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World Congress on Continuing Professional Development 2016: Highlights from San Diego

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The global scope of the World Congress on Continuing Professional Development: Advancing Learning and Care in the Health Professions clearly indicates the broadening field of CPD in the health professions. Held in San Diego, California, March 17-19, the event underscored the importance of the need for continued improvements in the learning and teaching environments as well the clinical care and patient experience.

Convening every four years, the event grew out of the CME Congress established in 1988 as a major international meeting, primarily North American. The event is sponsored by the three major professional associations in the CE/CME/CPD field (the Tri-Group):

Society for Academic Continuing Medical Education (SACME)
Association for Hospital Medical Education (AHME)
Alliance for Continuing Education in the Health Professions (ACEhp)

This year’s Congress was co-chaired by Mary G. Turco, EdD, President, Society for Academic Continuing Medical Education, Consultant, Center for Learning and Professional Development Dartmouth-Hitchcock and the Assistant Professor of Medicine at The Geisel School of Medicine at Dartmouth and Robert Baron, MD, MS, Associate Dean for Graduate and Continuing Medical Education and the Professor of Medicine at the University of California, San Francisco School of Medicine. It was convened by the Tri-Group and led by a group of international leaders in medical education as advisors and an active Steering Committee and a number of the operational committees. The logistics were provided by the UC Consortium of Medical Schools.

The program was delivered over three gem-packed days and encored in five exceptional, thought-provoking speakers and sometimes controversial keynote presentations:

The opening keynote Why What We Do Matters: The Patient’s Story was delivered by Alicia R. Cole. This dramatic and moving rendering of a personal story that began with a series of medical errors and the long and brave road to recovery from a passionate patient advocate clearly placed the patient in the center of everything that was to happen at the Congress. (See related story at right)

Lorelei Lingard, PhD, a rhetorician and a prominent researcher from the University of Western Ontario, Canada delivered the second keynote and held everyone’s attention with Truths and Myths About Healthcare Teamwork and Their Implications for How We Understand Competence. Lorelei shared findings from her observations and research of different teams across the healthcare systems. Most of our training and CPD focuses on ensuring that we deliver highly competent individuals, but unfortunately these highly competent individual clinicians often end up delivering incompetent care to patients with complex needs. The dynamics of how individual competency differs from that of teams and the importance of the better system design continued through many sessions of the Congress.

Another exciting keynote, What Do We Need to Protect, at All Costs, in the 24th Century was delivered by a charismatic physician, educator, researcher, advocate and philosopher Alex Jadad, MD, DPhil, who leads the Institute for Global Health Equity and Innovation at the University of Toronto. Alex weaved his presentation through a dialog with the audience of approximately 500, with the help of technology. His innovative and refreshing approach and informal style resonated well with most, and clearly annoyed some. I think that he achieved his goal of making us think about the “human” side of medicine, as he posed the philosophical questions about what does it mean to be healthy, the goal of including patients in co-production of their health, and how to measure the meaningful outcomes of that approach.

Zeke Emanuel, MD, PhD, the Chair of the Department of Medical Ethics and Health Policy and the Vice Provost for Global Initiatives at the University of Pennsylvania, was perhaps the biggest star of the Congress. He delivered his remarks as an imperative and a call for radical changes needed in the approach we take to the development and delivery of education in response to the shifting healthcare horizon.

The endnote was provided by Stephen Downes, known as the originator of the Massive Open Online Course (MOOC). He is also a theorist and educator specializing in online learning technology, and he left us with his thoughts about the differences in learning that occur as a result of outside stimuli and deeply individualized personal learning, which can serve as an organizing principle of everything we do and share with our communities. Ultimately, “The Learning is in the Doing.”

For those who attended, the World Congress on CPD 2016 was an unforgettable experience. Those who were not able to make the trip should know that the Society for Academic CME (SACME) is sponsoring a JCEHP Supplement this fall from the proceedings of the Congress that will include manuscripts based on a number of key sessions. In addition, the plenary sessions of the program were recorded. Check the official website at www.worldcongresscpd.org for information about the archived webcast which should be available soon.

For me, this was an exhilarating professional and personal experience that spans two years of planning the program, working with dear colleagues and faculty from across the US, Canada and the world. I will never forget the excitement of seeing it all come to life.

Why What We Do Matters: The Patient’s Story

Patricia Levy, MS, CHCP, MCHES
Manager, Medical Education,
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Alicia R. Cole’s life changed dramatically in 2006 when a routine surgical procedure left her fighting for her life against sepsis, multi-drug resistant bacterial infections, and necrotizing fasciitis. Following a month in the ICU and six additional surgeries, the healthcare associated infection survivor endured nine years of aftercare. Hyperbaric wound care, physical therapy, and multiple other modalities were utilized to treat her infections and pain.

Ms. Cole told her story March 17, 2016 as a keynote address, Why What We Do Matters: The Patient’s Story, at the 2016 World Congress on CPD. In fact, Ms. Cole was still battling pain at the conference and was wearing a TENS unit to help combat the on-going disability left by these infections. Her message was that each and every one of us should utilize patient input in the design and implementation of our continuing professional development. Patients have knowledge and experience that can help to teach healthcare providers in all facets of their professional development.

As a result of her experience, Ms. Cole and her parents founded The Alliance for Safety Awareness for Patients (ASAP), a non-profit education and awareness organization working to eliminate preventable infections. Ms. Cole is a nationally recognized patient safety consultant, public speaker and patient advocate. She helped co-sponsor the California law mandating annual infection prevention education for all healthcare workers with patient contact and mandatory public reporting of hospital infection rates. She serves on the California Department of Public Health’s Healthcare Associated Infection Advisory Committee and was recently appointed by President Obama to the Presidential Advisory Council on Combating Antibiotic-Resistant Bacteria as a voting member.

Ms. Cole’s death-defying survival and incredible journey back to health is a living case study providing unmatched clinical experience to share with the medical community and propelling her passionate advocacy work.
More World Congress Highlights from San Diego
Mila Kostic, CHCP, FACEHP
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Beyond the keynote presentations, the World Congress on CPD 2016 included nine high quality and interesting invited plenary sessions. Topics included the Evolving Trends in Online Social Communities: Intersection in Patient Engagement, Care Coordination and Care Delivery by Joseph King, MD, MPH, Creating Quality in Healthcare Through Learning and Dissemination by Eric Holmboe, MD, Greg Ogrinc, MD, and Tina Foster, MD and Is the Hidden Curriculum Getting in the Way of Effective Interprofessional Education by Fred Hafferty, PhD, Joe O'Donnell, MD, and Richard Frankel, PhD. Craig Campbell, MD explored Competency-Based Curriculum in CPD, he was later joined by Graham McMahon, MD, MMSC, ACCME President and Chief Executive Officer, and colleagues in reviewing new ideas for CPD Without Boarders: Accreditation Around the World. Another international and global view was provided from a researcher, clinician and educator from Saudi Arabia, Samy Azer, MD, MEd who Explored Top-Cited and Most Influential Articles in Medical Education. Don Moore, PhD reviewed with the audience the growing area of interest in medical education theory, Adaptive Learning: Application of the Conceptual Model in CPD. Final invited plenary was delivered by Ajit Sachdeva, MD with his vision for CPD in the 21st Century.

A record response to the call for abstracts resulted in approximately 230 additional high quality presentations that were available to the participants. Over a hundred posters were presented during facilitated sessions throughout the Congress. Participants could choose from many concurrent sessions that include 27 best practice and 29 research oral presentations, 36 skill-building workshops and 16 innovation labs. These sessions were organized around the following tracks/themes:

- Workplace learning and improvement
- Learner engagement
- CME/CPD as full partner in rapidly-changing healthcare systems
- Interprofessional education for team-based care
- Delivering CPD internationally
- Faculty development
- Patients in CME/CPD for coproduction of health
- Engaging the local community in CPD
- Leading change/Adaptive leadership
- Supporting master adaptive learning expertise.

For those who came to pick some additional, practical tips, three clinics were offered, including one on practical tips for Using Twitter in CPD by Brian McGowan, PhD, another on Practical Pointers on the Road to Educational Research by Joan Sargeant, PhD and Tanya Horsley, PhD, and a third on Where to Submit My Manuscript from the Editor-In-Chief of JCEHP, Curtis Olson, PhD.

Barbara Barnes, MD and Mila Kostic, CHCP, FACEHP led an open-to-all session of the SACME Journal Club on the topic of Implications of Professional Identity Formation to CPD. The session will be repeated as a virtual journal club on June 20. Registration is available on the SACME website.

The first official day of the Congress concluded with a special tribute to Dave Davis, MD who retired this year from his role of the Director of Continuing Education and Improvement at the AAMC. Several moving and very personal notes were delivered by Robert Fox, PhD, Karen Mann, PhD and Michael Fordis, MD and a great welcome reception followed. In addition to this one, many opportunities were built in for networking such as daily Reflections and Connections sessions, and optional Friday Night On the Town.

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SURVeY TIme
Where would you like the 2017 and 2018 MAACME meetings to be located?
Click here to share your opinion today!

MAACME Annual Meeting
Thursday, November 17, 2016
Lehigh Valley Health Network
Allentown, PA
TED Talks for Med Ed

Maria Sullivan, Director of Office of Continuing Medical Education  
Warren Alpert Medical School of Brown University

CME providers are expected to incorporate educational formats that are appropriate to their activities’ setting, objectives, and desired results. Realizing the role that format plays in enhancing the learning experience and engaging audiences, one technique that can be considered is the TED-style talk.

Most everyone has heard of TED Talks, short, powerful talks, started by the nonprofit organization, TED. TED began in 1984 as a conference where Technology, Entertainment and Design would come together and today covers topics from science to business to global issues. The popularity of Ted Talks has led to businesses and organizations incorporating TED-style talks in their own settings. What sets the TED-style apart from the traditional lecture format is that the speaker delivers the subject matter in a storytelling style but very focused and concise, with passion and emotion and limited visuals.

Brown University’s CME Program has experimented with this type of format by offering an annual Med Ed Talks! as part of its Program in Educational Faculty Development. The purpose of this half-day event for medical educators is to:

- Raise awareness of and excitement about medical education
- Convey Med Ed content in bite-sized form
- Showcase talents of our community of medical educators
- Spark ideas for Med Ed projects

Mini-talks (10 minutes) on teaching and learning are presented by Brown academic and clinical faculty on an array of topics ranging from premedical to medical to resident education as well as exciting innovations, meaningful stories, BIG IDEAS, small gems, and novel perspectives. The event recognizes expertise, fosters excitement, inspires innovation, and creates community. A sampling of the topics presented at the 2015 Med Ed Talks! are: The Physician-Leadership Paradox, Social Media and Medial Professionalism, Unexpected Dangers of the EHR, and Teaching Medical Illustration to Medical Students.

Interprofessional Education: Good for You, Good for Your Institution

Molly Caldwell, Office Assistant, Lancaster General Health/Penn Medicine

Physicians and advanced practice providers (APPs) work closely with nurses, physical therapists, and other medical professionals every day – shouldn’t they learn together as well? As CME providers, we should be looking for opportunities for interprofessional education when appropriate. Not only does this satisfy ACCME criterion 20 (“The provider builds bridges with other stakeholders through collaboration and cooperation”), it also offers added value to your CME program and to other educational programs in your institution. Here are some tips for working with other professionals (in our case, nurses) to develop interprofessional education activities:

Is this event appropriate? Not all events for physicians and APPs are appropriate for nurses, and likewise, not all events for nurses are appropriate for physicians and APPs. The objectives should be applicable to the stakeholders you intend to invite.

Can we save trees and time? When we took a look at our institute’s CME application and nursing credit applications, they were strikingly similar. We decided to revisit both applications and make one joint application that satisfied everyone’s needs.

Who do we need to know? Before we started working with the nursing education department at our institution, we had very limited knowledge about who we needed to know to get nursing credit. We now have a good understanding of how the nursing education department is set up and what the process is to be approved for nursing credits.

So happy together: We invited a nursing education facilitator to join our CME committee. Our CME committee approves every application, so she is aware of all of our events and has been able to comment on which ones she felt were valuable to the nursing staff.

By following these tips, you should be able to streamline processes and bring about successful education programs for all involved.
Six Tips for a Successful Reaccreditation
Sarah Schott, Program Manager, AOE Consulting

At the onset, the reaccreditation process can seem daunting and complex. However, with proactive planning, accredited providers can drive their reaccreditation to be a seamless process embedded with opportunities for reflection and improvement of their CME program.

Where to start?

Reaccreditation is initiated by the ACCME which notifies the primary contact via e-mail approximately 15 months prior to a provider’s current accreditation term expiration. Accredited providers must confirm their intent to apply for reaccreditation, an electronic process that takes about five minutes.

Tip #1: If the electronic submission of your Confirmation of Intent to Apply for Reaccreditation is not done immediately upon receipt of the ACCME’s e-mail, set a calendar reminder so that this simple but important step isn’t forgotten!

Tip #2: Following this initial step, accredited providers should utilize the ACCME Reaccreditation Timelines and Provider Milestones to develop a comprehensive, internal timeline and reaccreditation plan. This plan should incorporate key ACCME deadlines as well as milestones for initial drafts, reviews, revisions and final document compilation. Additionally, this plan should identify key stakeholders and clearly delineate responsibilities throughout the reaccreditation process – consider who needs to review document drafts or provide input.

This internal project timeline formally kicks-off a provider’s reaccreditation process and should start at least nine months in advance of the accreditation term expiration. Providers may choose to kick-off their reaccreditation sooner by starting their project plan shortly after receipt of the ACCME’s initial e-mail.

What about reaccreditation deliverables?

The ACCME relies on three primary sources of data to determine if a provider’s CME program is in compliance with the ACCME Accreditation Criteria and Policies: the Self-Study Report, the Performance-in-Practice Review, and the Accreditation Interview.

Tip #3: While the Self-Study Report should thoroughly address each section and the questions imbedded within, succinctness and clarity should prevail.

To keep the Self-Study Report clear and concise, follow the what, why, how framework. In one-to-two sentences explain the policy or process (what). Next, in one or two sentences, articulate why this policy or process matters. Lastly, in two to three sentences, explain how the policy or process is utilized or applied.

The Performance-in-Practice Review consists of three stages: 1) submission of CME activity data via PARS (Program and Activity Reporting System), 2) ACCME selection of up to 15 activities based on activity data submitted, and 3) submission of evidence of performance-in-practice for all 15 activities. Note that the ACCME requires that providers select one approach for submission – either the structured abstract or the labels.

Tip #4: Audit each ACCME-selected activity utilizing a check-list that clearly outlines all necessary compliance elements. If your organization doesn’t already have a checklist, you can create one utilizing the following resources: the ACCME Accreditation Criteria, Standards for Commercial SupportSM, and the Performance-in-Practice Structured Abstract.

Tip #5: Organization, organization, organization! Approach the organization of reaccreditation deliverables from an ACCME Surveyor’s perspective. A surveyor will not be familiar with your CME program, so organize your materials in a manner that clearly paves the way.

Preparing for Your Interview

A provider’s reaccreditation journey ends with participation in an ACCME interview. As with any interview, preparation and practice are key. The ACCME expects providers come prepared to discuss the structure, goals and strategies of their CME program as well as strengths, accomplishments, and challenges as detailed in submitted materials. Providers should ensure that individuals responsible for planning and implementing the CME program are prepared to participate in the interview and speak to compliance with the ACCME’s Accreditation Criteria.

Tip #6: Prepare for an ACCME Interview by anticipating questions that surveyors might ask. Anticipated questions are best garnered through a formalized assessment of a provider’s CME program.

Overall, the reaccreditation process can be, and hopefully is, a valuable opportunity for growth and evolution of a provider’s CME program. Proactive planning, strong organization, and preparation can lead providers to a successful, stress-free (as possible!) reaccreditation.

We are looking for stories for upcoming issues. Email Roxanne at rbolinger2@lghealth.org if you are interested!
When planning your CME courses how often have you gotten an objective that goes something like this: “The instructor will explain the clinical manifestations of pancreatic cancer using a case study approach”? The problem with this type of objective is that it is really a teaching objective and not a learner objective, explained Laura Petri, PhD, RN-BC, Director of Education & Research at Saint Agnes Hospital, Baltimore. Petri presented her session on “Writing Better Test and Evaluation Questions starts with…” at the November 5 MAACME meeting in Wilmington, Delaware.

Before you tackle the evaluation and test questions for your CME activity, Petri noted that you must have well written objectives. The best learner objectives have three components:

- Learner: Description of the learner
- Behavior: What the learner will exhibit at the end of the instruction
- Content: The content to which the behavior relates.

The objectives should be measurable, complete, appropriate, relevant, and shared with students, she explained. Unfortunately, in addition to mistakenly offering teaching objectives, course directors or authors developing the objectives may incorrectly:

- Include more than one behavior in a single objective
- Forget to use all three components
- Use verbs that are not action oriented
- Add in unnecessary information or lists
- List behaviors that are unattainable or unrealistic

Once objectives are in order, you can tackle the evaluation and test questions. Petri noted that many evaluations CME planners offer center on the learner’s “reaction” to the event. These so-called “Happy Sheets” tend to focus on the learner’s happiness or satisfaction with the class, their perception of learning, the effectiveness of the teaching method and the effectiveness/knowledge of the presenter.

When designing evaluation of reaction sheets, course directors should:

- Know what you want to find out
- Design a form that collects quantitative data
- Determine acceptable standards
- Allow and encourage written comments
- Obtain immediate response.

Even better than evaluation of reaction, planners should consider actually evaluating the learning instead because it provides support for the program and is formative so you can restructure the program for future use. It is what attendees have learned in the moment. Some of the methods for evaluating learning are written exam, skills test, simulation, role play or case study.

Other evaluations you might pursue are evaluation of behavior (on the job). In this case the physician is observed with real patients to see if the physician is implementing the new behavior. Another option might be evaluation of results, which is the highest level of outcomes, where you are looking at patient care and physician performance.

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Tips for Writing Better Objectives, Evaluation and Test Questions
Roxanne Bolinger, M.Ed, CHCP, CME Manager
Lancaster General Health/Penn Medicine

Tips for writing multiple choice questions
With exams with multiple choice questions there is a stem (question) and several alternatives (which are the answer and distractors).

The stem should be clear and explicit to the problem to be solved. It should not include instructional information or negative statements. The alternatives should be similar in length, avoid the terms, “all of above,” “never,” “or” and “none of the above.” The answer should not have a clue and should be randomly assigned a position in the list. There should be only one clear, correct answer.

Test your skill on assessing these objectives:

“At the completion of the unit, the student will be able to understand the process of hemostasis.”

This objective doesn’t fly because the verb “understand” is not measurable, Petri noted, advising attendees to consult Bloom’s Taxonomy of Educational Objectives, which has a list of cognitive verbs stratified into six levels.

“At the completion of this course, the student will be able to describe the management of a patient with congestive heart failure”

This objective passes muster as it has all three components and uses a measurable verb.

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