Appendix 1: Gaps, Needs Assessments, Objectives, Desirable Physician Attributes, and Outcomes

What's a Gap?

A *Gap* is the difference between current practice (what *is*) and the ideal, evidence-based practice (what *should be*).

Isn't that the same as a Needs Assessment?

No. A *Needs Assessment* is the supporting data showing the existence of the *Gap*. You can use a *Needs Assessment* to identify *Gaps*, or you can identify a *Gap* and then do a *Needs Assessment* to show how big the *Gap* is.

The *Needs Assessment* looks at individual practices that might be improved in order to make the *Gap* smaller.

THE GAP IS BROAD.

Example: The 30-day mortality rate for heart attack patients in Southwest Michigan is higher than the national 30-day mortality rate.

THE NEEDS ASSESSMENT IS NARROW.

Example: A retrospective study of discharge orders showed that, despite hospital protocol, they did not always include an aspirin regimen. A survey of hospital staff also indicated that discharge orders are not always clearly explained to patients. A retrospective study of follow-up appointments showed a high number of no-shows; there was a strong correlation between these missed appointments and increased mortality.

So how does that relate to Objectives?

The narrow points identified in the *Needs Assessment* show us what we might be able to focus on in a CME activity.

e.g. The *Needs Assessment* identified these three deficiencies: 1) Incomplete discharge orders, 2) Poor communication of discharge orders to patients, 3) Poor showing to post-discharge follow-up appointments. We can turn them into *Objectives*: Upon completion of this activity, physicians should be able to 1) provide complete discharge orders as indicated by hospital policy and 2) clearly communicate discharge orders to their patients.

But wait! What happened to #3?

Decreasing the number of no-shows at follow-up appointments isn't something that can really be addressed in a CME activity, so we'll have to address this problem another way, using a *Non-Educational Strategy*.

This means the *Objectives* for the CME activity are: Upon completion of this activity, physicians should be able to 1) provide complete discharge orders as indicated by hospital policy and 2) clearly communicate discharge orders to their patients.

Needs and *Objectives* should always go hand in hand.

And this is different from Desirable Physician Attributes how?

Desirable Physician Attributes are national standards that all practicing physicians should have. (See Appendix 2 for a table of the most commonly used *Desirable Physician Attributes*.) By achieving the *Objectives* you've identified for your CME activity, physicians should also have improved in one of these areas.

e.g. Using our example, physicians who attended this activity should have improved in the area of Patient Care and Interpersonal and Communication Skills (ACGME/AAMC).

On your application, you should indicate both the *Desirable Physician Attribute(s)* as well as the source (IOM, ACGME, ABMS, etc.). There are more *Desirable Physician Attributes* than those listed in Appendix 2. If you are focusing on a very specific specialty, you might want to look at that Board's competencies for their *Desirable Physician Attributes*.

So then, what are Outcomes?

Outcomes are the measure of what was achieved at the CME activity. There are seven levels of achievement:

1 – Participation

2 – Satisfaction

3 – Knowledge (either declarative or procedural)

4 – Competence

5 – Performance

6 – Patient Health

7 – Community Health

In the past, it was okay for CME activities to achieve levels 1-3. Today, we want CME to do more. We want to reach an *Outcomes* level of at least 4.

Objectives are what we *want* to happen. *Outcomes* are how we measure what *has* happened. We use the *Objectives* to identify what we want to measure in our *Outcomes* assessment.

e.g. *Objectives:* Upon completion of this activity, physicians should be able to 1) provide complete discharge orders as indicated by hospital policy and 2) clearly communicate discharge orders to their patients…

…become *Outcomes:* 1) Discharge orders include all indicated medication orders. 2) Patients better understand their discharge orders.

So how do we measure Outcomes?

There are multiple ways that we can measure whether or not *Outcomes* have been achieved. We can do Pre and Post Tests. We can do surveys that ask physicians whether or not they have changed their practice.

Surveys aren't the best way to measure *Outcomes*. Depending on the design of your activity, we may follow-up with you in 3, 6 or 12 months. We know what the initial status was because that was in your *Gap* and *Needs Assessment*. We may ask to see what that data looks like now. Again, depending on the design of your activity, this may mean we're able to measure *Outcomes* at levels 5, 6, or 7.

But isn't this data confidential? What about HIPAA?

This data is for internal use only so that we can measure the impact of a CME activity on a physician, hospital, or the community at large. We will never ask for PHI.

If you're concerned about confidentiality, there are many topics addressed in CME activities that might be related to data reported to the US Department of Health and Human Services. These data are publicly available on the HHS Hospital Compare website and should be acceptable measures for both planning a CME activity (*Gaps* & *Needs*) and while doing an *Outcomes* assessment after the activity is over.

What if the Outcomes assessment shows no improvement?

That's okay. That just means that we need to use a different strategy to address the *Gap*. It doesn't mean that physicians didn't learn anything at your activity. Most likely, it means that there are some *Barriers* that are preventing physicians from putting what they learned into action. This is a good time to do a physician survey to ask them what these *Barriers* are so that we can determine whether we need to use a different type of educational format or use *Non-Educational Strategies* such as posters, brochures, or emails to reinforce the needed change.

It probably isn't possible to completely eliminate a *Gap*. The goal is to improve and to continue to look for new ways to minimize *Gaps*.

Appendix 2: Desirable Physician Attributes

Standards for Desirable Physician Attributes can be found in multiple sources. Some of these sources have overlapping standards. In your application, you should indicate both the source(s) as well as the Attribute(s).

Source	ABMS/ACGME	Institute of Medicine (IOM)	Interprofessional Education Collaborative
Desirable Physician Attribute	**Patient care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health	**Provide patient-centered care** – identify, respect, and care about patients' differences, values, preferences, and expressed needs; relieve pain and suffering; coordinate continuous care; listen to, clearly inform, communicate with, and educate patients; share decision making and management; continuously advocate disease prevention, wellness, and promotion of healthy lifestyles, including a focus on population health	**Values/Ethics for Interprofessional Practice** – Work with individuals of other professions to maintain a climate of mutual respect and shared values.
	Medical knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences, and the application of this knowledge to patient care	**Work in interdisciplinary teams** – cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable	**Roles/Responsibilities** – Use the knowledge of one's own role and those of other professions to appropriately assess and address the healthcare needs of the patients and populations served.
	Practice-based learning and improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care	**Employ evidence-based practice** – integrate best research with clinical expertise and patient values for optimum care, and participate in learning and research activities to the extent feasible	**Interprofessional Communication** – Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to the maintenance of health and the treatment of disease.

Source	ABMS/ACGME	Institute of Medicine (IOM)	Interprofessional Education Collaborative
	Interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and other health professionals	**Apply quality improvement** – identify errors and hazards in care; understand and implement basic safety design principles such as standardization and simplification; continually understand and measure quality of care in terms of structure, process, and outcomes in relation to patient and community needs; design and test interventions to change processes, systems of care, with the objective of improving quality of care	**Teams and Teamwork** – Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient-/population-centered care that is safe, timely, efficient, effective, and equitable.
	Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population	**Utilize informatics** – communicate, manage, knowledge, mitigate error, and support decision making using information technology	
	Systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system for health care and the ability to effectively call on system resources to provide care that is of optimal value		

There are more Desirable Physician Attributes than those listed here. If you are focusing on a very specific specialty, you might want to look at that Board's competencies for their Desirable Physician Attributes.

Appendix 3: Disclosure Forms & Disclosure to Learners

To stay in compliance with the ACCME, we need to ensure that CME activities are free of commercial bias and that the individuals involved in developing CME activities have no conflict of interest (COI). In order to prevent potential COI, a process of disclosure has been created.

The disclosure process consists of two parts.

Part One
Every speaker and everyone involved in the planning of the activity must complete a *Disclosure Form*. This form is used to collect information about the possibility of COI. (Those involved in the planning of an activity include directors, planning committee members, abstract reviewers, staff members, coordinators, etc.)

Part Two
The information found on the *Disclosure Forms* must be shared at the activity. This is called *Disclosure to Learners*.

How do we make sure everyone who needs to complete a Disclosure Form has done so?

Electronic Submission
Disclosure Forms are completed and submitted online. The CE Office sends the request for completion via email. Each request contains a link to a website where the *Disclosure Form* is completed. The link is unique to both the activity and the person completing the form. Your link for an activity is different than my link.

When the form has been completed and the "submit" button clicked, an email message is automatically sent to the CE Office and to the Course Coordinator. That way we both know who has completed their form and who is still delinquent.

Annual Disclosure Process
Because so many individuals are involved in planning or speaking at more than one activity, they are asked to complete a blanket *Disclosure Form* each year. This means the CE Office doesn't have to send multiple requests throughout the year. And it also means people don't have to complete a new form each time they speak at Grand Rounds or join the planning committee for an annual conference.

WMed
WMed residents, faculty, staff, and students are sent a request to complete their forms in June. Their forms are valid July 1 – June 30.

Non-WMed
People who are not part of WMed are sent a request to complete their forms in December. Their forms are valid January 1 – December 31.

RSS Renewals

Most of our activities are Regularly Scheduled Series (RSS). These are renewed each November and are approved for credit from January 1 through December 31. On the renewal application, you will be asked for a list of planning committee members and their email addresses. This list will let the CE Office know who needs to be sent a link to complete a *Disclosure Form* for the upcoming year. Once all of your planning committee members have completed their forms (and assuming the rest of your renewal application is acceptable), credit will be approved for the calendar year.

Ongoing RSS

For most of our RSS, information about sessions, topics, and speakers are sent throughout the year. As you're scheduling new sessions, go to https://cmetracker.net/WMUMED/Login?formname=OutDiscAccess and check to see if the speaker has already completed a *Disclosure Form* for the year*. If they haven't, please send the speaker's name and email address to the CE Office, and they'll be sent a request to complete a form that will then be valid for the rest of the year.

*Your planning committee members should have been listed on your renewal application, so you already know that they've completed their forms for the year.

New Courses & New RSS

There's a good chance that the majority of people who need to complete a *Disclosure Form* for your activity have already done so. Before submitting a new application, go to https://cmetracker.net/WMUMED/Login?formname=OutDiscAccess and search for the individuals you've listed as speakers and planning committee members. If they've completed a *Disclosure Form* within the past 12 months, print a copy to include with your application and keep a copy for your own file.

On the application, you're asked to list the names and email addresses for all of your speakers and planning committee members. Put an X next to the names of those for whom you've printed off a completed form. The CE Office will send links to everyone else.

What does all of this have to do with Disclosure to Learners?

Everyone has completed a *Disclosure Form*, so we're done, right? Well, no. We still need to make sure that this information is shared at the activity.

What needs to be disclosed?

Everything listed on the *Disclosure Form* needs to be shared at the activity. This means the name of the person, the company they have a relationship with, and the nature of the relationship.

For example: Dr Smith owns stock in ABC Pharmaceuticals and is on the speaker's bureau for XYZ Manufacturing.

But what if people said they have nothing to disclose?

That needs to be disclosed, too.

For example: Dr Smith owns stock in ABC Pharmaceuticals and is on the speaker's bureau for XYZ Manufacturing. All others involved in the planning of this activity have no relevant financial relationships to disclose.

Where do I find that information?

Go to https://cmetracker.net/WMUMED/Login?formname=OutDiscAccess to pull up a PDF of a person's completed *Disclosure Form*. The information that needs to be disclosed is on page two.

How should I share this information at the activity?

The best way to *Disclose to Learners* is in writing. If you plan to have handouts at the activity, include a page with the disclosure information. You can put a disclosure statement at the top of the sign-in sheet. You can have a disclosure slide up on the screen as people come into the room and take their seats. This way you don't have to rely on one of your speakers to make a disclosure statement at the beginning of your activity.

So I can't share this information verbally?

Yes, you can. Just be prepared to do a bit more work after the fact to confirm that *Disclosure to Learners* took place.

Everyone completed a Disclosure Form and that information was Disclosed to Learners. Now what?

All that's left for you to do is submit proof of *Disclosure to Learners* to the CE Office.

Now you can see why we recommend *Disclosing to Learners* in writing. If you have a handout, slide, or sign-in sheet with the disclosure statement on it, you can send a copy to the CE Office. (And, yes, we welcome them as email attachments!)

But what if we didn't have a written statement? You said that was okay.

The CE Office still needs proof that *Disclosure to Learners* took place. You need to submit an Oral Disclosure Attestation Form. This form asks for details on what was disclosed and *must be completed by someone other than the person who made the disclosure.*

But if someone checks the "yes, I do have relationships to disclose" box, will we lose credit for our activity?

Don't panic. That just means that there's a potential conflict of interest that needs to be resolved before that person can participate in planning or speaking at a CME activity. And because people are filling out a Disclosure Form that covers multiple activities, that relationship might not be relevant to your activity. (E.g. They own stock in a company that manufactures insulin, but you're doing an activity on the brain tumors, so the relationship isn't relevant.)

But this does mean that the CE Office will follow up with that person. They may be asked to submit a copy of their presentation for review** or to limit their participation in the activity to areas outside where there is a potential COI. As long as the COI can be resolved, your CME for the activity will not be affected.

If a copy of the presentation is requested by the CE Office, it must be provided.

When does all of this need to be done?

30 Days In Advance
The list of people who need to disclose should be submitted to the CE Office *at least* 30 days before your activity.

2 Weeks In Advance
All *Disclosure Forms* should be completed.

1 Week In Advance
Any potential COI is resolved by the CE Office.

30 Days After
Proof of *Disclosure to Learners* should be submitted to the CE Office no more than 30 days after your activity.

What if I miss the deadline?
Because disclosure is such an important aspect of our accreditation, we will have to revoke credit for your activity. **In other words, don't miss the deadlines!**

Appendix 4: Interprofessional Continuing Education

What is interprofessional education?
Interprofessional education or IPE is "when students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes."[*]

Students from two or more professions? What does that mean?
We provide education, so the individuals who attend our activities are students. The healthcare team is made up of more than just physicians. Nurses and pharmacists are just two of the professions that work collaboratively with physicians to care for patients. If nurses or pharmacists attend one of our activities, they are students just like the physicians in attendance are.

Many of WMed's CME activities are already interprofessional. By expanding our mission, we can gather the data that will allow us to apply for Joint Accreditation for Interprofessional Continuing Education™. Achieving this accreditation will allow us to offer credit for more of our attendees.

What kind of data needs to be collected?
The planning process for educational activities classified as "interprofessional" must demonstrate:

- o   An integrated planning process that includes health care professionals from 2 or more professions.

- o   An integrated planning process that includes health care professionals who are reflective of the target audience members the activity is designed to address.

- o   An intent to achieve outcome(s) that reflect a change in skills, strategy, or performance of the health care team and/or patient outcomes.

- o   Reflection of 1 or more of the interprofessional competencies to include: values/ ethics, roles/ responsibilities, interprofessional communication, and/or teams/teamwork.

We track most of these items for our CME accreditation. We are simply expanding the professions that we are educating.

Our application has been revised to determine whether or not an activity is interprofessional. We will use this data to apply for additional accreditations.

How long will that take?
We need to collect 18 months' worth of data before we can begin the application process.

---

[*] Interprofessional Education Collaborative Expert Panel. (2011). Core Competencies for Interprofessional Collaborative Practice: Report of an Expert Panel. Washington, D.C.; Interprofessional Education Collaborative.

When will the new accreditations be available?

The application process takes a little over a year. If we are approved, the new accreditations won't be available until the middle of 2018.

Does this affect credits today?

No. We are still accredited by the ACCME. Our credits can still be used by nurses for their Michigan licensure.

What if my activity is only for physicians? Can I still apply for CME?

Yes. Although a lot of continuing education is focused on the entire healthcare team, there are times that it is best to focus on just one profession.

I'm designing an activity that is only for nurses? Can WMed provide credit?

Not yet. At this time, we can only accredit activities that are for physicians or are both for physicians and interprofessional. If our application is approved, we will be able to accredit activities that are designed just for nurses in addition to activities that are just for physicians.

You mentioned pharmacists. What was that about?

If we are approved, we will also be accredited to offer CPE for pharmacists. Joint Accreditation for Interprofessional Continuing Education™ is a collaboration between the ACCME, the ANCC, and the ACPE.[†] Achieving this accreditation will allow us to offer each of these three credit types separately or in any combination.

[†] ACCME: Accreditation Council for Continuing Medical Education
ANCC: American Nurses Credentialing Center
ACPE: Accreditation Council for Pharmacy Eduation