



Keynote Speakers Will Share Their Stories with Us at the 2013 Alliance Annual Conference

Shelly Rodrigues, MS, CAE, CCMEP, FACEHP, Maureen Doyle-Scharff, MBA, CCEMP, FACEHP and Mary Ales, BA, Alliance for Continuing Education in the Health Professions 2013 Annual Conference Committee

In designing your Annual Conference, the Conference Committee embraced the idea of story-telling and has selected three keynote speakers with important stories and insight to share. These speakers, while not nationally recognized in our CPD world, are recognized leaders in their own worlds: health care policy, patient safety, education and writing. Their experiences and expertise have direct bearing on our daily lives and pursuits, and their insight will trigger discussion throughout the conference and beyond. Let us proudly introduce the keynote speakers.

Thursday, January 30, 9:00–10:00 am, Edward O’Neil, PhD, MPA, FAAN



Edward O’Neil recently retired as the principal investigator for the California HealthCare Foundation’s Health Care Leadership Program. He also served as the Director

of the Center for the Health Professions, a research, advocacy and training institute created to assist health care professionals, health professions schools, care delivery organizations, and public policymakers respond to the challenges of educating and managing a health care workforce capable of improving the health and well-being of people and their communities.

The Center for the Health Professions houses a number of initiatives that are designed to understand and address the issues facing health care and health professionals. Dr. O’Neil served as the Principal Investigator for the Pew Scholars and Latin American Fellows Programs in the Biomedical Sciences, the Robert Wood Johnson Executive Nurse Fellows Program, and the California Workforce Initiative.

His thought-provoking stories about the changes necessary in interprofessional education, workforce allocation, and leadership will set the tone for the annual conference.

Friday, February 1, 8:30–9:30 am, Charles Denham, MD



Charles Denham is an internationally-renowned expert in the field of patient safety and quality improvement (QI). He utilizes stories as an integral part of learning, engagement and change.

Dr. Denham holds various academic appointments, and serves as editor of the *Journal of Patient Safety*. He is a founder and Chairman of the Texas Medical Institute of Technology, a non-profit medical research organization dedicated to drive adoption of clinical solutions in patient safety and health care performance improvement. Through his efforts, thousands of hospitals have been involved in the adoption of high impact performance improvement solutions. He also serves as Chairman of the Global Patient Safety Forum in Geneva, Switzerland, a convener of global health care leaders in high performance accountable health care, which affords him a unique perspective on the global health care stage and the movement toward efficiency and accountability.

His stories are personal. His lessons are invaluable. His insights on patient safety and storytelling can help the CE/CME/CPD community save lives.

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Saturday, February 2, 8:30–9:30 am, Margaret Edson, MA



Margaret (Maggie) Edson walks multiple paths, and her stories reflect all of them. She's a sixth grade teacher in Atlanta;

she's a partner and mother of two sons; she's a daughter and sister. And threading through all the paths, she's a storyteller and Pulitzer Prize winning playwright.

As a child she wrote and acted in amateur plays with neighborhood friend Julia Louis-Dreyfus. She graduated with a BA in Renaissance History from Smith College and received a master's in English literature from Georgetown University. Her jobs have included being a bicycle shop sales clerk and a volunteer English as a second language teacher.

Maggie's first play was *Wit*, first produced in 1995 at South Coast Repertory in California, about a John Donne scholar who is hospitalized for and dying of ovarian cancer. She used her work experience in a hospital as part of the background in writing the play. The play won her the 1999 Pulitzer Prize for Drama, was performed on Broadway in 2012, and was nominated for two Tony awards.

Maggie's stories, and the story of her characters, will inspire and give us the permission and push we need to think creatively about our roles in education.

A Rich Learning Environment

The eight themes for this year's annual conference span the education needs of Alliance members—from those new to our profession who may want an overall look at CME/CPD/CE to those who want to tailor an in-depth learning experience (in outcomes and research, for example). The keynote speakers will challenge us, the mini-plenaries on each day will bring the messages closer to our

world, and the breakout sessions will offer the practical information we need to implement what we learn on Monday. The pre-conference meetings, intensives, and member section activities will all expand our learning opportunities.

The Annual Conference Committee also gave a great deal of thought to the strategic priorities of the Alliance. In particular, we designed the meeting with our new membership groups in mind. We have embraced the expansion of our team much the way our members and learners have expanded their own practice teams. The committee selected abstracts submitted by all member segments—from medical and nursing to pharmacy. The interplay among the professions is highlighted in several of the breakouts. At the very core, we are all educators, and we celebrate the breadth of our experience and the differences we make in the education of the entire health team.

Sharing Our Stories

As you can tell from reading this, one of our goals for this annual conference is to share our stories. And, we're happy to begin by sharing the following stories with you.

On a recent call with expert faculty and learners to discuss curriculum, questions were asked of the learners about current practices and reasoning behind the practices. The expert faculty member listened and asked pertinent questions of the learners. When the call was over, the expert faculty member stayed on the line to debrief with a few educators. This expert began explaining how this process of discussing content with the learners gave him a new appreciation for educating based on learner needs. He stated, "This will change the way I educate physicians both at CME events and the medical center."

—Chris Larrison,
Healthcare Performance Consulting

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For ten years I have been a planner and faculty member in the American College of Cardiology Foundation's (ACCF's) biannual workshop, Presentation Skills for Emerging Faculty. We could barely come up with 20 nominees at the outset of this program. We just held the most recent workshop, where we had a cohort of 25 participants selected from a much larger pool of nominees. More than 100 young (at least younger than me) educators are now *emerging faculty*, who willingly give their time to the ACCF as teachers, committee members, and volunteers. The workshop still features improvement in presentation skills, including *real-time* practice with feedback, but perhaps the most important—and unanticipated—outcome of the program is the networking and peer-bonding that has occurred with each cohort. Health professions education doesn't exist without the educators, and these persons represent our future. We are in good hands!

—Marcia Jackson, PhD,
Education by Design

Share Your Story

We'd also like to share your stories. Please send them to us today at one of the following email addresses:

- Shelly Rodrigues
srodrigues@familydocs.org
- Maureen Doyle-Scharff
maureen.doyle-scharff@pfizer.com
- Mary Ales
males@ipmameded.org

Email editorial ideas to
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Multidisciplinary vs. Interprofessional Education: Design, Development, and Evaluation

John J.D. Juchniewicz, MCIS, CCMEP, American Academy of CME

Karen J. Thomas, MEd, FACEHP, CCMEP

Question: What is the difference between *multidisciplinary* and *interprofessional* education? Aren't they the same? Well . . . not exactly. Team-focused educational formats are being designed with more regularity within the CME/CE landscape. With an increased focus on bringing multiple disciplines together for an enriched educational experience, the terminology used to define the type of learning that is being fostered is sometimes unclear or is being used incorrectly.¹

The generally accepted definition of multidisciplinary education is having more than one discipline participate in an educational activity. This type of activity may have learning objectives that focus on providing knowledge for knowledge's sake, and may include discussion of new, updated guidelines, patient communication, non-role specific disease/diagnostic criteria, baseline treatment algorithms, and patient/disease management skills. By contrast, interprofessional education involves multiple types of health care professionals participating in a cooperative environment deliberately created to address specific educational goals. These types of activities focus on enhancing the collaborative skills of the total health care team, resulting in improved patient outcomes.²

Some activities designed for multiple groups of health care professionals would be categorized as multidisciplinary education. While these educational activities may target physicians, nurse practitioners, physician assistants, nurses, and pharmacists (or some combination thereof), they are not

designed to enable participants to learn from their colleagues in the other professions. Education that is focused on knowledge transfer and economies of scale are desirable, and a multidisciplinary educational design is completely reasonable.

Another key consideration for multidisciplinary education is the appropriate level of the activity's educational objectives. Are they appropriate for all learner types? Based on learner roles, should different educational objectives be developed specific to each profession? Does the educational content address the various learner types that you are targeting? It is important when planning educational activities that each discipline have generally accepted goals and objectives determined and accepted by each learner grouping.³

If your goal is to develop an interprofessional educational activity, it will require more than adding multiple certifications and listing multiple groups in the target audience. Interprofessional education takes into account the roles of the entire team and considers how each team member's responsibilities are linked to others.

Interprofessional education is systems-focused and may require customized objectives based on the defined roles specific to each learner type. The learning environment for the interdisciplinary team is typically designed to reach certain goals through the use of group/team-based, live activities that are designed to foster learner interaction to learn *from and about each other* and not just be in the room together.⁴

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The Elephant in the Room

Many health care professionals are challenged by an interprofessional learning environment because they were not trained in this manner.^{5,6} Thus, there are a number of barriers for planners to consider and overcome in order to deliver effective multidisciplinary and/or interprofessional education:

- Competing professional identities, values and professional/institutional cultures (including language and jargon)⁷
- Differences in professional routines⁸
- Stereotyping/lack of understanding about other professions⁵
- Professions protecting their territory^{9,10}
- Differences in accountability, payment and rewards.^{11,12,13}

It is important to note that these barriers exist not only among learners but also among the educational planning faculty. While the barriers are real, they are not insurmountable. To overcome barriers among learners, consider the following:

- Assist learners from different professions to define their roles/concerns (perhaps use a white board to have individuals from different professions list the roles and concerns in front of the group)
- Challenge learners to rethink how system changes will work in their setting
- Acknowledge how roles have changed or might need to change
- Think outside-the-box about educational design to find ways of promoting comfort in learning and helping individuals to learn from and about each other.

To overcome barriers among planners and faculty, consider the following:

- Eliminate committee titles like *activity chair*, or identify co-chairs to represent each discipline

- Recognize differences among professions and state them explicitly
- Dispel and challenge old patterns of thinking by preventing one member of the committee from making all decisions related to what the team members need to know. Manage content development and activity design responsibilities so that all planners have the opportunity to provide input. Be mindful of those who do not share actively in planning—they may be struggling with some level of intimidation.
- Periodically conduct a *reality check* to determine where everyone in the group is (or is not)—working together presents its challenges.

The Role of Accredited Providers as Educators

For multidisciplinary and/or interprofessional education to occur, each profession needs to know and draw on the others' expertise and capabilities in a patient-centered systematic approach.⁶ Therefore, as educators we should be using learning methods that encourage sharing of knowledge and counteract preconceived ideas.

We also need to help learners answer the question: *What's in it for me?* Let's be honest—we are asking more of learners in an interprofessional educational activity than many are used to. We are asking them to do something difficult—to step outside their comfort zone and approach education in a different way. If we want them to embrace interprofessional education, we need to help them see the *direct relevance* to their current or future practice. If we're not meeting their short-term learning needs, we should expect to confront resistance.

Making the Formats Work

A good place to begin is to reassess scope of practice. Educators,

faculty and learners can be out of touch in their thinking about scope of practice. They may need education about the current scope of practice of the professions you are looking to target.

Consider the team dynamic in educational design. This might involve one member from each profession/role serving as part of a learning group, having the actual team work together as a learning group, and/or having each member of the team stating their responsibilities and role.⁹ Utilizing interactive learning methods such as problem-based learning and role playing will help facilitate interactions that promote learning from each other.

Also, do not lose sight of the fact that you are part of the planning team. Prepare and educate planners and faculty about what interprofessional education is, what it is not, and its implications for instructional design. Provide clear instructions and foster participation of *all* planning committee members. At times, you will serve in the role of teacher, coach, organizer, planner, facilitator, and even referee. If you embrace these roles and apply the tools at your disposal, you will develop education that will significantly impact the health of patients cared for by your learners. Patient care is optimal when members of the team work in concert to deliver competent medical care.⁴

Evaluation and Outcomes

The educational continuum for all activities involves thinking with the end in mind. The end result should always be the focus and ultimate goal of efforts behind the educational planning and execution of an initiative. Designing evaluations for multidisciplinary and/or interprofessional educational activities is similar in many respects; however, interprofessional education

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presents evaluation results that represent the enhancement of team dynamics as well as the collaborative improvements of an individual. Activity evaluation design must take into consideration discipline-specific educational objectives and how the objectives compliment the goals of the team and roles of the alternating degree types. The inclusion of clinical decision questions may assist learners in the full appreciation and understanding of the keys steps that are role specific as well as patient diagnosis/treatment focused.

Outcomes measurement studies assist in measuring the overall impact of the education specific to behavior change modification, determination of readiness to change levels, and/or identification of barriers to change. They also provide opportunities to gauge further understanding from the individual learner's perspective on each discipline's role, reduce narrow-mindedness, and heighten awareness relative to the systematic approach to care.²

Conclusions

Multidisciplinary and interprofessional educational formats provide great educational opportunities for the total health care team. As learning coaches accredited providers must train and encourage faculty, from the planning stage through activity execution, to interact and transfer knowledge and competence across disciplines. To produce optimal outcomes success this interaction must transcend the activity level to the learner's environment. The inclusion of educational reinforcement tools to maintain and further the educational message would additionally sustain learning beyond the activity.

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Points for Practice

- Interprofessional education does not come naturally for many health care professionals.
- Educators need to plan and design activities to encourage interaction and knowledge transfer among health care professionals while counteracting preconceived ideas among learners.
- Interprofessional education activities should have direct relevance to current or future practice.

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Evaluating Grand Rounds: Challenges and Suggested Solutions

Pesha Rubinstein, BA, CCMEP, Almanac Assistant Editor

Many hospital CME program directors report that they face the challenge of collecting meaningful data from their regularly scheduled series (RSS) CME meetings. The main problem is event volume. Generally, in addition to many services having weekly grand rounds meetings, there are morbidity and mortality meetings, tumor boards, and case conferences, while some also plan conferences

and symposia that occur throughout the year. So many meetings, and so little time for evaluations. Participants get survey fatigue. How often have we seen attendees submit blank evaluation forms, or mark one long line through one rating for all questions?

Several hospital CME program directors have developed a number of strategies to stimulate the submission

of more robust, meaningful evaluation data for RSS meetings. Brooke Taylor, MPH, CCMEP, Director of CME at the Beaumont Health System, and Assistant Dean, CME, Oakland University William Beaumont School of Medicine, uses a simple evaluation card that works with an optical scanning system (see Figure 1). Taylor reports that simplified questions inspire participants to complete

Figure 1. Beaumont Health System CME Card (reprinted with permission)

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Staff ID Number	Meeting Number (See back)	Month	Year
0 <input type="radio"/>	0 <input type="radio"/>	<input type="radio"/> January	<input type="radio"/> 2011
1 <input type="radio"/>	1 <input type="radio"/>	<input type="radio"/> February	<input type="radio"/> 2012
2 <input type="radio"/>	2 <input type="radio"/>	<input type="radio"/> March	<input type="radio"/> 2013
3 <input type="radio"/>	3 <input type="radio"/>	<input type="radio"/> April	<input type="radio"/> 2014
4 <input type="radio"/>	4 <input type="radio"/>	<input type="radio"/> May	
5 <input type="radio"/>	5 <input type="radio"/>	<input type="radio"/> June	
6 <input type="radio"/>	6 <input type="radio"/>	<input type="radio"/> July	
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If you don't have a Beaumont Clinical Staff ID, enter your employee ID: <input style="width: 100%;" type="text"/>	If claiming less than the maximum number of credit(s), enter amount claimed: (see back of card) <input style="width: 50%;" type="text"/> . <input style="width: 50%;" type="text"/> (Example: 0.75)
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	Yes	No	
Presented without bias; no product promotion:	<input type="radio"/>	<input type="radio"/>	If no, describe:
My expectations & objectives of the presentation were met:	<input type="radio"/>	<input type="radio"/>	
Clinical content presented is consistent with accepted practices:	<input type="radio"/>	<input type="radio"/>	

I plan to make changes in my practice as a result of this session Yes No

If yes, please describe the changes: _____

Future topics for **this** conference: _____

Comments: _____

Submission of this card to the CME department will serve as attestation of attendance.

CME cards must be submitted within **30** days of the date of the meeting. After this date, CME cards will no longer be accepted.

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evaluations. However, the scanning equipment used with these cards will soon be obsolete, and Beaumont will then most likely move to an electronic web-based system.

Steven Kawczak, PhD, Associate Director for the Center for Continuing Education at the Cleveland Clinic, and Debra Jordan, MS, CCMEP, Director of Medical Education, Cook Children's Medical Center, rely on electronic systems to collect evaluations and to issue CME certificates. Both Cleveland Clinic

and Cook Children's condition the awarding of CME credit on the submission of evaluation surveys. Kawczak emphasizes the importance of engaging the activity's physician course directors in order to collect meaningful evaluation data. By encouraging the submission of intelligently completed surveys, the course directors get to review feedback that will help them improve their series. When participants see their feedback has been incorporated into the next activity, they are motivated to continue the conversation enabled by the evaluation form.

Jorden points out that Cook Children's program offers multidisciplinary activities that are CE-accredited for several health care professions. Because other accrediting organizations, such as the Accreditation Council for Pharmacy Education and the American Nurses Credentialing Center, mandate participant evaluation of each activity, her CME program evaluates each grand rounds meeting as a matter of course. To assess whether each service has achieved its RSS goals,

Jorden notes her institution does not rely on participant evaluation data alone. She says, "We've had more success by creating relationships with staff in Medical Records, QI/Risk Management, Research, Library, and the RSS specialty's statisticians." Physician course directors of each RSS at Cook Children's are required to submit a *brief exemplar, attestation, and/or data supporting the effectiveness of the past year's topics or case conferences in changing clinical practice or improving patient outcomes.*


With a smart phone or Blackberry® as omnipresent with physicians today as the doctor's black bag was in times gone by, it is inevitable that all CME management systems will be completely electronic. However, collecting thoughtful responses from participants requires engagement among the CME office, physician course directors and participants. This kind of communication produces the quality improvement loop that characterizes the most exemplary programs.

Points for Practice

To improve participant evaluation data collection for RSS activities, the CME program can:

- Simplify the evaluation instrument.
- Partner with physician activity course directors who will remind participants to submit meaningful evaluation feedback.
- Incorporate into policies and procedures an annual RSS evaluation tool for the physician activity course director to complete.
- Require evaluation survey submission rather than participant sign-in be a condition for the awarding of CME/CE credit.
- Partner with other stakeholders, such as Medical Records, QI/Risk Management, or the RSS specialty's statisticians, to get more of a 360° evaluation picture of the entire RSS series.

If none of these solutions will work for your program, go to the Communities tab at <http://www.acehp.org> to start a conversation on this topic.


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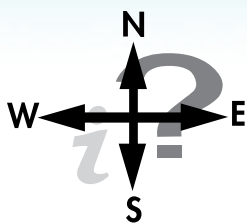
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Question

Does the Accreditation Council for Continuing Medical Education (ACCME) require a minimum pass/fail score for online activities?

Answer

The ACCME does not require post-tests for any type of CME activity except for journal-based CME. In journal-based CME, some sort of challenge must be presented to the learner that is based on the content of the educational activity. The ACCME does require participants to verify learner participation and evaluate all the CME activities. Therefore, some accredited providers choose to include a post-test for online activities as a way to comply with those two requirements.

In 2010 The American Medical Association (AMA) announced a

modification in the AMA Physician's Recognition Award and credit system that went into effect in July 2011. The modification requires that certified online enduring materials released after July 1, 2011 provide an assessment of the learner that measures achievement of the educational purpose and/or objective(s) of the activity with an established minimum performance level. This means that accredited online content must include a post-test based on the material's educational purpose and/or learning objectives. It is important to note that the requirement does not dictate a required pass/fail score; however, CME/CPD providers should establish a consistent minimum passing score for each activity and convey these requirements to learners in advance of the program offering. In

addition, the AMA requirements do not specifically dictate the number of required test items per activity. However, providers should generate a comprehensive tool that is reflective of the overall content and is reflective of the educational objectives and presented content.

Providers that produce online enduring materials must review each enduring material at least once every three years—more frequently if indicated by new scientific developments. Associated test items should be an integral part of the review and updated to ensure that the content is still up-to-date and reflective of any content alterations.

By Kolette Massy, MEd, CCMEP,
Assistant Editor

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Mission | The Alliance is a community of professionals dedicated to accelerating excellence in health care performance through education, advocacy, and collaboration.



Alliance for Continuing Education
in the Health Professions

Calendar of Events

November 14, 2012

Mid-Atlantic Alliance for Continuing Medical Education Fall Meeting
MedChi, The Maryland State Medical Society, Baltimore, MD

<http://www.maacme.org>

Registration now open

December 1–31, 2012

CCMEP Exam at local testing centers

<http://www.nccme.org>

Registration closes November 30

January 30–February 2, 2013

Alliance for Continuing Education in the Health Professions 38th Annual Conference

Celebrating Professional Advancement, Performance Improvement and Personal Growth

San Francisco Marriott® Marquis, San Francisco, CA

<http://www.acehp.org>

Registration now open

April 10–13, 2013

Society for Academic Continuing Medical Education Spring Meeting
Hosted by the University of Wisconsin

Fluno Center, Madison, WI

<http://www.sacme.org>

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