Designing Interprofessional Continuing Education for Impact

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Current Health Care Environment
Teamwork could have saved baby

A CORONER has savaged Mil- 
ton Keynes Hospital's mater-
ning department at an inquiry 
into a baby's death.

This comes 15 weeks after a 
Healthcare Commission report 
ruined its services for UK's 
trust.

Hospital obstetrics and gynaecology consultant Dr Kim 
Dowd said baby Y's death could have been prevented 
and there were two earlier cases.

Instead, warnings - including○ serious errors - high 
erroneous - were ignored.

More than 40 Luton care gave 
birth to baby at five hours after 
being admitted. This week's 
report has been told.

Dr Dowd said, in hindsight, 
we should have performed the 
C-section.

Resident also suggested 
patients born at weekends, like 
Y's, are at greater risk - no 
decision-making consultants 
usually are not called.

Dr Dowd also said “one of the 
errors that were made was not 
notifying the consultant.

Y's parents have not told 
the coroner about the 
actual events.

The coroner told the 
commission that the 
actual events at 
Y's death should 
have been notified.

Dr Dowd said “we've had 
a great deal of it - when we know you 
have a mistake of 33 years' expe-
rience, you've been on the 
staff for over 10 years and 
you don't talk to me.

There's no reason to believe 
that they're not talking to 
the consultant.

Commissioners aren't 
involved in the decisions.

There's no teamwork 
when you're consultant.

A coroner's report of 
Milton Keynes Hospital's 
trust.

They were not told at the 
actual event.

Delays surrounding the 
actual event, negligence 
and an error.

All test results passed 
without further testing.

A home-based consultant 
was outside by plane.

Guidelines say there should 
be 20 minutes maximum 
between an emergency 
arriving and delivery.

Dr Dowd said “we've 
been waiting for years.

A polyclinic nurse per 
the cause of death as late as 
weeks in the brain and lung bleeding.

The three doctors at Mil-

ton Keynes were the 
commission today (Thursday) when 
were killed including the 
consultant and the 
consultant was questioned.

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Terminology

**Interprofessional education (IPE):** when *students* from two or more professions *learn with, from and about each other* to enable effective collaboration and improve health outcomes (World Health Organization, 2010)

**Interprofessional continuing education (IPCE):** when *members* from two or more professions *learn with, from and about each other* to enable effective collaboration and improve health outcomes ([www.jointaccreditation.org](http://www.jointaccreditation.org))

**Interprofessional collaborative practice (ICPC):** when multiple *health workers* from different professional backgrounds *work together* with patients, families, carers, and communities to *deliver the highest quality* of care (WHO, 2010)
Interprofessional Continuing Education (IPCE)

- An integrated planning process that includes health care professionals from 2 or more professions.
- An integrated planning process that includes health care professionals who are reflective of the target audience members the activity is designed to address.
- An intent to achieve outcome(s) that reflect a change in skills, strategy or performance of the health care team and/or patient outcomes.
- Reflection of 1 or more of the interprofessional competencies to include: values/ethics, roles/responsibilities, interprofessional communication, and/or teams/teamwork.
- Opportunity for learners to learn from, with and about each other
Reflection

Interprofessional Education vs Single Profession Education

Differences Similarities
Interprofessional education is a minority component of the educational activity.

Emphasis on interprofessional collaboration dominates the educational activity.
Effective Continuing Education

- Incorporates needs assessments (gap analysis) to ensure that the activity is controlled by and meets the needs of health professionals;

- Is interactive (e.g., group reflection, opportunities to practice behaviors);

- Employs ongoing feedback to engage health professionals in the learning process;

- Uses multiple methods of learning and provide adequate time to digest and incorporate knowledge; and

- Simulates the clinical setting.

*Redesigning Continuing Education in the Health Professions, 2010*
Effective Interprofessional Continuing Education

- Emphasizes the value proposition
- Approaches from a systems perspective
- Develops faculty/educator skills
- Incorporates active learning strategies
- Creates a safe environment
- Uses practical, meaningful scenarios
- Build time for practice and reflection
- **Incorporates team skills in practical ways**
- Uses formative and summative evaluation
- Reinforces skills used in daily practice

Weaver et al., 2010
To develop competence, learners must have:
  • A deep foundation of factual learning
  • They must understand facts and ideas in the context of a conceptual framework
  • And they must organize knowledge that facilitates retrieval and application

Bransford and colleagues, 2000
How People Learn
PROFESSIONAL PRACTICE GAP
Problem in practice or opportunity for improvement (professional practice gap)

- How do you know it is a problem?
- What data do you have to validate the problem?
- What is the reason that the problem exists?
Gap is the difference between the current state of “what is” and the desirable or achievable state “what should be or desired”
Professional practice gap

what is currently being done

35-50% of known diabetics screened

what could or should be done

annual dilated exam for diabetics
Kirkpatrick

1 Reaction
2 Learning
3 Behavior
4 Results
Miller’s Model of Clinical Competence

Knows: learner has knowledge about the topic/subject

Knows how: learner is capable of applying the knowledge

Shows how/does: learner is able to apply knowledge and skills in a simulated setting (shows how) or the practice environment (does)
Moore’s Model of CME Outcomes

- Community Health
- Patient Health
- Performance
- Competence
- Learning
- Satisfaction
- Participation
## Gap analysis worksheet

<table>
<thead>
<tr>
<th>Current State</th>
<th>Desired State</th>
<th>Healthcare team, individual member</th>
<th>Gap in knowledge, skills/strategy, performance</th>
<th>Desired Outcome</th>
<th>Method of Evaluation</th>
<th>Outcome Measure</th>
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EDUCATIONAL INTERVENTION

Community Health
Patient Health
Performance
Competence
Learning
Satisfaction
Participation
PLANNING
Engaging Learners

• Strategies to engage learners may include but are not limited to:
  ▫ Integrating opportunities for dialogue or question/answer
  ▫ Including time for self-check or reflection
  ▫ Analyzing case studies
  ▫ Providing opportunities for problem-based learning
  ▫ Incorporating Twitter, polling questions, chat box

• Active learner engagement may function as an opportunity for formative assessment during the educational activity by providing the presenter with immediate learner feedback.
Evaluation

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<tr>
<td><strong>Short-Term</strong></td>
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<tr>
<td>• Intent to change practice</td>
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<tr>
<td>• Active participation in learning activity</td>
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<tr>
<td>• Post-test</td>
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<tr>
<td>• Return demonstration</td>
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<td>• Case study analysis</td>
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<td>• Role-play</td>
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Learners Gain Understanding of the IP Care Team

As a result of participating in this program, I have a clearer understanding of the role the care team (including physicians, nurse practitioners, pharmacists, nurses, and case managers) plays in the management of patients with COPD.

Strongly agree: 55%
Agree: 42%
Disagree: 1%
Strongly disagree: 2%

43% primary care physicians and NPs; 12% physician specialists; 34% nurse case managers; 7% pharmacists; 4% physician assistants

N = 1067 (post-activity results)

*Engaging COPD in Patients in Shared Decision-Making Across the Continuum of Care. PRIME Education, Inc.*
March 2016.
More Work to Be Done!

(Pharmacists’ survey) I believe that nurses can best collaborate with pharmacists in:

(Nurses’ survey) I believe that pharmacists can best collaborate with nurses in:

Post-Activity Results (N = 263)

- Coordinating patients in medication therapy management: 39% (Pharmacists) vs 42% (Nurses)
- Risk-benefit decision-making about treatments: 21% (Pharmacists) vs 5% (Nurses)
- Providing patient education about treatments: 21% (Pharmacists) vs 32% (Nurses)
- Improving patient adherence: 26% (Pharmacists) vs 0% (Nurses)
- Implementing quality improvement strategies: 9% (Pharmacists) vs 5% (Nurses)

- 26% of pharmacists believe that nurses can best collaborate with pharmacists in improving patient adherence; zero nurses feel pharmacists can work with nurses to improve adherence.

* 21% of nurses believe that pharmacists can best collaborate with nurses in risk-benefit decision-making about treatments; only 5% of pharmacists view nurses as able to support pharmacists in risk-benefit decision-making.

Case-based Debates About Utility of PCSK9 Inhibitors in Patient Populations for Lipid Reduction
Strategies

- Start with an icebreaker that has nothing to do with planning CE
- Use first names, not professional titles
- Mix professions by deliberate seating
- Maintain a patient or problem-centric focus
- Be prepared to handle professional hierarchy behaviors (dominating conversation, passivity)
- Mix up tables/conversation – Popcorn, “Table 630”
What to do with...

- Naysayers ("it will never work")
- Overly enthusiastic supporters (everything is an interprofessional activity!)
- Those that want to stay in their silos and do not want their turf invaded
- Those that do not see the need for teamwork or the value of other health professionals
Questions?