

Continuing Medical Education

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Examples of “Umbrella” Practice Gap and Needs Assessment Statements For CME events with Multiple Presentations

Planners of CME events that contain multiple presentations on multiple topics (RSS/grand rounds, or multi-day live conferences) sometimes struggle to provide unifying, “umbrella” practice gap and needs assessment statements on their applications. The following examples demonstrate practice gap and learning needs statements that apply to broadly-based CME events.

HINT: For the Practice Gap statement, it might help you to think of the clinical area your event is addressing, not the specific topics.

PRACTICE GAP: EXAMPLE 1

Primary care practitioners and other health professionals living in rural, border, tribal, and other primary care HPSA need to deliver primary care services to a disparate and sometimes underserved population. In the opinion of several statewide experts (leaders from Arizona chapter of the American College of Physicians, Arizona Latin American Medical Association, and Arizona Telemedicine Program), Arizona's primary care practitioners working in these areas often do not understand the magnitude and significance of the impending changes that will come from the implementation of the Affordable Care Act (ACA) in 2014. This conference will address a number of provisions of the ACA that will help practitioners ensure optimal care is delivered, and so that patients don't “fall through the cracks” in the near future.

HINT: In the Learning Needs statement, we want know about the specific learning your participants will acquire that will help them to close the identified practice gaps. We also want to know about the process you used to identify the gap and develop the specific topics your event will cover.

LEARNING NEEDS ASSESSMENT STATEMENT: EXAMPLE 1

This year's Latino Health Promotion Summit aims to increase the knowledge of the impact of the ACA on the delivery of primary care services, as well as increase participants' knowledge of new models of care and creative strategies to enhance access and quality of care for Latino, American Indian, and other underserved populations of our state. The Planning Committee for the Third Latino Health Promotion Summit met over the past year to discuss the impact that the ACA will have on Arizona's rural and sometimes underserved populations. We discussed numerous areas of the ACA that will affect the delivery of health care services to rural populations, such as that the ACA: 1.) sets a ban on exclusion of children younger than 19 years of age with preexisting conditions, 2.) provides for coverage of young adults up to 26 years of age under their parents' plans, 3.) expands appeals rights when claims are denied, 4.) enacts a ban against lifetime limits, and 5.) places restrictions on annual coverage limits. To address how these provisions will affect delivery of health care in HPSA and other rural areas, we invited national and state experts involved in the implementation of the ACA to speak at this event in order to close the gap in primary care practitioners' understanding and preparation for the upcoming implementation of the ACA.

PRACTICE GAP: EXAMPLE 2

Many primary care practices are challenged when it comes to promoting healthy lifestyles. Many patients seem unable to amend unhealthy habits in order to lose weight and address other risky behaviors (smoking, excessive alcohol use, etc.) that result in chronic health conditions even though they understand the importance of healthy eating, healthy behaviors, and regular physical exercise (National Prevention Council, 2011). Though prescribing medication is rarely the sole solution for successfully managing chronic health conditions, physicians often focus primarily on prescribing medications instead of on counseling and advocating healthier lifestyles (Elmer et al., 2006). This is in spite of the fact that lifestyle changes have been shown to reduce morbidity and mortality significantly (Kromhout et al., 2002). The proposed CME activity will provide participants with the knowledge, skills, and abilities to increase incorporation of wellness and healthy lifestyle practices into the care they deliver to their patient populations.

REFERENCES:

Elmer PJ, Obarzanek E, Vollmer WM, Simons-Morton D, Stevens VJ, Young DR, et al. Effects of comprehensive lifestyle modification on diet, weight, physical fitness, and blood pressure control: 18-month results of a randomized trial. *Ann Intern Med.* 2006;144:485–495.

Kromhout D, Menotti A, Kesteloot H, et al. Prevention of coronary heart disease by diet and lifestyle: evidence from prospective cross-cultural, cohort, and intervention studies. *Circulation.* 2002 Feb 19;105(7):893-8.

National Prevention Council. National Prevention Strategy, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011.

LEARNING NEEDS ASSESSMENT STATEMENT: EXAMPLE 2

Based upon literature reviewed and an ongoing assessment of existing professional clientèle, we believe that most doctors focus exclusively on sickness care. The current disease burden, as demonstrated from numerous epidemiological studies, has shown the importance of healthy lifestyles to reduce the individual's total disease burden. These efforts to assess educational needs have led to the knowledge, skills, and abilities listed in our practice gap statement and reflected in our learning objectives. The program planners maintain continuous contact with the University of Arizona Faculty and the Medical Library and their research librarians. Computerized searches are conducted periodically to ensure the documented needs of practicing physicians are identified. Further needs assessment information is obtained from lecture evaluations, focus groups, CME Q&As, and luncheons with faculty physicians.

PRACTICE GAP: EXAMPLE 3

Physicians caring for patients with respiratory disease and critical illness must integrate knowledge and expertise from multiple domains of clinical medicine to make rapid medical decisions with a very low error rate. However, no physician in respiratory or critical care can stay current with new information in every specialty. The primary remedy has been the development and promotion of guidelines for best practices in multiple areas of clinical medicine. The use of practice guidelines is believed to improve the quality and efficiency of care (Woolf, 1999), partially by relieving physicians' cognitive burden in complex or busy situations, thereby reducing medical errors.

However, significant gaps exist in physician understanding and/or consistent use of practice guidelines. These gaps have been documented in multiple domains in respiratory and critical care medicine, including ICU care generally, cardiopulmonary resuscitation, the treatment of pneumonia, asthma, and multiple other areas of clinical practice (Doerschug et al., 1999; Gazmuri et al., 2007; Lang et al., 2007; El-Khatib et al, 2010; Sinuff et al, 2007). Schema have been proposed for how these gaps in knowledge and practice can be closed, thereby improving patient care and outcomes. However, these schema are too theoretical to be of practical use. This CME activity will educate physicians on current best practices in respiratory and critical care medicine and will help them integrate this knowledge for rapid recall in their future medical decision making.

REFERENCES:

Doerschug, et al. Asthma Guidelines- An Assessment of Physician Understanding and Practice. American Journal of Respiratory and Critical Care Medicine, Vol. 159, No. 6 (1999), pp. 1735-1741.

Gazmuri, R et al. Scientific Knowledge Gaps and Clinical Research Priorities for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Identified During the 2005 International Consensus Conference on ECC and CPR Science With Treatment Recommendations. Circulation. 2007; 116: 2501-2512.

Lang, ES et al. Knowledge Translation: Closing the Evidence-to-Practice Gap. Annals of Emergency Medicine. Volume 49, Issue 3, March 2007, 355–363.

El-Khatib, MF et al. Critical Care Clinicians' Knowledge of Evidence-Based Guidelines for Preventing Ventilator-Associated Pneumonia. Am J Crit Care. May 2010 vol. 19 no. 3 272-276.

Woolf, S. Potential benefits, limitations, and harms of clinical guidelines. BMJ. 1999 February 20; 318(7182): 527–530.

Sinuff, T et al. Facilitating clinician adherence to guidelines in the intensive care unit: A multicenter, qualitative study. Critical Care Medicine. September 2007 - Volume 35 - Issue 9 - pp 2083-2089.

LEARNING NEEDS ASSESSMENT STATEMENT: EXAMPLE 3

There is a well-described need in the medical literature for an enhancement of physicians' understanding and consistent use of evidence-based best practices in respiratory and critical care medicine [*see above references*]. These best practices are published and promoted through clinical practice guidelines, but although intended as digests, these bulky documents are too onerous for most physicians to read or regularly reference. More user friendly and practical methods are needed to transmit knowledge from subject matter experts to practicing physicians in respiratory and critical care, worldwide. This CME activity will include board review-style test questions that will integrate evidence-based best practices into clinical scenarios in respiratory and critical care medicine. The result for participants will be enhanced retention of best practices and improved medical decision making.