

EDUCATIONAL PLANNING TOOL:
Designing a Regularly Scheduled Series (RSS)

This planning tool has been designed to guide you through the educational planning process and facilitate the collection of information required to complete the UC San Diego RSS accreditation application.

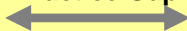
CME activities, including all RSS, are meant to foster the continuing professional development of physicians and other health care professionals. RSS must address educational needs defined by at least one professional practice gap (the difference between current practice and optimal practice) with the intent of changing physician competence, performance and/or patient outcomes (as opposed to merely increasing knowledge).

Effective design of an RSS requires understanding the professional practice gaps which need to be addressed, generating specific measurable learning objectives to bridge the gaps and meaningful evaluation to demonstrate the resulting practice improvements. *The major reason for planning your RSS should be to close the gap(s) you have identified.*

RSS offer the unique opportunity cover a complex topic over several sessions and to reinforce what was learned in previous sessions over time. Because of this, one need or gap could be the driver for one session, or for many. There may be one or more practice gaps that your series will need to address.

EDUCATIONAL PRACTICE GAPS / NEEDS ASSESSMENT

The planning process begins with a needs assessment to identify practice gaps in your target audience. A gap can be defined as the “difference between current and optimal practice.”

CURRENT/ACTUAL STATE		OPTIMAL/IDEAL STATE
What learners know and do	Practice Gap 	What learners should know and do

Following are some questions that may help identify areas in practice that your learners have difficulty with or find challenging:

- What data or sources are available that might identify areas where improvement is needed? (quality or departmental data, reports, chiefs, committees, or staff)
- What keeps your Chief up at night? Why?
- What are the most common cases seen in your department?
- Why do these problems/challenges exist? What is contributing to them?
- What are the key issues or obstacles to care you or your colleagues encounter?
- What kinds of clinical situations do you or your colleagues find difficult to manage or resolve?

EXAMPLE:

What is the current/actual state/?

Despite the fact that prophylactic mechanical and pharmacologic interventions have been shown to decrease the rate of VTE (venous thromboembolism) only one-third of all patients at risk for VTE who are appropriate candidates receive such therapy.

What is the optimal/ideal state?

All eligible patients should receive prophylaxis.

What is the gap this activity is attempting to address?

Two-thirds of eligible patients do not receive in-hospital VTE prophylaxis but should.

Using the process described above, clearly state the practice gaps this RSS will address.

The second step is to determine *why the gaps exist* and whether they are based on a lack of knowledge or competence, or are due to sub-optimal physician behavior (did the physician do something wrong or fail to do something). An effective needs assessment should identify why the professional practice gaps exist and what improvements in practice that are needed to close the gaps.

Is the need related to...

- Giving physicians new knowledge?
- Giving physicians new abilities/strategies?
- Helping physicians modify their practice?

This would be a gap in...

- Knowledge
- Competence*
- Performance

*Competence: being able to apply knowledge, skills, and judgment in practice (knowing how to do something)

EXAMPLE:

Lack of Knowledge: Clinicians are unaware of benefits or methods of prophylactic mechanical and pharmacologic interventions, which have been shown to decrease the rate of VTE.

Lack of Competence: Clinicians are unable to implement prophylaxis in different clinical settings, or lack the ability to counsel patients, or work in teams and advocate for organizational change.

Lack of Performance: Systematic improvements may be needed to elicit and increase use of prophylactic mechanical and pharmacologic interventions (such as electronic reminders, preprinted orders, etc.).

Select all that apply	Why do the practice gaps exist and what are the underlying educational needs?	
<input type="checkbox"/>	Lack of Knowledge	
<input type="checkbox"/>	Lack of Competence	
<input type="checkbox"/>	Lack of Performance	

The third step is to indicate what sources and kinds of information (needs assessment data) you used to identify the gaps and determine the cause of the gaps.

Note that at least two different sources must be used, such as patient care indicators; quality improvement data; scientific evidence from the literature; opinion from clinical or scientific experts; information from the general public, the media and/or other environmental sources; observed data from local or national databases; and/or surveys from past participants or prospective learners. Whenever possible, quality improvement and/or patient safety data should be included as a component of the needs assessment. You will be required to provide supporting documentation for all sources selected.

Select all that apply	Source	Examples
<input type="checkbox"/>	ACGME Competencies	www.acgme.org
<input type="checkbox"/>	County, State and Federal Sources	APHA, www.apha.org
<input type="checkbox"/>	Expert Faculty Opinion	Summary of notes; minutes of meetings; list of expert names and summary of recommendation(s)
<input type="checkbox"/>	Focus Groups	Summary of meeting minutes discussing information related to areas of educational need/topics of interest
<input type="checkbox"/>	Institute of Medicine (IOM)	www.iom.edu
<input type="checkbox"/>	Literature Review	Abstracts, full journal articles, government-produced documents describing educational need and physician practice gaps.
<input type="checkbox"/>	Medical Chart Review	Audit reports; chart reviews
<input type="checkbox"/>	Morbidity and Mortality Data	www.cdc.gov/mmwr/

<input type="checkbox"/>	National Practice Guidelines	NIH, www.guideline.gov
<input type="checkbox"/>	New Medical Knowledge	Description of new procedure, technology, treatment, etc.
<input type="checkbox"/>	Patient Safety Data	Description of the safety goal and current data statistics
<input type="checkbox"/>	Prior Activity Feedback	Summary of requests or surveys showing information related to areas of educational need/topics of interest
<input type="checkbox"/>	Quality Improvement Data	AHRQ, www.ahrq.org
<input type="checkbox"/>	Research Findings	PubMed, http://www.ncbi.nlm.nih.gov/pubmed/
<input type="checkbox"/>	Other (please describe)	Association or Foundation sites regarding the topic area

The final step in the practice gap analysis/identification of needs is to summarize your data and provide a short description of the needs assessment process you performed. You will want to provide an overview of **where** you retrieved your data, **what** information was extrapolated, and **how** it was analyzed and synthesized. This commentary will be reviewed to ensure that the identified gap is clearly supported by the data sources selected.

EXAMPLE:

Almost all hospitalized patients have at least one risk factor for VTE and approximately 40% have three or more risk factors. Without thromboprophylaxis, the incidence of objectively confirmed, hospital-acquired DVT is approximately 10-40% among medical or general surgical patients and 40-60% following major orthopedic surgery. It is estimated that of the more than seven million patients discharged from 944 American acute care hospitals, postoperative VTE was the second most common medical complication, the second most common cause of excess length of stay, and the third most common cause of excess mortality and excess charges. The mortality, acute and long-term morbidity, and resource utilization related to preventable VTE strongly supports effective prevention strategies, especially for moderate- and high-risk patients. Finally, a vast number of randomized clinical trials over the past 30 years provide irrefutable evidence that primary thromboprophylaxis reduces DVT and pulmonary embolism (PE), and that fatal PE is prevented by thromboprophylaxis. PE is the most common preventable cause of hospital death, and its prevention is the number one strategy to improve patient safety in hospitals. Routine use of thromboprophylaxis reduces adverse patient outcomes while, at the same time, decreasing overall costs. The substantial clinical evidence is, that if appropriately used, thromboprophylaxis has a desirable benefit-to-risk ratio and is cost-effective.

Despite the overwhelming research trials and guidelines published in the past two decades, adherence to these evidence-based strategies and recommendations has been low in the US and internationally. Several reviews have shown that recommendations from clinical practice guidelines have only been moderately effective in changing clinical practice.

Suggestions for ways to improve adherence to guideline recommendations by physician users include more education, increasing exposure to the guidelines, simplifying the guidelines and making them clearer to the practicing health care provider. This activity will attempt to educate physicians and other health care providers about the screening guidelines, and raise awareness of VTE risk factors, and benefits and risks of current and emerging therapies.

Example References

National Quality Forum: National Voluntary Consensus Standards for Prevention and Care of Venous Thromboembolism: Policy, Preferred Practices, and Initial Performance Measures.

http://www.premierinc.com/safety/topics/Venous-Thromboembolism/downloads/5_NQF-VTE-Vote-draft22707b.pdf. Accessed 6-22-10

Health Technol Assess 2004, 8(6):1-72 Grimshaw JM, Russell IT: Effect of clinical guidelines on medical practice: a systematic review of rigorous evaluations.

Lancet 1993, 342(8883):1317-1322. Grimshaw J, Freemantle N, Wallace S, Russell I, Hurwitz B, Watt I,

Long A, Sheldon T: Developing and implementing clinical practice guidelines.

J Gen Intern Med 2006, 21(Suppl 2):S14-S20. Grol R: Improving the quality of medical care: building bridges among professional pride, payer profit, and patient satisfaction.

JAMA 2001, 286(20):2578-2585. Lugtenberg M, Burgers JS, Westert GP: Effects of evidence-based clinical practice guidelines: a systematic review.

Clancy, CM. Testimony before the Joint Economic Committee: Arming health care consumers with better information and incentives. (Available at: (<http://www.hhs.gov/asl/testify/t060510a.html>)). Accessed October 1, 2009.

Summarize your data and provide an overview of the needs assessment process

DESIRED OUTCOME(S)

All CME activities should strive to **increase competence, improve physician behavior and/or patient outcomes**. The major reason for planning your CME activity should be to close the gaps you have already identified. The activity's desired results should link back to the cause of the practice gaps. Note that while increased knowledge is an acceptable need for the activity, knowledge alone is not considered by the current accreditation system to be a sufficient outcome. At a minimum, the goal of the activity should be improved competence. *Only include desired outcomes that you actually plan to evaluate and monitor.*

Increased Competence: Giving physicians new abilities/strategies.
 Improved Performance: Helping physicians modify their practice.
 Improved Patient Outcomes: Providing tangible improvements in overall health and patient outcomes as measured by reviews of clinician practices.

EXAMPLE:

Competence: The ability to identify patients eligible for prophylaxis, the ability to counsel patients, or ways to advocate for organizational change.

Performance: Screening more eligible patients and administering prophylactic treatments.

Patient Outcomes: Decreased rates of VTE or death.

Select all that apply	Considering the practice gaps identified, what is the desired outcome of the activity? What improvement is needed to close the gap?	
<input type="checkbox"/>	Increased Competence	
<input type="checkbox"/>	Improved Performance	
<input type="checkbox"/>	Improved Patient Outcomes	

LEARNING OBJECTIVES

When you have identified the practice gaps, educational needs, and the desired outcomes for the activity, it is time to develop learning objectives. **Visualize the learning objectives as “stepping stones” that enable you and your faculty to take the learner from the identified educational needs to the desired outcomes.**

Learning objectives must be measurable and written from the perspective of what you expect the learner to do in the practice setting with the information you are teaching. As such, objectives should contain action verbs and criteria that help activity planners evaluate whether the gaps were closed (i.e., whether the activity helped increase competence, improve physician behavior and/or improve patient outcomes). Verbs that are commonly used but should be avoided include: know, learn, understand and appreciate.

When writing your objectives, consider the following:

- *Do objectives define a concrete, observable, measurable behavior you expect learners to exhibit?*
- *Do objectives logically lead to accomplishing the final desired outcome?*

Typical activities list approximately 1-2 learning objectives per practice gap, or 3-4 learning objectives per overall series.

EXAMPLE:

Upon completion of this RSS, participants should be able to:

- Describe and implement current guidelines for VTE prophylaxis
- Perform an effective problem-focused history and physical examination for evaluation of eligibility for VTE prophylaxis
- Describe and implement systems which have been shown to increase selection accuracy
- Improve rates of implementation for VTE prophylaxis

**Based on the identified gaps and the desired result,
what are the learning objectives of the activity?**

In addition, UCSD CME utilizes global learning objectives that are applicable to most RSS. Please indicate which of these objectives apply to your series:

- Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
- Demonstrate application of scientific methodology to clinical situations
- Know and apply the basic sciences which are appropriate to your discipline
- Demonstrate effective communication skills with patients, families and professional associates

DESIRABLE PHYSICIAN ATTRIBUTES / CORE COMPETENCIES

All CME activities, including RSS, need to be developed in the context of desirable physician attributes/core competencies. The application will ask you to select all that apply.

ABMS/ACGME

- Patient Care**
Provide care that is compassionate, appropriate and effective treatment for health problems and to promote health.
- Medical Knowledge**
Demonstrate knowledge about established and evolving biomedical, clinical and cognate sciences and their application in patient care.
- Practice-based Learning and Improvement**
Able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence and improve their practice of medicine.
- Interpersonal and Communication Skills**
Demonstrate skills that result in effective information exchange and teaming with patients, their families and professional associates (e.g. fostering a therapeutic relationship that is ethically sound, uses effective listening skills with non-verbal and verbal communication; working as both a team member and at times as a leader).
- Professionalism**
Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to diverse patient populations.
- Systems-based Practice**
Demonstrate awareness of and responsibility to larger context and systems of healthcare. Be able to call on system resources to provide optimal care (e.g. coordinating care across sites or serving as the primary case manager when care involves multiple specialties, professions or sites).

Institute of Medicine

- Provide Patient-centered Care**
Identify, respect, and care about patients' differences, values, preferences, and expressed needs; listen to, clearly inform, communicate with, and educate patients; share decision making and management; and continuously advocate disease prevention, wellness, and promotion of healthy lifestyles, including a focus on population health.
- Work in Interdisciplinary Teams**
Cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable.
- 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.

- 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; and design and test interventions to change processes and systems of care, with the objective of improving quality.
- Utilize Informatics**
Communicate, manage knowledge, mitigate error, and support decision making using information technology.

Inter-professional Educational Collaborative

- Values/ethics for Inter-professional Practice**
Work with individuals of other professions to maintain a climate of mutual respect and shared values.
- 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.
- Inter-professional 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.
- 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.

Other Competencies

- Please specify: _____

BARRIERS

Your RSS should give consideration to the system of care in which the learner will incorporate new or validate existing learned behaviors. What potential barriers do you anticipate the learner may encounter when trying to make the changes this activity is designed to promote? How can you address those in the activity delivered?

- Cost
- Lack of Time to Asses/Counsel Patients
- Lack of Administrative Support/Resources
- Insurance/Reimbursement Issues
- Patient Compliance Issues
- Lack of Consensus on Professional Guidelines
- Formulary Restrictions
- No Relevant Barriers
- Other:

OTHER FACTORS TO CONSIDER IN THE RSS PLANNING PROCESS

Content

The topics chosen and the content developed should help the learner close the gaps identified, to ultimately achieve the desired outcome of increased competence, improved performance and/or patient outcomes. For example, if your gap is designed to address the issue of hospital acquired infections and the fact that 40% of patients acquire an infection in the hospital, the content developed may focus on hand washing, surgical techniques, equipment processing inside your institution, etc. The content would be driven by that single professional practice gap of hospital acquired infections and their role in it.

Instructors/Faculty/Participants

Faculty should be selected only after the content has been chosen and the educational methodology has been determined. You should select faculty who are best prepared to teach the activity that you have planned. For many RSS, there are no instructors but rather multidisciplinary teams discussing the care of patients and lessons learned. In those cases, your “faculty” is made up of those health care practitioners participating in this discussion and we ask that you submit a list of the department staff and other care teams involved.

Non-Educational Strategies

Obviously, education of health professionals is only one strategy that should be used to improve patient safety and healthcare quality. Importantly, there are many non-educational strategies that may play a crucial role in improving quality. This is especially true when one considers the gaps that can best be addressed with “system-level” interventions. As such, identification of non-educational strategies may help close the identified gaps. Examples of non-educational strategies include patient reminders, order sets, computer decision support systems, guidelines, etc.

Evaluation Tools/Outcomes Measurement

In order to determine whether the identified gaps have been closed, the activity must be evaluated. Similarly, the evaluation methodology must match the type of gaps that were initially identified. For example, an activity designed to change the behavior of a physician should not be limited to a post-activity survey that only asks whether participants were satisfied with the quality of the handout materials. The RSS application will ask you how you plan to evaluate the outcome of your activity.