance trumps style. That is to say, that the buzz that surrounds an innovation can only tell us so much about whether the innovation is a bona fide improvement or not. But since it isn't always easy to separate fact from fiction in the midst of innovation, it seems good practice to do a little bit more digging so that we can fully understand what the data actually tell us. With this context, let's see if we can work through the evidence base behind what is surely the most buzz-worthy educational innovation in the last five year: MOOCs, or massive open online courses.

MOOCs were originally conceived and studied by a small group of educational technologists in Canada nearly seven years ago. The early work of Downes, Cormier, and Siemens led to number of very loosely structured online courses including: Social Media & Open Education (2007), Connectivism (2008), and Personal Learning Environments Networks and Knowledge (2010). With these courses the emphasis was on educators teaching other educators how to educate—a respectable, but not necessarily generalizable experience. For a more complete listing see Stephen Downes Partial History of MOOC's.[1]

By 2011, MOOCs began migrating to the US and were being piloted within higher education environments as an evolution of distance learning models. In several of these early examples learners could attend the course on campus for credit, or elect to be an "open participant"—participating through a patchwork of web-based videos and wiki projects. The idea was that a learner could join in whenever they liked and leave whenever they needed. Courses were often free (open) to anyone who wanted to take them, and the only requirement was an Internet-connected device.

Over time, the subject matter of the courses moved away from being purely 'for and by educators' as additional academic fields took to the task. In the fall of 2011, Stanford Engineering professors began offering three of the school's most popular computer science courses for free online—and the cat was officially out of the bag. The most popular of these courses is what put the 'M' in MOOCs, attracting 160,000 students from over 190 countries. In many cases, this is where the buzz began to overwhelm the substance.

Pedagogically, these earliest MOOC's from Stanford were in no way innovative. Watching video lecture recordings, reading course materials, completing assignments, and taking quizzes and an exam was no more pedagogically sound than other available learning models—the courses were bigger, but not necessarily better. These courses simply migrated campus-based didactic methods of teaching to the online environment. The scale of participation made it impossible for the educators to engage learners or for learners to effectively interact with each other.

So what do we really know about MOOCs?

In January of 2014, working papers were released which drew on data from 17 MOOCs offered by Harvard and MIT in 2012 and 2013. The first of the working papers, which was written jointly by researchers at both universities, provides an overview of the available data from those 17 MOOCs (principally Level One, Moore's). Findings include:[2]

- 841,687 people registered for the 17 MOOCs from Harvard and MIT.
- 5% of all registrants earned a certificate of completion.
- 35% never viewed any of the course materials.
- 66% of all registrants already held a bachelor's degree or higher.
- 74% of those who earned a certificate of completion held a bachelor's degree or higher.
- 3% of all registrants were from underdeveloped countries.

What do we make of these data? For one, completions rates consistently demonstrate that upwards of 95% of learners who begin the MOOCs are unable (or unwilling) to complete them and 75–90% never engage with any of the course content. Moreover, any argument about course content reaching and impacting those who would have never previously had access to the content does not seem to hold much water either. While by and large the MOOC courses have made it possible for enrollment of millions of students around the world, the reality is that a vast majority of the students who enroll are already 'over-educated'—raising concerns that MOOCs actually heighten the knowledge divide instead of overcoming it. As a result, academic leaders remain unconvinced MOOCs represent a sustainable model and only 30 percent of chief academic officers believe their faculty accept the value and legitimacy of new forms of online education—a rate lower than that recorded nearly a decade before.[3]

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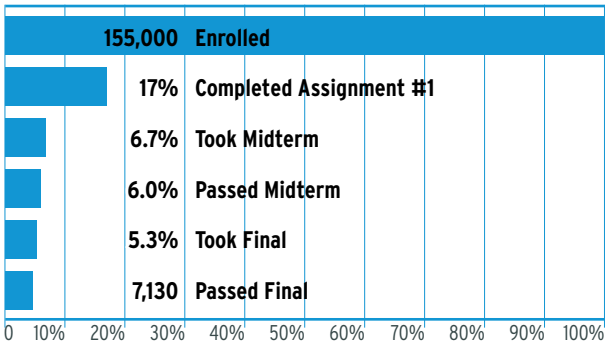
TO LOOK AT ONE MOOC IN A LITTLE MORE DETAIL[3]



Content dissemination does not equate to learning.

Unfortunately, this is where the MOOC model, like so many educational methodological innovations before it, falls short—engagement and learning lie in the complex workings of self-direction and motivation, something that no methodology can guarantee. Instead, educational modeling is simply a structure along which learning may take place. With too little structure the learner must do all the work themselves, and with too much structure the learners disengage, expecting to passive receive new knowledge.

Seen this way, MOOCs differ little from other forms of online learning if they are structured as a laundry list of things to do and therefore appear only marginally better than presenting learners with a bookshelf stocked with encyclopedias. As a result, we haven't learned anything new about online learning from the broadly available MOOCs (much like those explored in the data above). Instead, the types of real engagement and learning we need from MOOCs has yet to surface.

Learning is unequivocally a meta-cognitive experience. As educators therefore we are obligated in MOOCs (like lectures, or tumor boards, or problem-based workshops) to structure a learning experience that nudges learners beyond simple linear thinking to make connections to experiences and to other learners. As Morris and Stommel recently wrote,

"When we design, or begin thinking about designing, online or hybrid learning, we must not take anything for granted—including such instructional standards as the lecture, the discussion, the assignment, the assessment. We must remember that learning happens often without these things, and so adjust our thinking and design to make room for a more rampant sort of learning."[4]

In the end, it seems quite likely, given existing evidence that MOOCs may have a unique impact in niche situations—as described, characteristics of being 'massive' and 'open' ensure that content is broadly available; but they do not necessarily equate to efficient or effective learning.

Over time, MOOCs will evolve and we have begun to see innovations even within our own community. Organizations such as New Jersey Academy of Family Physicians (NJAFP) and the American Academy of Family Physicians (AAFP) have begun to experiment with a virtual course model that, like existing MOOCs, is curriculum based but unlike MOOCs is delivered within a more manageable and restricted online classroom of no more than 50 learners. This model of smaller online courses (SMOCs?) values community, connectedness, and social learning over 'massive' and 'open'—which intuitively might address many of the deficiencies clearly evident in the MOOCs that have come to date. Who's to say where these edtech innovations will lead after that? As long as we continue to do our due diligence and remain led by evidence versus hype, we can ensure that educational inventions have the impact that is so sorely needed.

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Non-clinical Leadership: A Changing Health Care Environment Underlines Radiologists' Need for a New Skill Set

By Pesha Rubinstein, MPH, CCMEP, Director of Education, American Medical Informatics Association

The Radiology Leadership Institute® (RLI) is a *non-clinical* educational program that the American College of Radiology (ACR) has been offering radiologists since 2012.

After several years of assessing hundreds of radiologists' educational gaps, the ACR determined that among these specialists' knowledge and competence deficits were topics that clearly fell outside the clinical realm. Technology was transforming radiology practice in terms of newly available professional tools, ethical storage and use of private health information, and office management. Looming on the horizon were federal requirements such as the HITECH Act (Health Information Technology for Economic and Clinical Health) of 2009—which included payment incentives for the incorporation of electronic health records (EHR) and Meaningful Use (MU). The Affordable Care Act of 2010 would bring another set of changes for clinicians to decipher and implement. In addition, ICD-10 will need to be incorporated at some point in the near future.

Many of these educational gaps concerned strategic planning, project management, financial planning, and change management—topics more frequently seen in business school rather than in medical school curricula. The ACR leadership, headed by Cynthia Sherry, MD, MMM, FACR, recognized that in order to function successfully in today's health care environment, radiologists would need solid business skills; thus the Radiology Leadership Institute formed and now Dr. Sherry is the RLI's Chief Medical Officer.

The **seven domains** of the RLI Common Body of Knowledge are: finance and economics, ethics and professionalism, legal and regulatory, strategic planning, practice management, professional development, and service, quality, and safety.

Dr. Sherry and her team, along with experienced professional development consultants, grouped topic areas that would be required by today's most competent radiology leaders into seven domains:

- finance and economics,
- ethics and professionalism,
- legal and regulatory,
- strategic planning,
- practice management,
- professional development, and
- service, quality, and safety.

Organized under the seven domains are 151 competencies, which form the RLI Common Body of Knowledge (CBK). The RLI deemed these 151 competencies critical to radiology leadership success. The RLI designed the institute to offer four progressive levels of leadership skill, from the lowest level of "Leadership Fundamentals," to "Leadership Proficiency," to "Advanced Leadership Proficiency," and up to "Leadership Mastery." Many of the courses in the Institute offer CME credit, but they all offer the Institute's own "RLI Credits," which learners accrue to achieve each of the four leadership levels.

Anne Marie Pascoe, the RLI's Director, points out that because most of the competencies focus on non-clinical skills, such as how to evaluate a contract between a radiology practice and a hospital it supports, the RLI embarked on partnerships with leading business schools, which today include Harvard Business Publishing, Babson College, and the Kellogg School of Management at Northwestern University. Pascoe says, "The secret to our success is that the knowledge, skills, and resources that a business school experience gives you are even stronger when put into a radiology context." For example, the RLI/Harvard Emerging Leaders Seminar is a 12-week, online synchronous course in which a cohort of 50 radiologists meets by teleconference for 90 minutes each week. The Harvard instructors discuss a topic from the RLI Common Body of Knowledge, but the lecture is preceded by a radiologist who orients the participants on how the business topic will relate to the radiology world in which they practice. Pascoe comments, "This filter gives participants the business skills they can immediately apply to their practice."

A general business course is preceded by a radiologist's introduction that orients the participants on how the business practice will relate to the radiology world.

Currently, over 1800 radiologists have enrolled in the RLI, 25% of whom are radiology residents. Pascoe notes, "The residents are our next generation of leaders. They are very focused on what they need to complete Level I or Level II." Practicing radiologists are more interested in specific RLI CBK topics, which they learn on a need-to-know basis.

The RLI has gathered its initial outcomes results through classic CME-type evaluations. Anecdotal feedback has been positive, too, with participants commenting that they are benefiting from the actionable lessons they are taking away from the courses to apply to their daily practice. The RLI plans to conduct more sophisticated outcomes assessments in the near future, and hopes to find RLI participants more engaged in leading grass roots initiatives as well as in contributing the radiologist perspective to health care reform initiatives.

Should other medical specialty societies perform needs assessments among their members as the ACR did, the finding might be that non-clinical leadership is an important content area for these practitioners as well. As technology advances and legislation continues to bring about rapid reform in US health care, organizations representing health care providers in all disciplines may find that studies in non-clinical leadership address educational gaps in their own constituencies.

For more information on the RLI, go to www.radiologyleaders.org.

Partnership and Collaboration in Executing a Successful Performance Improvement Initiative

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Mind the Gap

In 2012 and 2013, National Jewish Health (NJH), in partnership with Rocky Mountain Youth Clinics (RMYC), conducted a performance improvement continuing medical education (PI CME) program titled *Targeting the Atopic March: Managing Atopic Dermatitis*. The initiative was funded by an educational grant from GlaxoSmithKline.

RMYC provides comprehensive primary care and related services to thousands of medically underserved children and adolescents in the Denver metropolitan region. Healthcare providers (HCPs) at RMYC had identified practice gaps in diagnosing and treating pediatric patients with atopic dermatitis (AD), a chronic, relapsing skin disorder that is thought by many experts to be a precursor of other allergic diseases, namely asthma, allergic rhinitis, and food allergy.

The purpose of the initiative was to improve the assessment and treatment of RMYC patients with AD. The goals of the program were to provide evidence-based AD diagnosis and treatment education to clinicians, as well as to educate and activate patients toward effective self-management of AD. Critical to achieving these goals was the partnership between NJH and RMYC, as well as partnership with the National Eczema Association (NEA), a national, patient-oriented organization governed by a Board of Directors and guided by a Scientific Advisory Committee with a mission of improving the health and quality of life for individuals with eczema through research, support and education.[1]

Through collaboration, several interventions were developed for the initiative:

- A live, multidisciplinary training led by NJH faculty
- In-clinic training visits by NJH health educators
- Clinician support tools, including new EHR care prompts for AD
- Bilingual patient AD education materials, including some for tablets utilized in each clinic
- Custom patient AD resource website (www.theADZone.org)

Twenty-four physician, nurse practitioner and physician assistant healthcare professionals were involved in the initiative, as well as 39 other ancillary healthcare staff. In addition to the development of the activity as a PI CME initiative, the activity was also approved for American Board of Pediatrics Maintenance of Certification (MOC) Parts 2 and 4.

Educational Resources for Sustainability

To extend the education delivered in the first intervention—a live, multidisciplinary half-day course featuring didactic lecture, small group sessions and hands-on training—provider and patient education tools were introduced via nurse educator visits to each clinic within RMYC. Resource carts were developed for the exam room with both provider and patient resources.

Provider resources included an educational manual, a checklist of 15 indicators of quality AD care for use in AD patient visits, a quality of life assessment (the Children's Dermatology Life Quality Index or Infant's Dermatology Quality of Life),[2] an itch severity scale, and dolls and moisturizers for hands-on demonstrations. The checklist was condensed over the duration of the initiative to eight items that were incorporated into the RMYC electronic medical record for ongoing care of AD patients:

1. Educational material given (Y/N)
2. Last ED visit for eczema (date)
3. Is this an eczema f/u visit (Y/N)
4. Are you using any topical steroids (Y/N)
5. Has patient missed school days for eczema (number of days)
6. Was patient seen by a specialist for eczema (Y/N, date)
7. CDLQI/IDQoL (score)
8. Itch scale (score)

Patient resources included booklets focused on patient and caregiver AD education, developed in print and also for tablets featuring informative videos and quick tips. Through the partnership with the NEA, we were able to provide existing NEA patient education materials, as well as translation of some of the materials into Spanish, providing a new resource for the NEA to offer nationally. A customized patient resource website housed the AD Kids Zone, a site developed throughout the initiative with activities and information specifically for children.[3]

What Worked?

On the 15-item AD Visit Forms utilized to gather data over the full initiative (chart audits), HCPs evaluated their performance of key components of AD care before (Phase 1) and over the course of the initiative (Phases 2, 3 and 4). Checklist data showed immediate improvement on care indicators following the live, multidisciplinary training and sustained performance throughout the program (see Table 1, grouped into outcomes goals identified at the onset of the initiative.)

Participant survey data collected during and at the end of the initiative demonstrated that HCPs were successfully engaged and motivated to make changes in how they managed AD patients in their practices. Significantly, in a self-reflection survey at the end of the initiative, all (100%, n=15) said they were now better able to treat AD patients as a result of the program. All of these HCPs reported they were either "extremely skilled" or "somewhat skilled" in 6 out of 7 skills recognized as key elements of quality AD care. Most (60-93%) of these 15 HCPs reported that they had made either "some change" or "significant change" in

specific behaviors related to optimal management of AD patients as a result of the initiative. The majority (80-93%) of HCPs thought that the practice changes would be sustainable going forward.

Key Take-Aways

In addition to data collected at multiple time points, understanding successes and barriers from other qualitative perspectives was important. During in-clinic training visits to RMYC sites, NJH educators observed whether elements of quality AD care were (or were not) being implemented. They recorded their observations and shared them with the NJH and RMYC AD initiative leadership. These communications helped NJH to provide customized supports to each clinic and served as an informal feedback mechanism for the clinics.

Seeking out existing resources through patient advocacy groups extended the reach of this initiative, connecting the network of clinics to ongoing support well beyond the life of this particular activity. The healthcare professional self-assessment survey administered at the conclusion of the initiative showcased results congruent with the above observations (see Table 2): in a question addressing the importance of interventions in increasing provider confidence, educational resources for patients rose to the top, with 80% saying that the patient manual was "Extremely Important" and all (100%) considering the patient manual "Extremely" or "Somewhat" important. Sustainable practice redesign relies heavily upon the provision of patient resources for the healthcare staff with whom we work. To provide education addressing identified gaps sets the stage for better patient care, but critical to improving performance in practice is access to resources for patients, and in particular resources that activate the patient to get involved in their own care.

TABLE 1

Percentage of Self-Assessment AD Care Checklists Documenting Elements of AD Care

Indicator of AD Care	Phase 1 n=238	Phase 2 n=108	*Point Increase Phase 1 to 2*	Phase 3 n=143	Phase 4 n=154	*Point Increase Phase 1 to 4*
Outcomes Goal: Assess AD Severity						
AD severity assessed and documented	39%	78%	+39	76%	77%	+38
Itch scale used	1%	67%	+66	57%	51%	+50
Outcomes Goal: Incorporate Team-based Care						
Document visit to ED for AD in last 6 months	4%	8%	+4	5%	1%	-3
Referral made to specialist for AD	8%	4%	-4	12%	6%	-2
Outcomes Goal: Provide Patient Education						
Home management plan provided	52%	81%	+29	69%	66%	+14
Skin care reviewed	89%	97%	+8	94%	90%	+1
Home moisturizing plan reviewed	61%	93%	+32	85%	87%	+26
Chronic nature of AD reviewed	45%	80%	+35	83%	82%	+37
Potential AD triggers discussed	32%	66%	+34	62%	69%	+37
Outcomes Goal: Prescribe Medications for AD						
Received a topical corticosteroid	83%	85%	+2	86%	78%	-5
Non-steroidal topical drug recommended/prescribed	76%	73%	-3	34%	31%	-45
Oral anti-itch drug prescribed	16%	26%	+10	15%	25%	+9
Outcomes Goal: Arrange for Follow-up Care						
Follow-up plan discussed	52%	80%	+28	81%	80%	+28

TABLE 2

Importance of Interventions in Increasing Provider Confidence
Percent of Respondents (Count)

Question: "How important do you feel each of the following interventions were in increasing your confidence in treating AD patients?"	Somewhat Important	Extremely Important	Somewhat or Extremely Important
Patient manual	20% (3)	80% (12)	100% (15)
Live group training by NJH staff	40% (6)	47% (7)	87% (13)
Provider manual	33% (5)	53% (8)	87% (13)
Resource cart with baby/bath, extra materials	53% (8)	27% (4)	80% (12)
Individual clinic visits by NJH staff	40% (6)	33% (5)	73% (11)
Tablet loaded with e-resources for patients in the office	60% (9)	7% (1)	67% (10)
Life quality indexes and itch scales	40% (6)	7% (1)	47% (7)

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Upcoming Events

September 9–10, 2014

CBI'S 12TH ANNUAL INDEPENDENT MEDICAL EDUCATION AND GRANTS BREAKTHROUGH SUMMIT

PHILADELPHIA, PA

http://www.cbinet.com/grants

September 23–25, 2014

ALLIANCE QUALITY SYMPOSIUM

Data Driven Quality Improvement CE

BALTIMORE, MD

http://www.ACEhp.org

January 14–17, 2015

40TH ACEhp ANNUAL CONFERENCE

GRAPEVINE, TX

http://www.ACEhp.org

The Alliance for
Continuing Education in the
Health Professions

July 15, 2014

Dear Members,

Robin King will be leaving the Alliance to pursue new healthcare leadership opportunities after a 2-year term as our Executive Director. Under Robin's guidance the Alliance crossed important milestones in our Strategic Plan.

First, we moved our headquarters from Birmingham, Alabama to be closer to the pulse of U.S. healthcare policy makers and healthcare associations near our nation's capital, in Bethesda, Maryland.

Second, we expanded the organization to address members' needs for more advocacy, through establishing the Coalition for Continuing Education in the Health Professions, with its own *OneVoiCE* newsletter circulated beyond the current membership to an additional 1,500 regulatory leaders.

Third, we further expanded the organization to address members' needs for more access to research, quality & grants, through establishing the Foundation for Continuing Education in the Health Professions, with its own *AdvanCE* newsletter circulated beyond the current membership to an additional 9,000 quality leaders.

Last, we have assembled an Advisory Panel that is both inter-professional and inter-disciplinary to guide the development of a report to guide the most effective methods to integrate education into quality improvement efforts, our "QIE" program.

As Robin transitions out of his role, we are pleased to welcome an Interim Executive Director to the Alliance, Mike Saxton, MEd, FACEHP, CCMEP. Mike recently retired as Chief Learning Officer of the American Academy of Physician Assistants and brings over 25 years of experience and contributions to the field from serving in education leadership roles across various types of healthcare organizations. He has also built a record of volunteer activities, including: the Alliance's own Board of Directors, Chair of the Alliance's 2007 Annual Conference, and Editorial Board of the *Journal of Continuing Education in the Health Professions*. He can be contacted at msaxton@acehp.org.

In his Interim role, starting July 15th, Mike will guide the organization with an eye on stability for members, executing on the Board's Strategic Plan, successful delivery of Phase I of our QIE program, and a search for a full-time Executive Director.

Sincerely,

Destry Sulkes, MD, MBA
President
Alliance for Continuing Education in the Health Professions

Education advances medicine.

Medical education is the foundation of continuous professional development, leading to faster application of new science, improved practice, and better patient outcomes.

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