Developing Team Competencies Through the Continuum of Medical Education

Learn
Serve
Lead

2016 AIAMC Annual Meeting
Tucson, AZ

Darrell G. Kirch, MD
President and CEO, AAMC
March 31, 2016

Association of
American Medical Colleges

"Teams" Across the Full Continuum for Medical Education
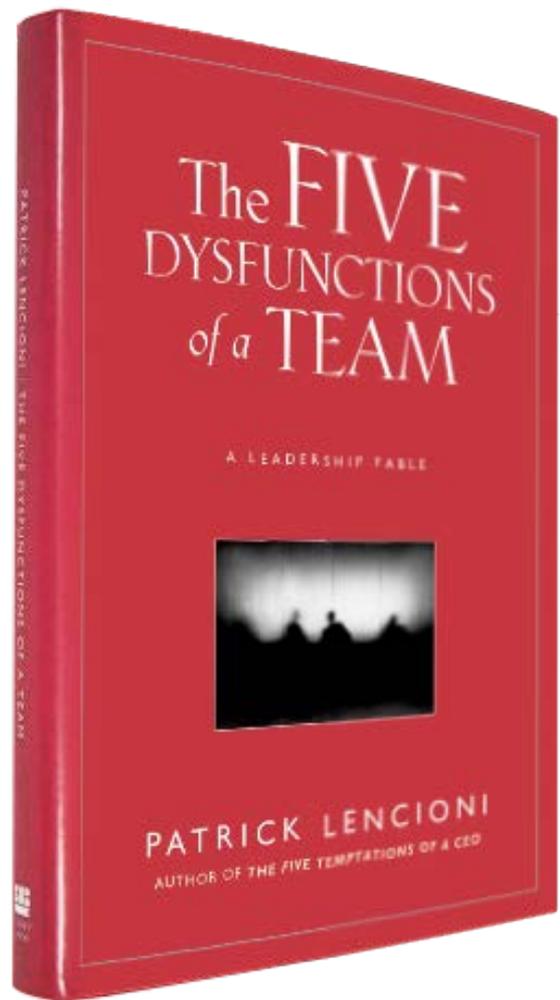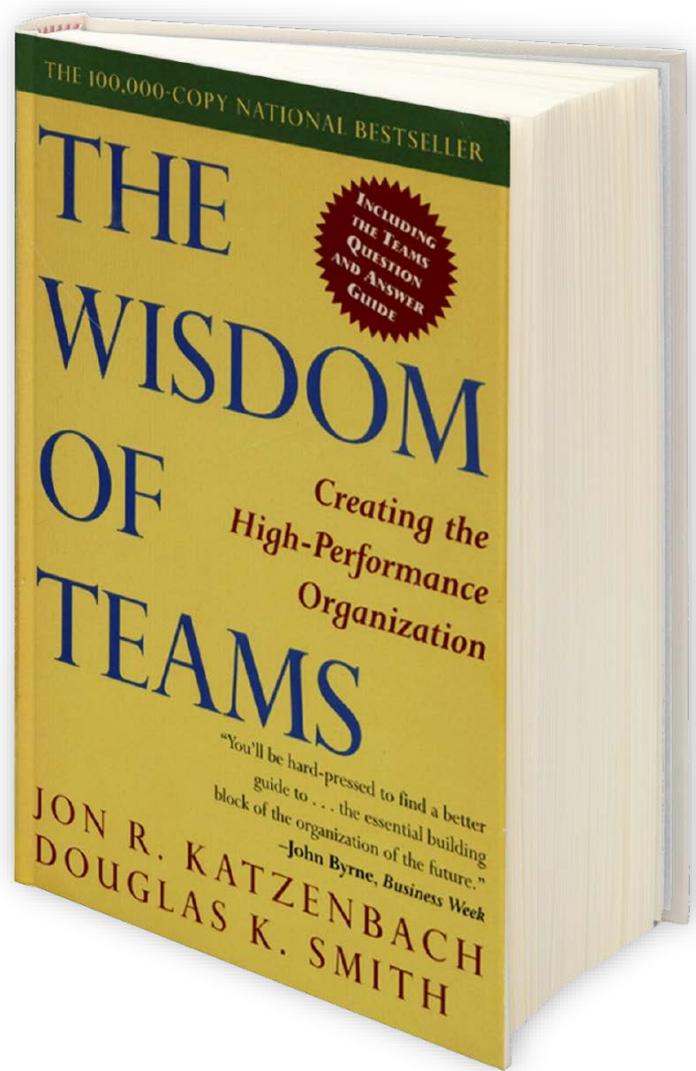

Learning
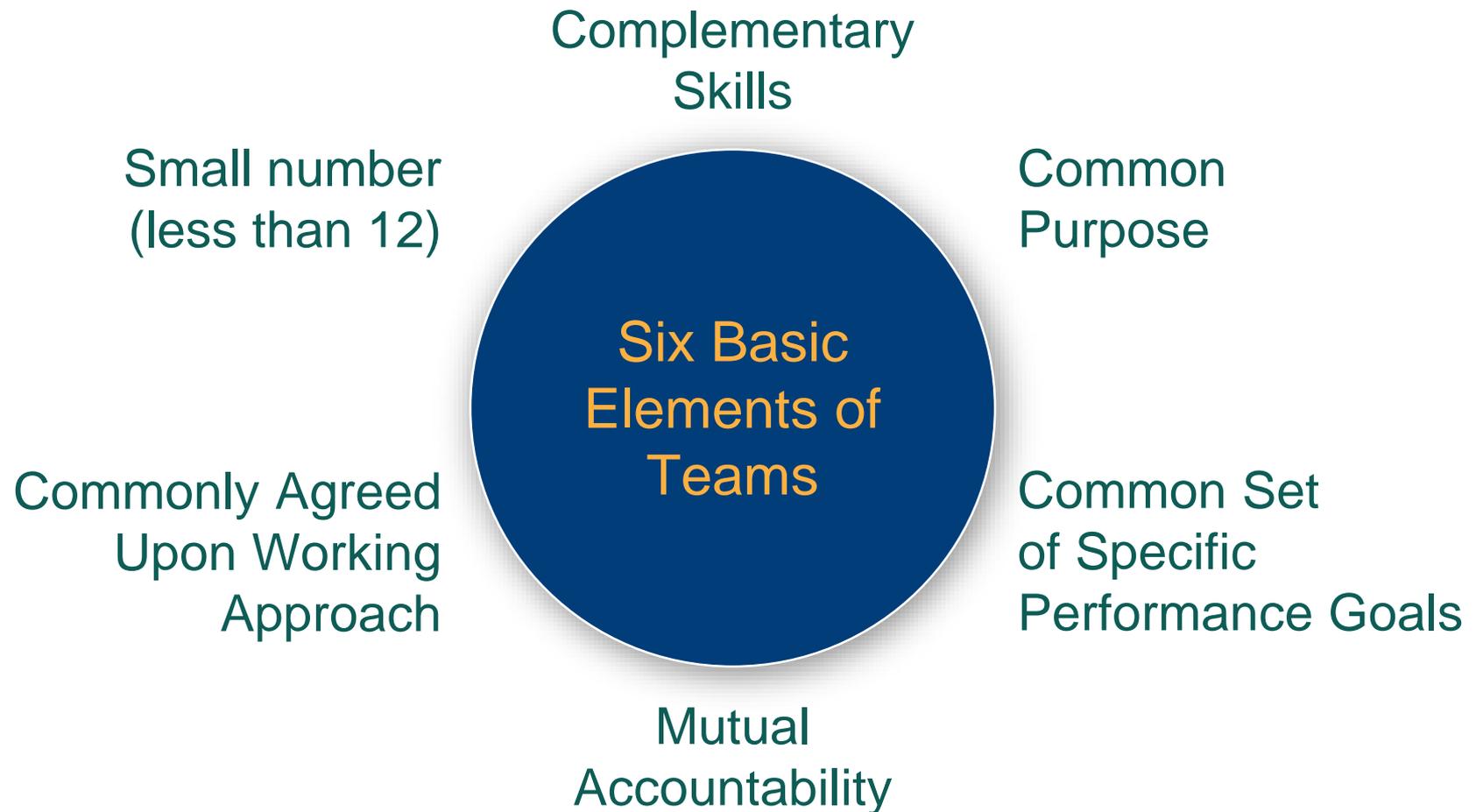
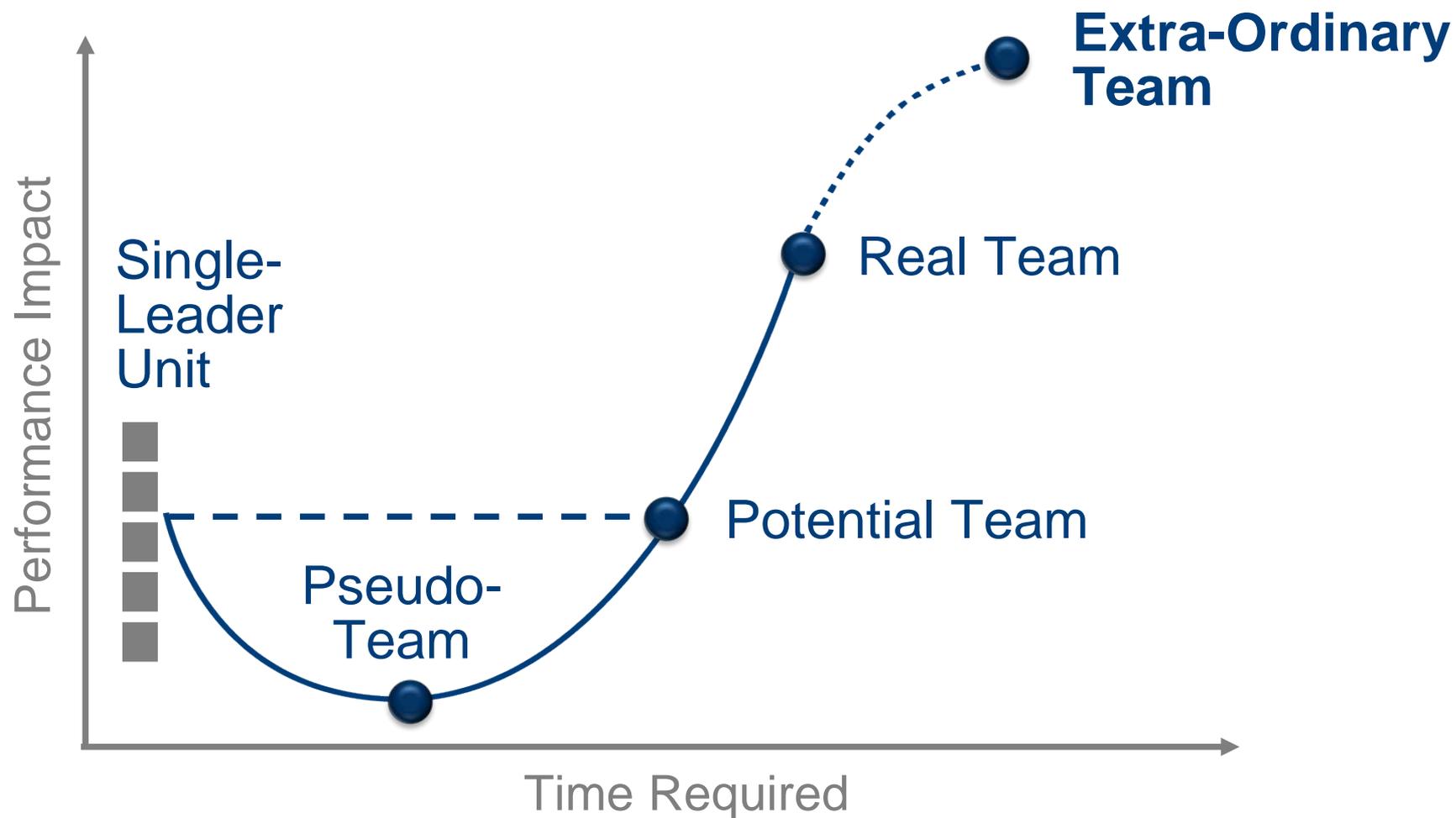Premedical → Medical School → Residency and Fellowships → Practice

Assessment

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THE 100,000-COPY NATIONAL BESTSELLER

THE WISDOM OF TEAMS

Including the Teams Question and Answer Guide

Creating the High-Performance Organization

"You'll be hard-pressed to find a better guide to . . . the essential building block of the organization of the future."
—John Byrne, *Business Week*

JON R. KATZENBACH
DOUGLAS K. SMITH

The FIVE DYSFUNCTIONS of a TEAM

A LEADERSHIP FABLE

PATRICK LENCIONI
AUTHOR OF *THE FIVE TEMPTATIONS OF A CEO*

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Six Basic Elements of Teams

According to Katzenbach and Smith

Complementary
Skills

Small number
(less than 12)

Common
Purpose

Six Basic Elements of Teams

Commonly Agreed
Upon Working
Approach

Common Set
of Specific
Performance Goals

Mutual
Accountability

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Harness the Power of Teams

Source: Katzenbach and Smith, 2006

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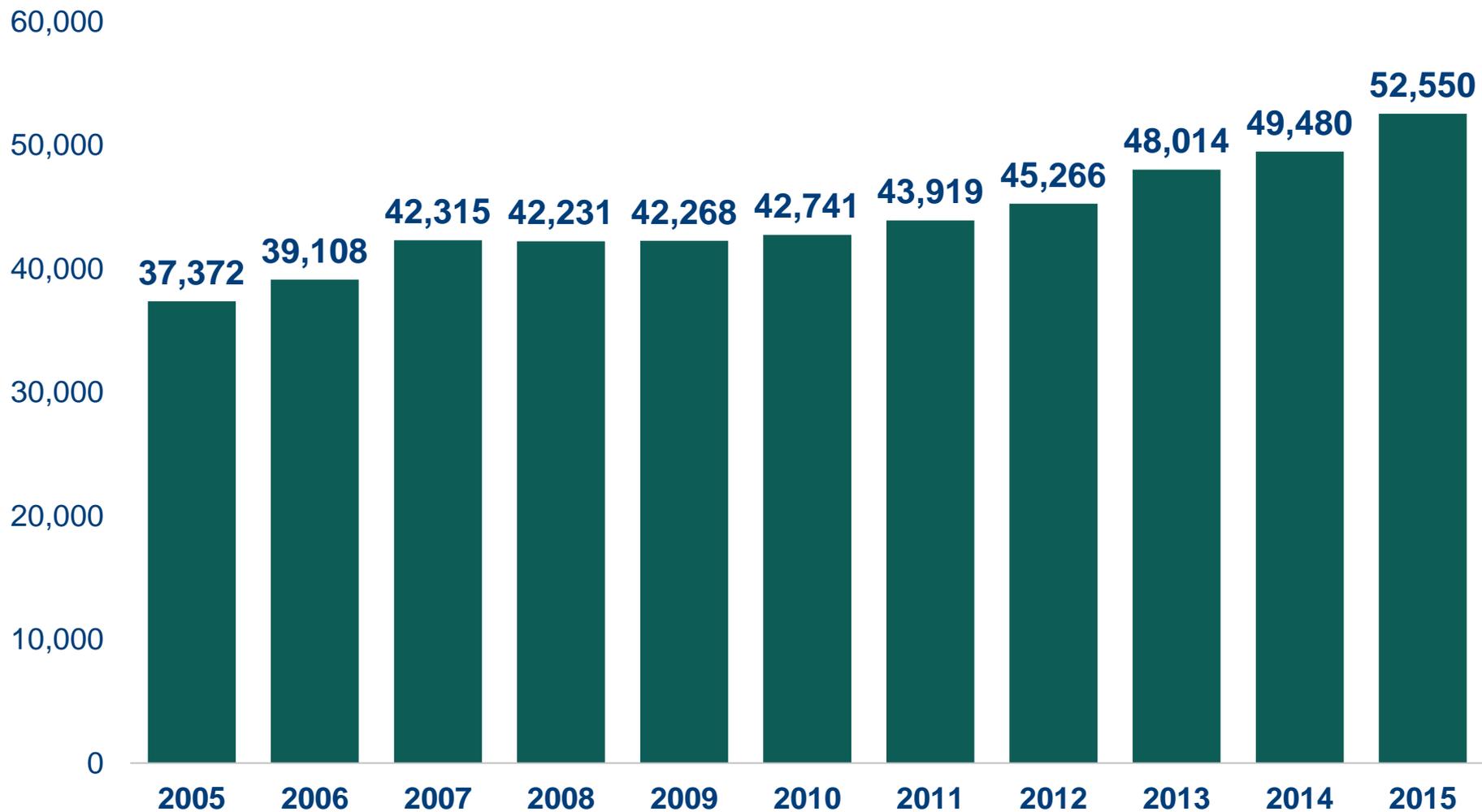AAMC
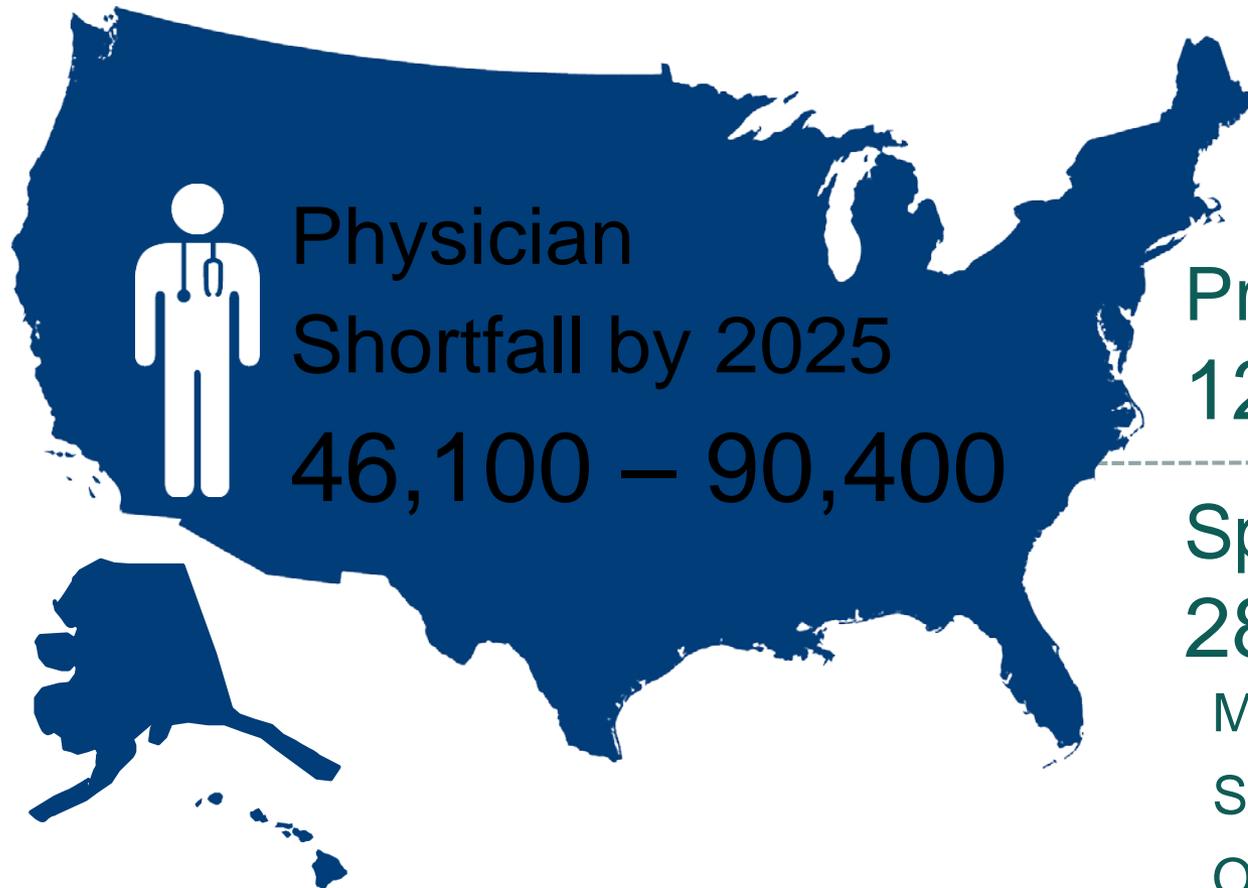
Premedical Education

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Medicine Remains an Attractive Career…

AMCAS Applicants to Medical School

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…But Can We Improve Learner Selection To Meet the Needs of the Nation?

Physician Shortfall by 2025
46,100 – 90,400

Primary Care
12,500 – 31,100

Specialty Care
28,200 – 63,700

| Medical | 5,100 - 12,300 |
| Surgical | 23,100 - 31,600 |
| Other | 2,400 - 20,200 |

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Core Competencies in Premedical Students

Service Orientation

Social Skills

Cultural Competence

Teamwork

Oral Communication

Ethical Responsibility

Reliability and Dependability

Resilience and Adaptability

Capacity for Improvement

Critical Thinking

Scientific Inquiry

Quantitative Reasoning

Knowledge of Living Systems

Written Communication

Knowledge of Human Behavior

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A New MCAT Exam – 1 Year Later
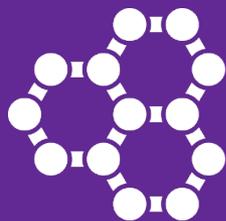
Biological and biochemical foundations of living systems

Chemical and physical foundations of biological systems
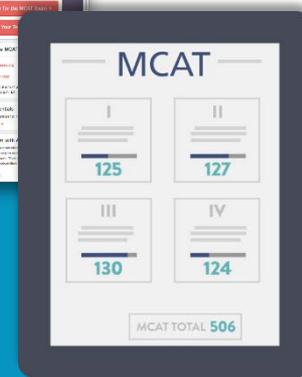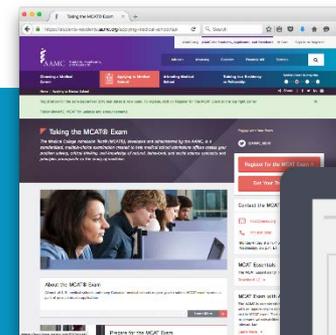
Psychological, social, and biological foundations of behavior

Critical analysis and reasoning skills

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Improving Admissions: Situational Judgment Test

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Matriculants Do Not Reflect The Diversity of the Nation!

American Indian or Alaska Native, 1%

Native Hawaiian or Other Pacific Islander, 0%

Other, 3%

Non-U.S., 2%

Unknown, 4%

Black or African American, 7%

Hispanic, Latino, or of Spanish Origin, 9%

White, 53%

Asian, 21%
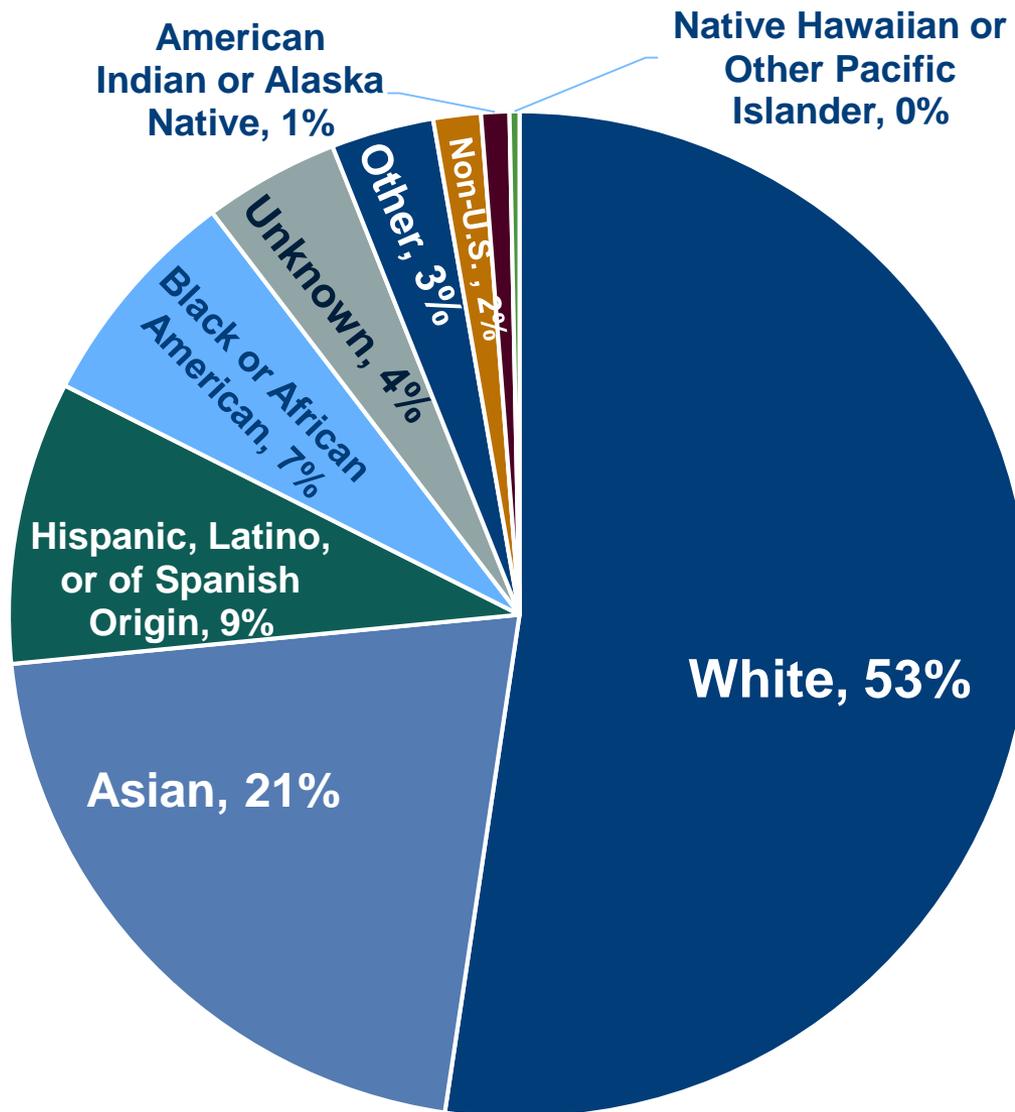
U.S. Medical School Matriculants, 2015

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Power of Diversity

"
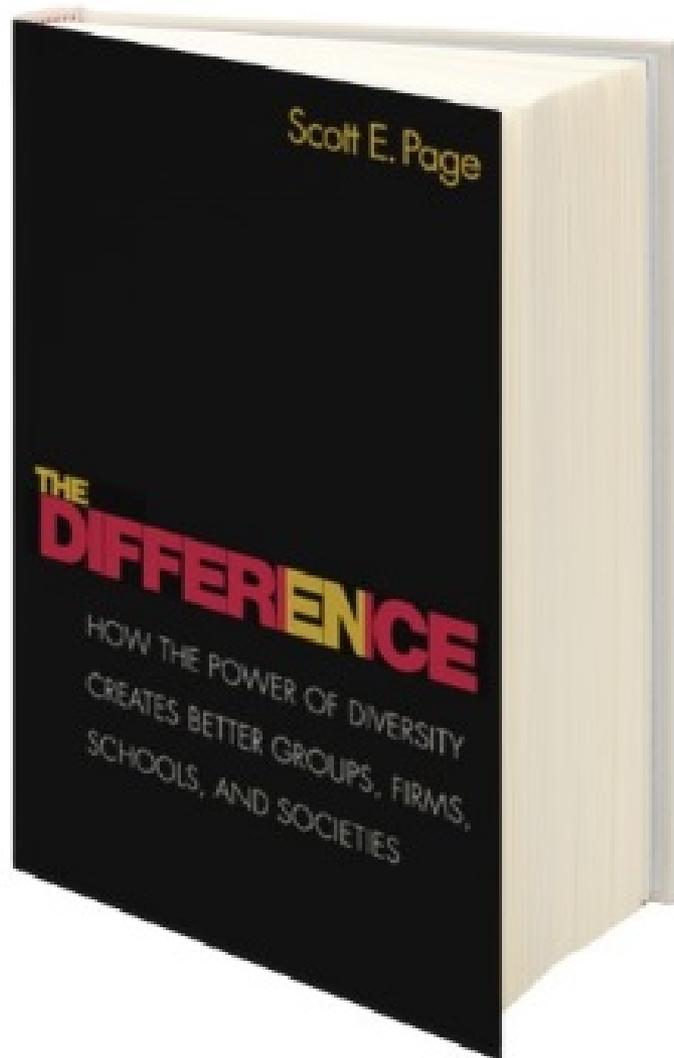
Progress depends as much on our collective differences as it does our individual IQ scores.

Scott Page, PhD

"

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Medical School

Learning

Premedical → **Medical School** → Residency and Fellowships → Practice

Assessment

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Improving the Educational Environment

AAMC Statement on the Learning Environment

We believe that the learning environment for medical education shapes the patient care environment. The highest quality of safe and effective care for patients and the highest quality of effective and appropriate education are rooted in human dignity.

We embrace our responsibility to create, support, and facilitate the learning environment shared by our patients, learners, and teachers. In this environment, our patients witness, experience, and expect a pervasive sense of **respect**, **collegiality**, **kindness**, and **cooperation** among health care professionals, administrators, sta learners from all health professio as patient care environments.

We affirm our responsibility to learning environment that fosters our responsibility to create an atm teachers are willing to engage wi inherently uncomfortable and challenging.

We affirm our commitment to shaping a culture of teaching and learning that is rooted in respect for all. Fostering resilience, **excellence**, **compassion**, and **integrity** allows us to create patient care, research, and learning environments that are built upon constructive **collaboration**, mutual respect, and human dignity.

For more information and to view a library of resources, visit **aamc.org/learningenvironment**.
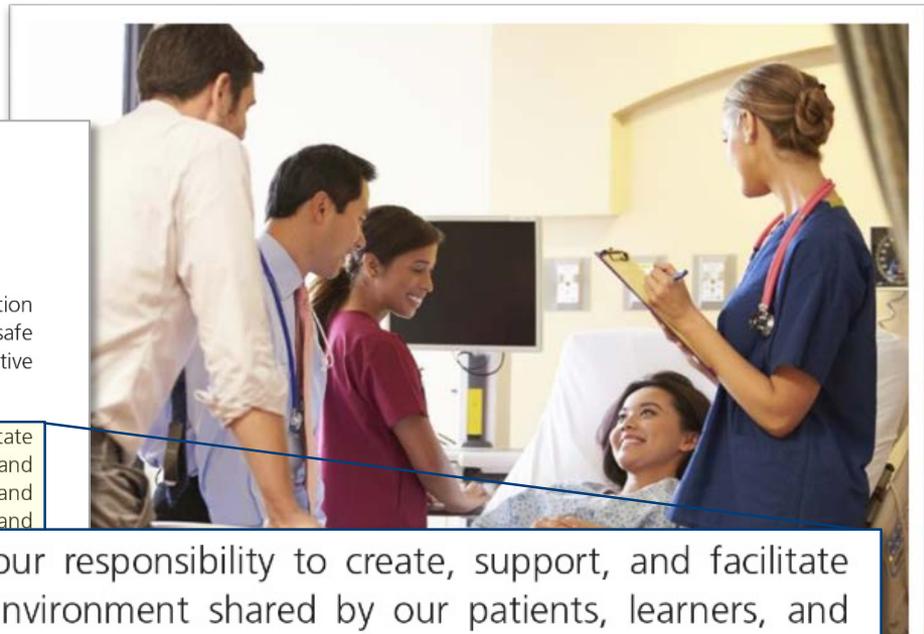
We embrace our responsibility to create, support, and facilitate the learning environment shared by our patients, learners, and teachers. In this environment, our patients witness, experience, and expect a pervasive sense of **respect**, **collegiality**, **kindness**, and **cooperation** among health care team members.

IPEC®
Interprofessional Education Collaborative

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13 Core Entrustable Professional Activities for Day One of Residency

1) Gather a history and perform a physical examination

2) Prioritize a differential diagnosis following a clinical encounter

3) Recommend and interpret common diagnostic and screening tests

4) Enter and discuss orders/prescriptions

5) Document a clinical encounter in the patient record

6) Provide an oral presentation of a clinical encounter

7) Form clinical questions and retrieve evidence to advance patient care

8) Give or receive a patient handover to transition care responsibility

9) Collaborate as a member of an interprofessional team

10) Recognize a patient requiring urgent or emergent care, and initiate evaluation and management

11) Obtain informed consent for tests and/or procedures

12) Perform general procedures of a physician

13) Identify system failures and contribute to a culture of safety and improvement

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Residency and Fellowships

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Celebrating Match Day

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Average ERAS Applications Per Applicant

Legend: US MD Overall, Canadian School, International School, Osteopathic School

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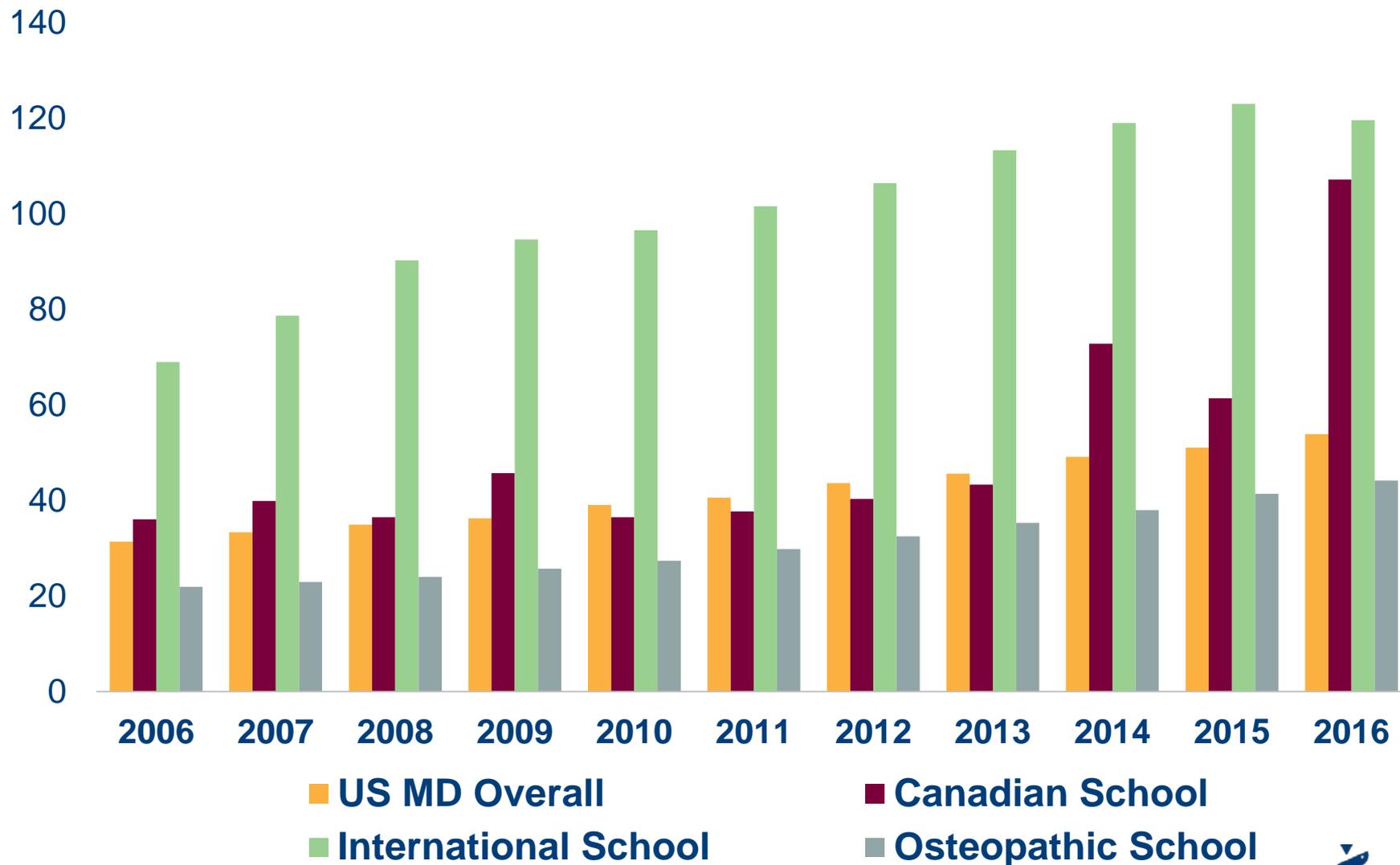
Tools for Improving Residency Selection

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Practice

Learning

Premedical › Medical School › Residency and Fellowships › Practice

Assessment

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The Anatomy of Integration vs. The Physiology of Integration

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True teams require a new model of leadership

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Leaders of Health Care as "Multipliers"
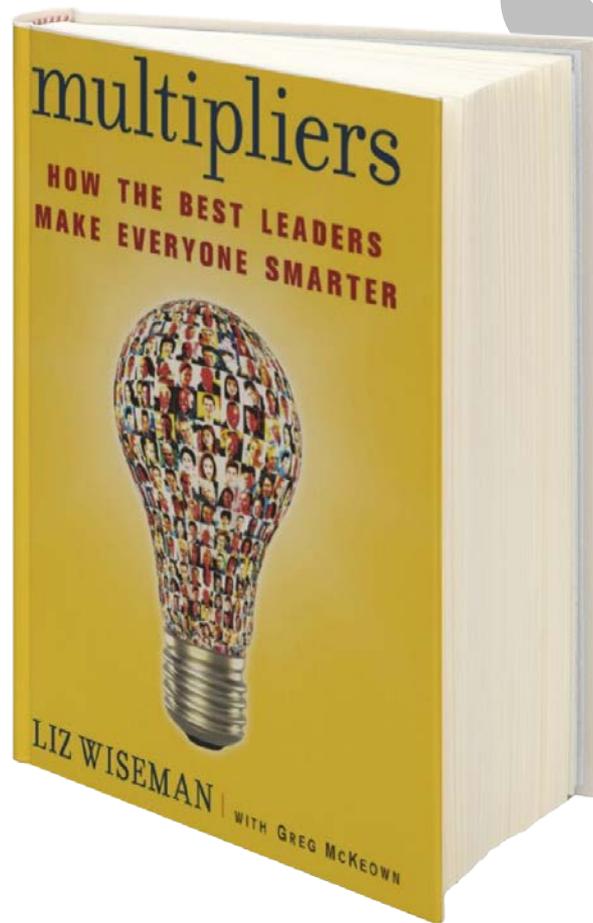
> Multipliers are leaders who look beyond their own genius and focus their energy on extracting and extending the genius of others.

Liz Wiseman

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Tomorrow's Doctors, Tomorrow's Cures®

Learn

Serve

Lead

Association of
American Medical Colleges

The Clinical Learning Environment, Milestones, and Team Competencies

Thomas J Nasca MD MACP
Chief Executive Officer

Disclosure

- Full Time Salaried by ACGME

- Professor of Medicine and Physiology
  Sidney Kimmel College of Medicine
  Thomas Jefferson University
  Senior Scholar, Department of Medical Education
  College of Medicine
  University of Illinois at Chicago

- No conflicts of interest to report

ACGME

- Baseline, 2013-2015
- Strengths, Progress
- Opportunities

CLER National Report of Findings 2016.
Accreditation Council for Graduate Medical Education
Chicago, IL. 2016.

"The ACGME would like to thank the Designated Institutional Officials of our accredited Sponsoring Institutions along with the executive leaders of the participating hospitals and medical centers for graciously hosting this first set of visits. We appreciate the efforts that were involved in arranging the visits, the open access to converse with residents, fellows, faculty members and staff, and your willingness to receive feedback. It was a privilege to spend time in your organizations."

ACGME

Assumption

- The quality of outcomes of experientially based education is related, in significant part, to the quality of the task or process the trainee participates in delivering

Sirovich, B.E., Lipner, R.S., Johnson, M., Holmboe, E.S.
The Association Between Residency Training and Internists' Ability to Practice Conservatively.
JAMA Internal Medicine. 2014;174(10):1640-1648

Chen, C., Petterson, S., Phillips, R., Bazemore, A., Mullan, F.
Spending Patterns in Region of Residency Training and Subsequent Expenditures for Care Provided by Practicing Physicians for Medicare Beneficiaries.
JAMA. 2014;312(22):2385-2393

Asch, DA, Nicholson, S, Srinivas, S, Herrin, J, Epstein, AJ.
Evaluating Obstetrical Residency Programs Using Patient Outcomes.
JAMA 2009;302(12):1277-1283.

Epstein, AJ, Nicholson, S, Asch, DA.
The Production Of and Market For New Physicians' Skill.
Working Paper 18678 – http:/www.nber.org/papers/w18678 National Bureau of Economic Research
1050 Massachusetts Ave, Cambridge MA 02138. January, 2013

ACGME

Assumption

- The Clinical Learning Environment Has Direct Impact on Graduates' Ability to Achieve the Triple Aim

Quadruple

The IHI Triple Aim

Population Health

Joy in Practice

Experience of Care

Per Capita Cost
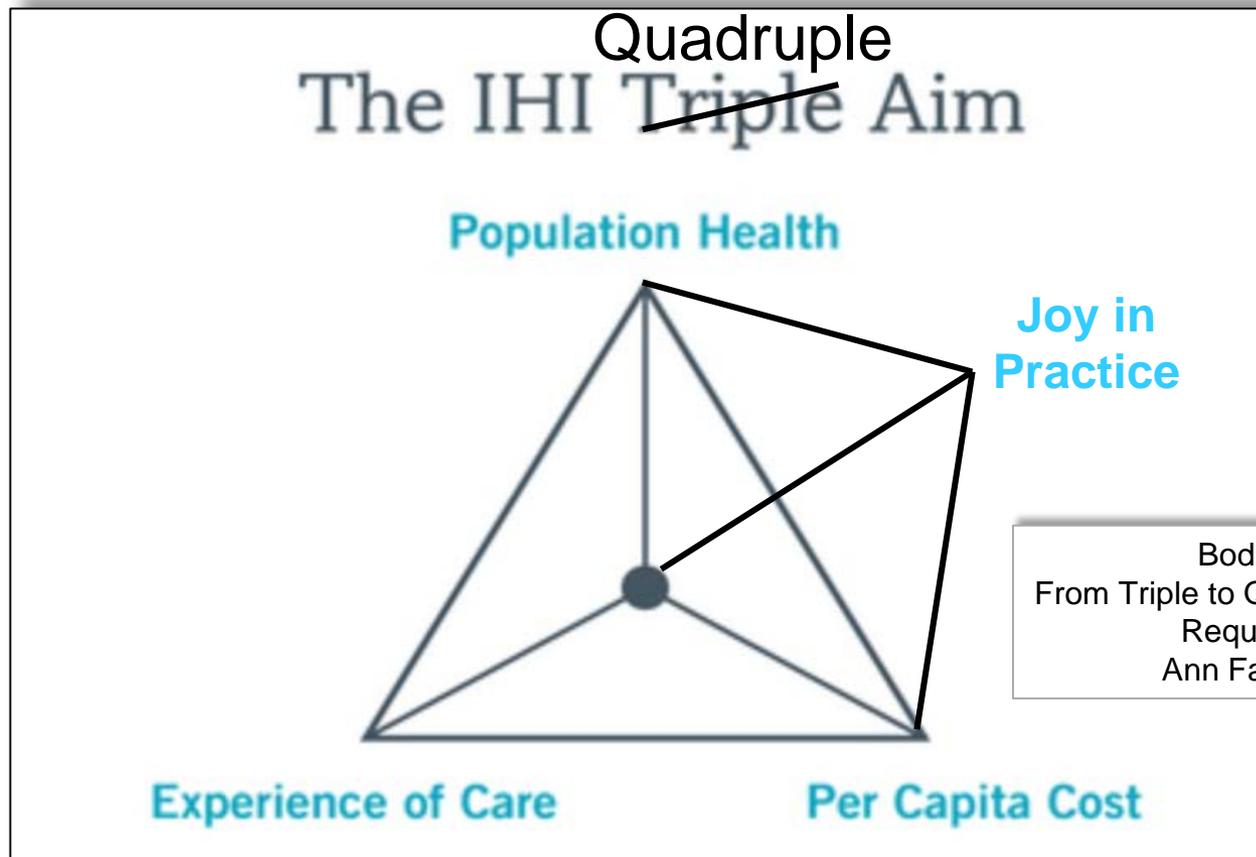
Bodenheimer, T, Sinsky, C.
From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider
Ann Fam Med 2014; 12:573-576

http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/TripleAimReady.aspx

Assumptions

- Residents will manifest "Teamwork" skills (Outcomes) that emulate the "Teamwork" manifest in the Clinical Learning Environment

- Evaluation of resident outcomes will, in part, be influenced by faculty conceptualization of "Teamwork," as manifest in the Clinical Learning Environment

Let's Look at Markers of "Teamwork" Competency

ACGME

B21. Percentage of residents and fellows who reported that their clinical site provided a supportive, non-punitive environment for coming forward with concerns regarding honesty in reporting (e.g., patient data, duty hours)

Distribution across CLEs[c]

Median 95%
IQR 90-100%
n=8,592

Number of CLEs

Percent of Residents and Fellows

ACGME
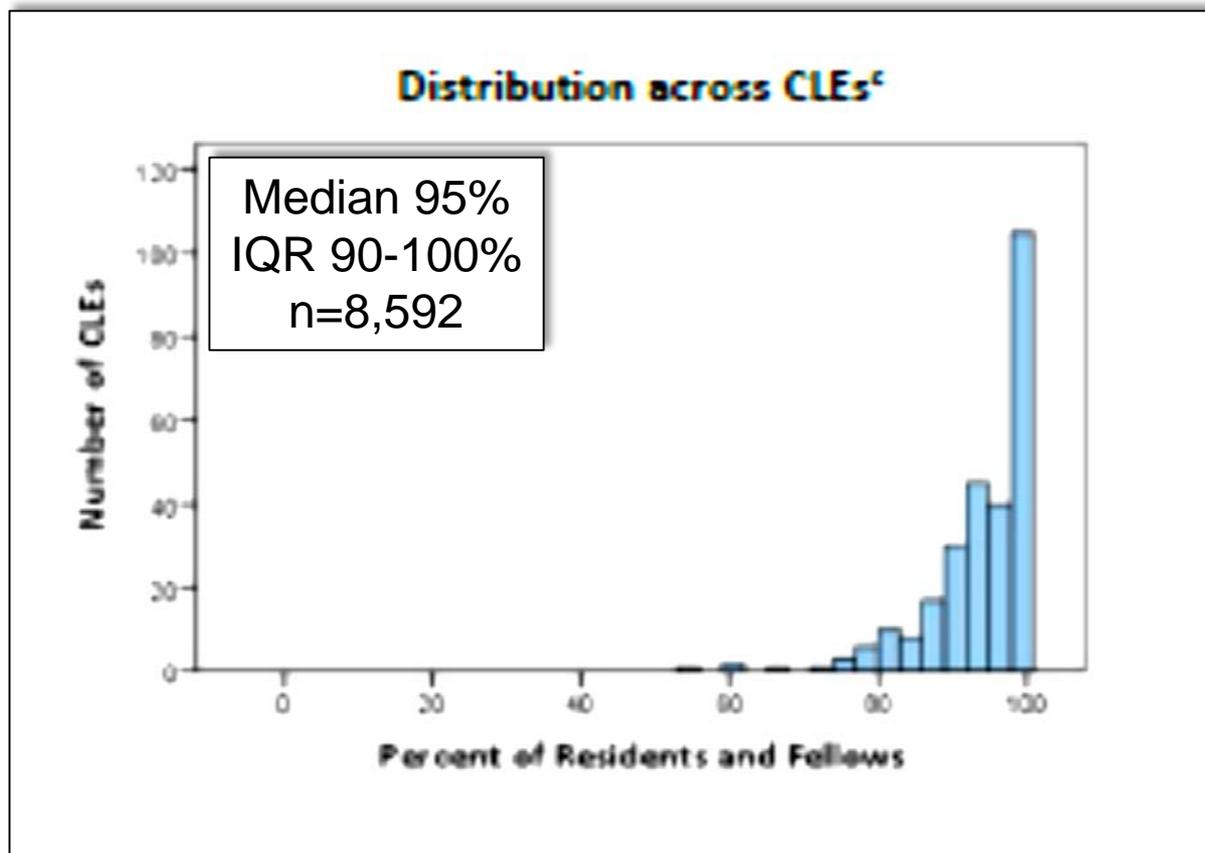
B22. Percentage of residents and fellows who reported having felt pressured to compromise their honesty or integrity to satisfy an authority figure during their training at the clinical site

Distribution across CLEs[c]

Median 14%
IQR 8-20%
n=8,609
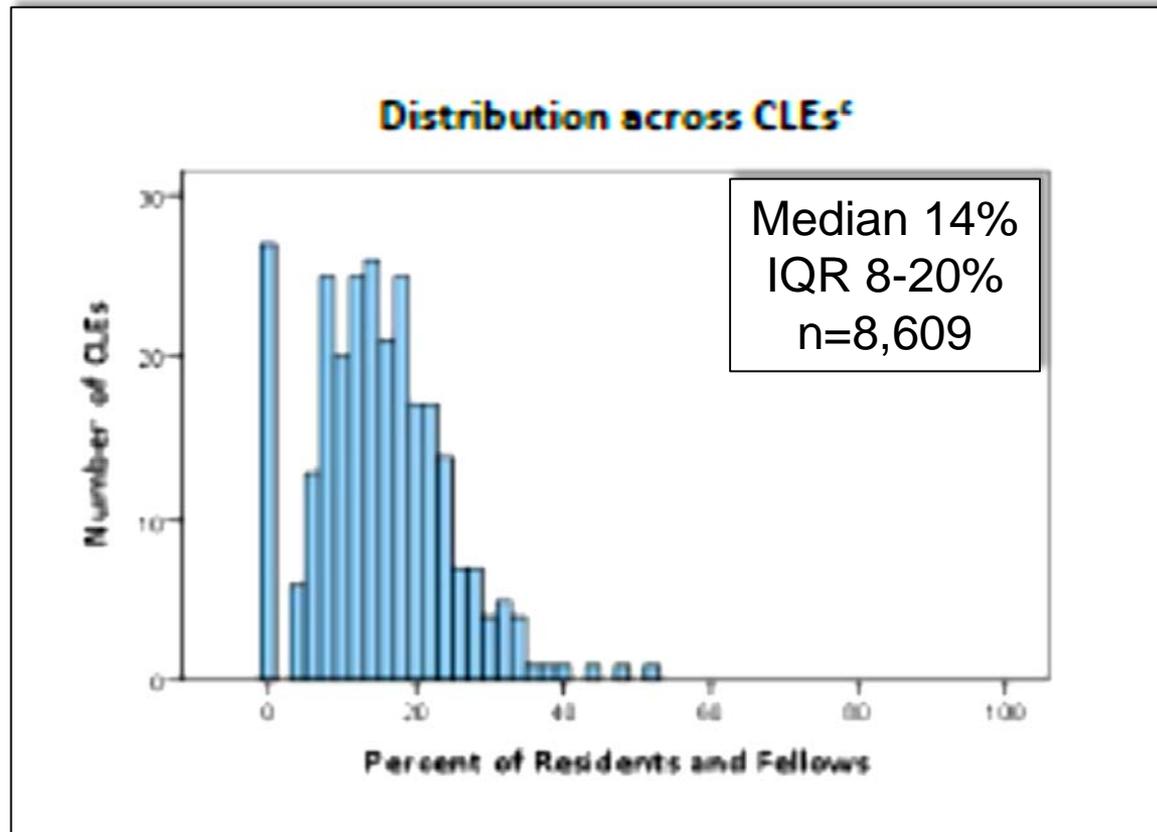
B7. Percentage of residents and fellows (PGY-3 and above) who reported participating in an inter-professional (physicians, nurses, administrators, others) investigation of a patient event (e.g., root cause analysis)

Distribution across CLEs[c]

Median 41%
IQR 32-52%
n=6,369

ACGME
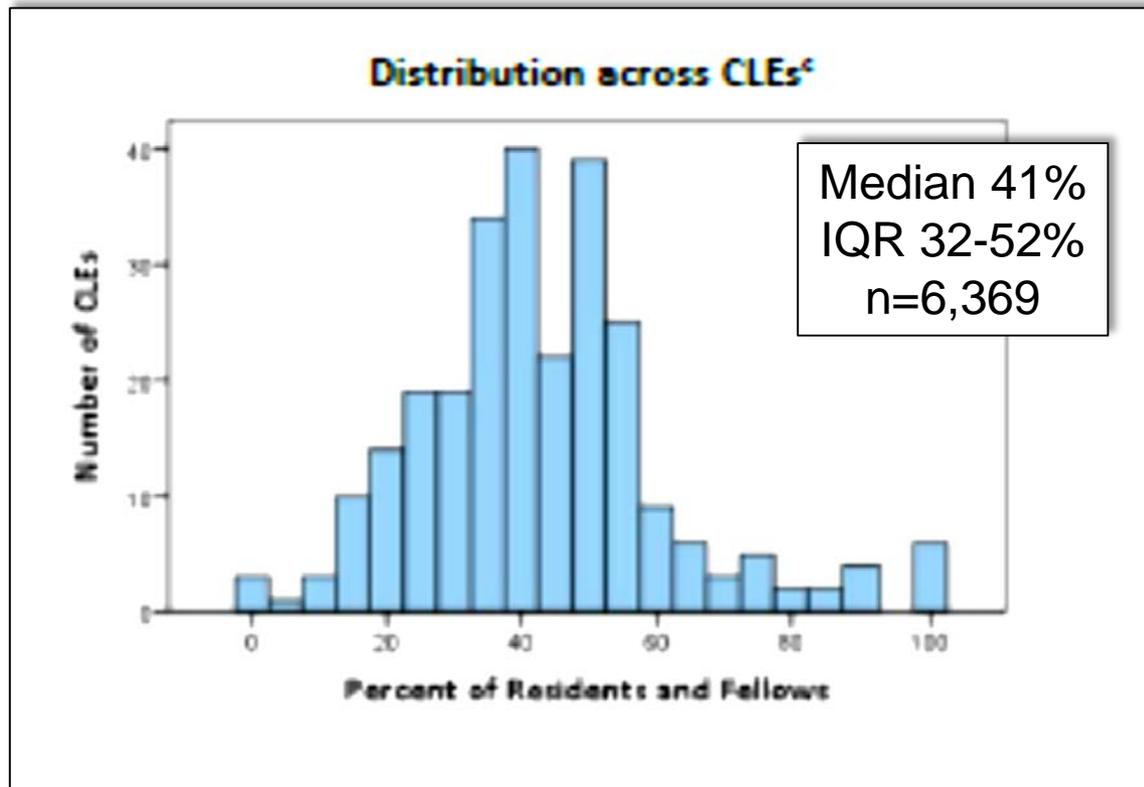
B11. Percentage of residents and fellows who reported being engaged in inter-professional quality improvement teams (e.g., nurses, administrators, pharmacists, etc.) while participating in a quality improvement project directly linked to one or more of the clinical site's quality improvement goals

Distribution across CLEs[c]

Median 75%
IQR 62-85%
n=3,113

ACGME
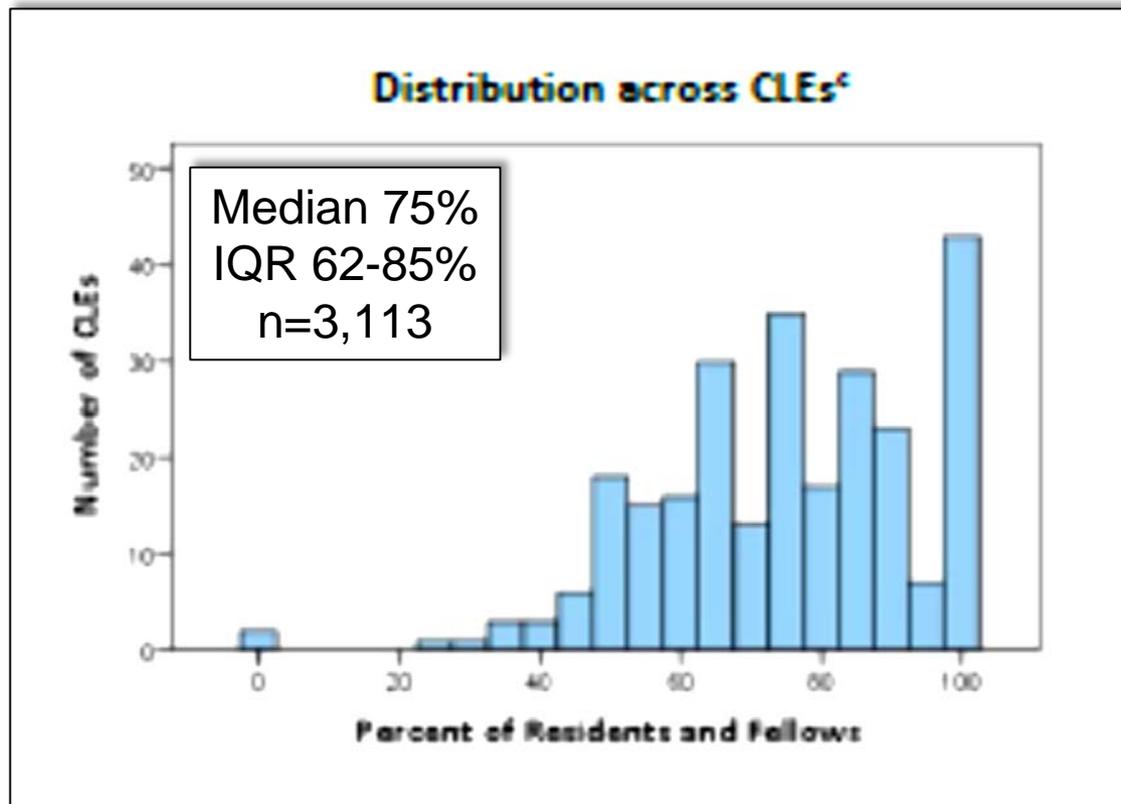
B13. Percentage of residents and fellows who reported knowing the clinical site's priorities with regard to addressing health care disparities

Distribution across CLEs[c]

Median 60%
IQR 43-76%
n=8,607

Number of CLEs (y-axis)
Percent of Residents and Fellows (x-axis)

ACGME
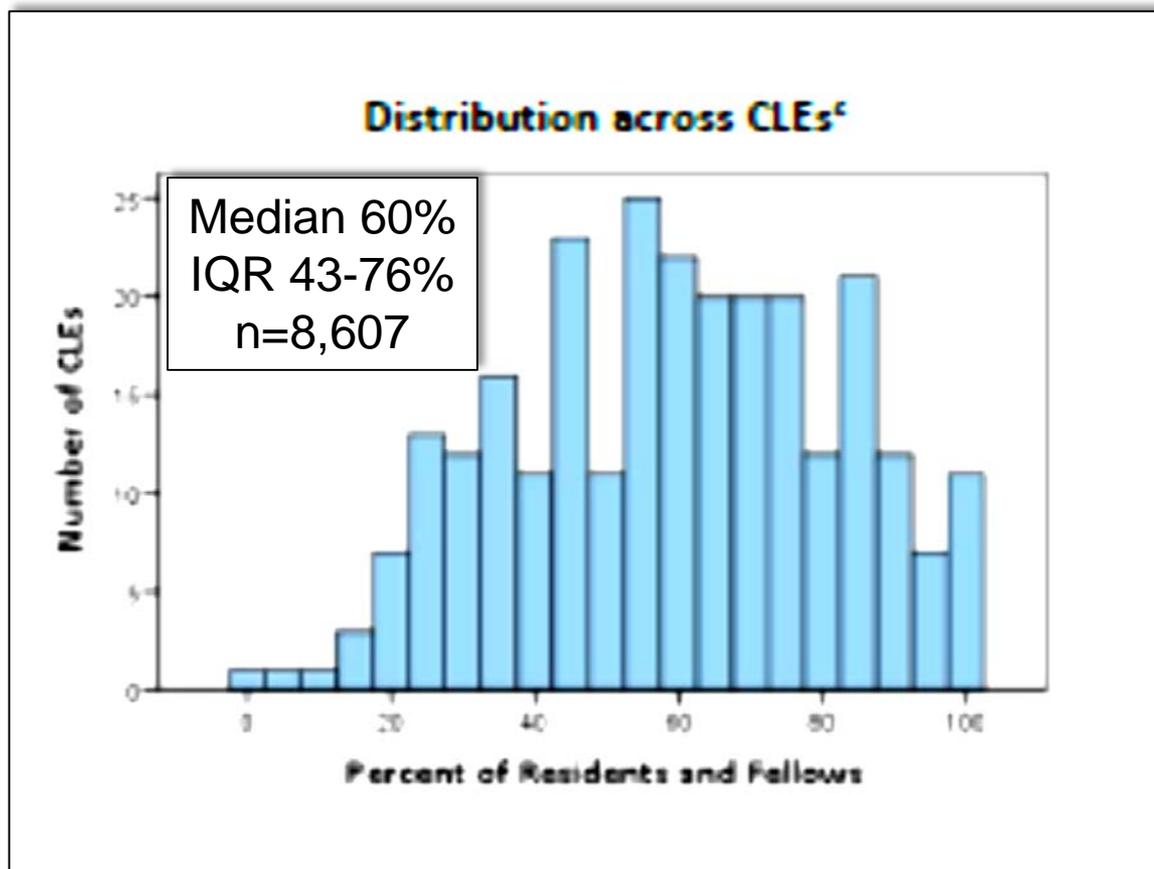
Let's Switch to Resident Outcomes Milestones

Milestones, A Preliminary Snapshot
Milestone Data Mean/SD of Sub-Competency Means
Each Level of Training, June 2014

Internal Medicine (n=21,767)
Overall Competency Means by Year of Training

"Level"

Year1 Year2 Year3	Year1 Year2 Year3	Year1 Year2 Year3	Year1 Year2 Year3	Year1 Year2 Year3	Year1 Year2 Year3
Patient Care	Medical Knowledge	Systems-Based Practice	Practice-Based Learning and Improvement	Professionalism	Interpersonal and Communication Skills

ACGME
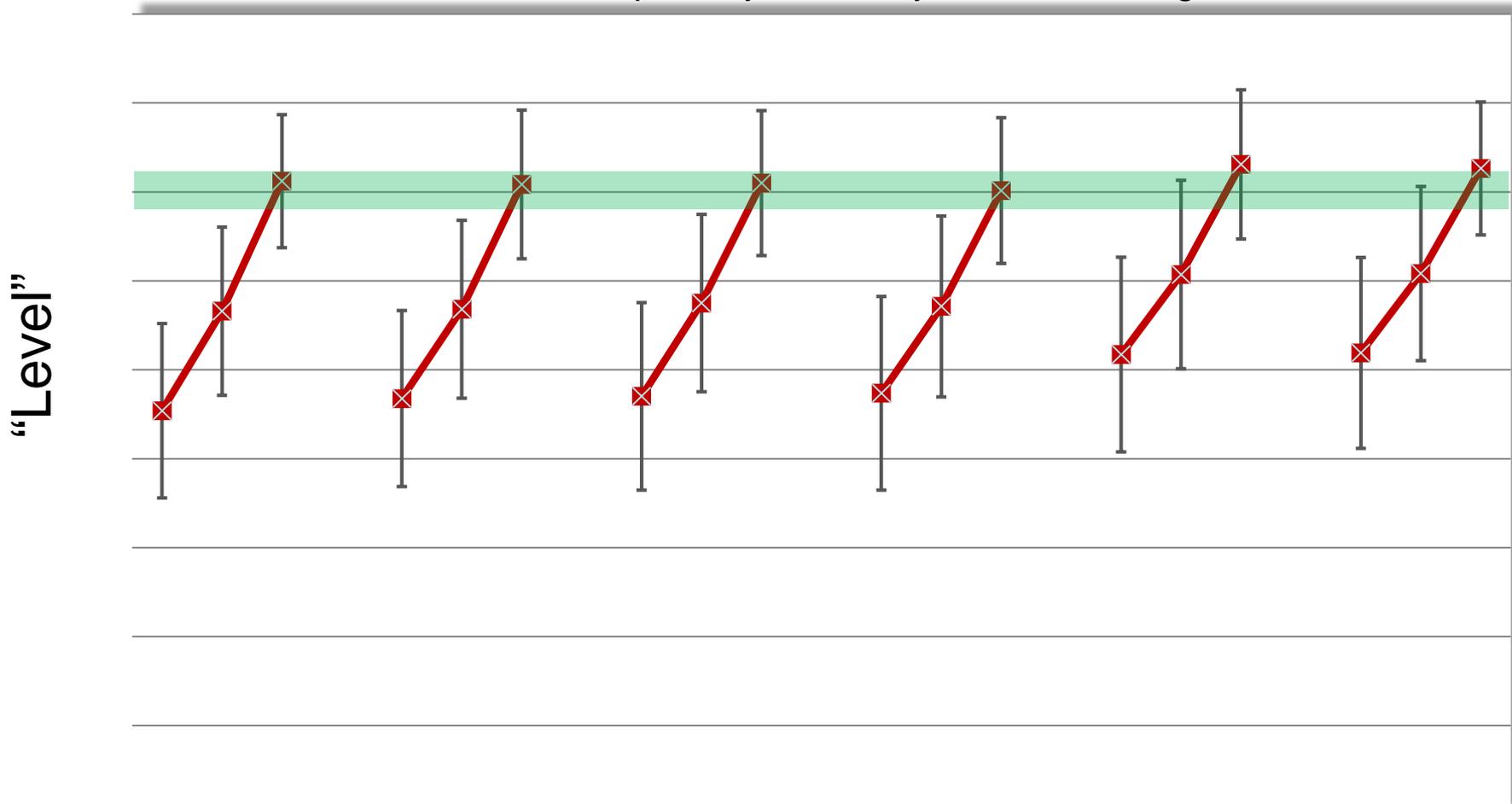
Median Ratings Across Programs, Patient Care
Obstetrics and Gynecology, 2015
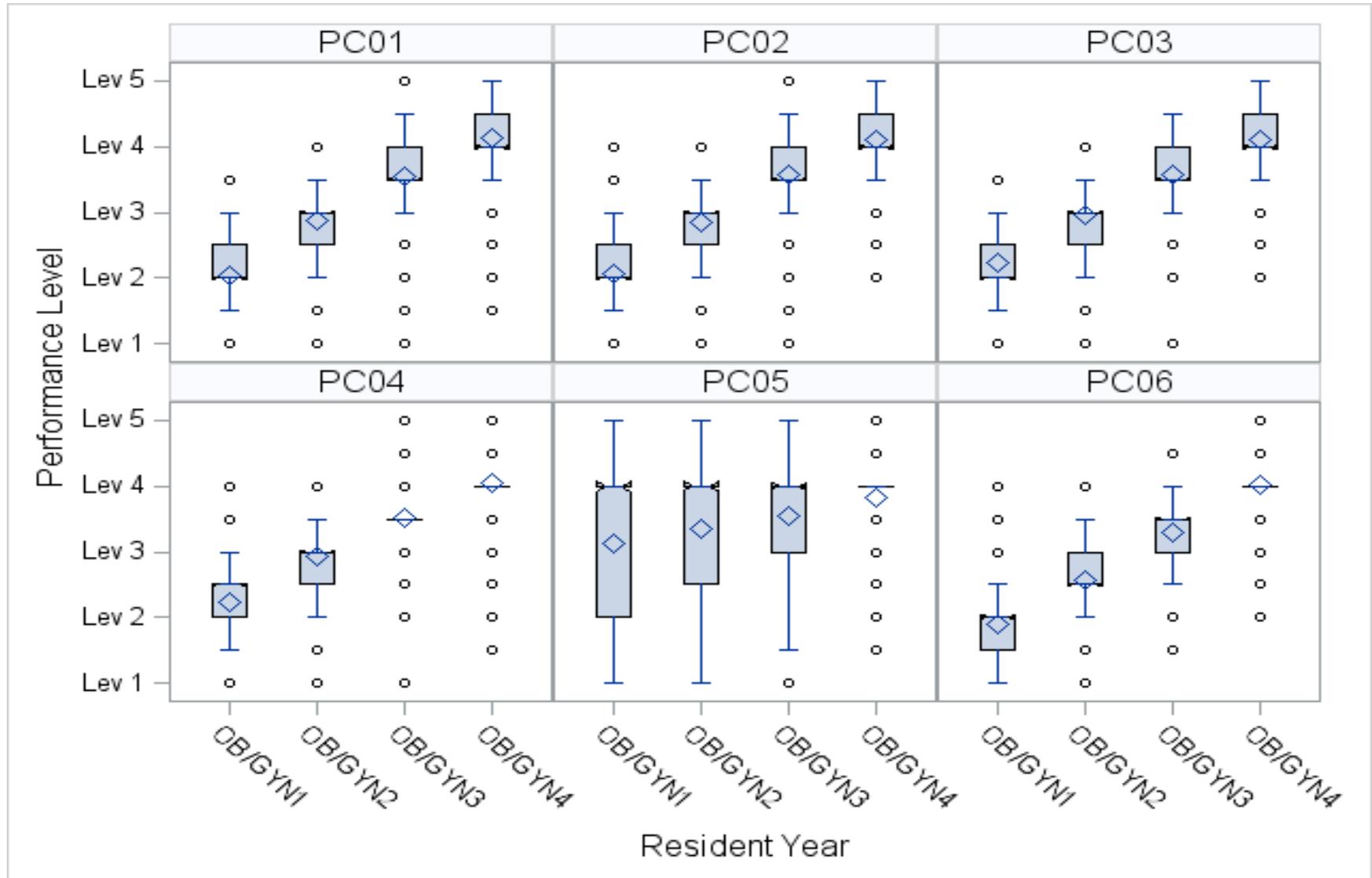
Medical Knowledge
Obstetrics and Gynecology, 2015
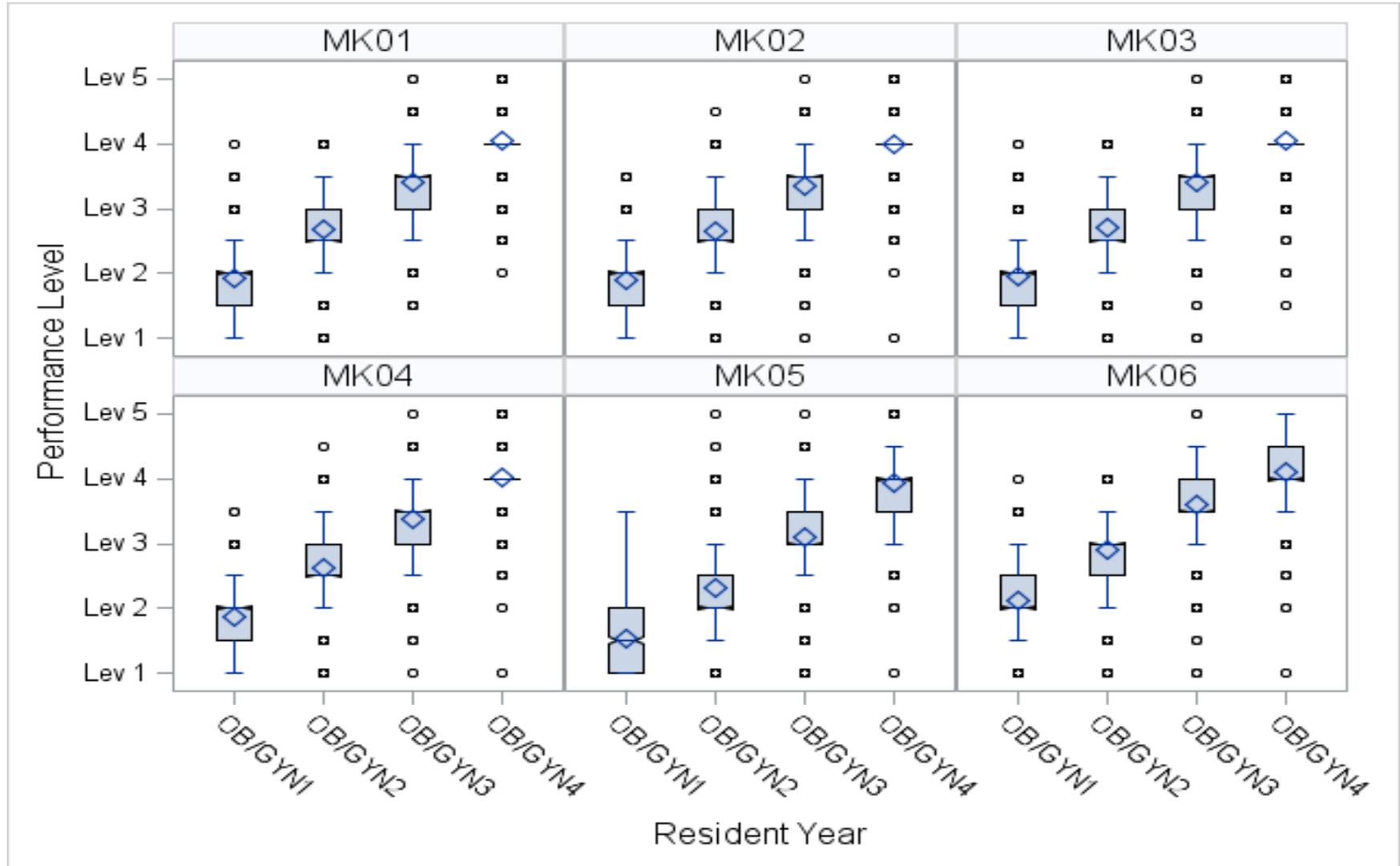
Professionalism
Obstetrics and Gynecology, 2015

Residents Attaining Level 4 or Higher

Radiation Oncology
(June 2015)
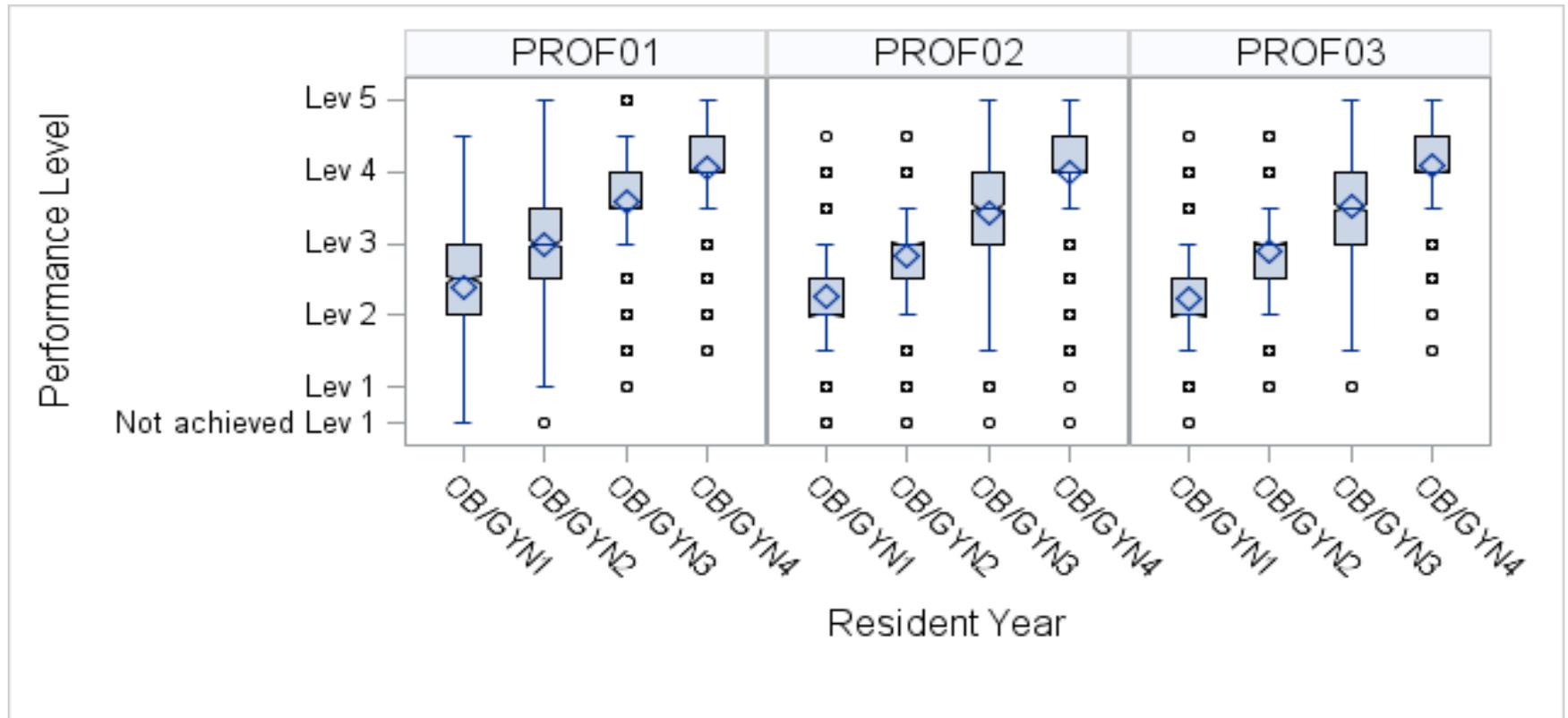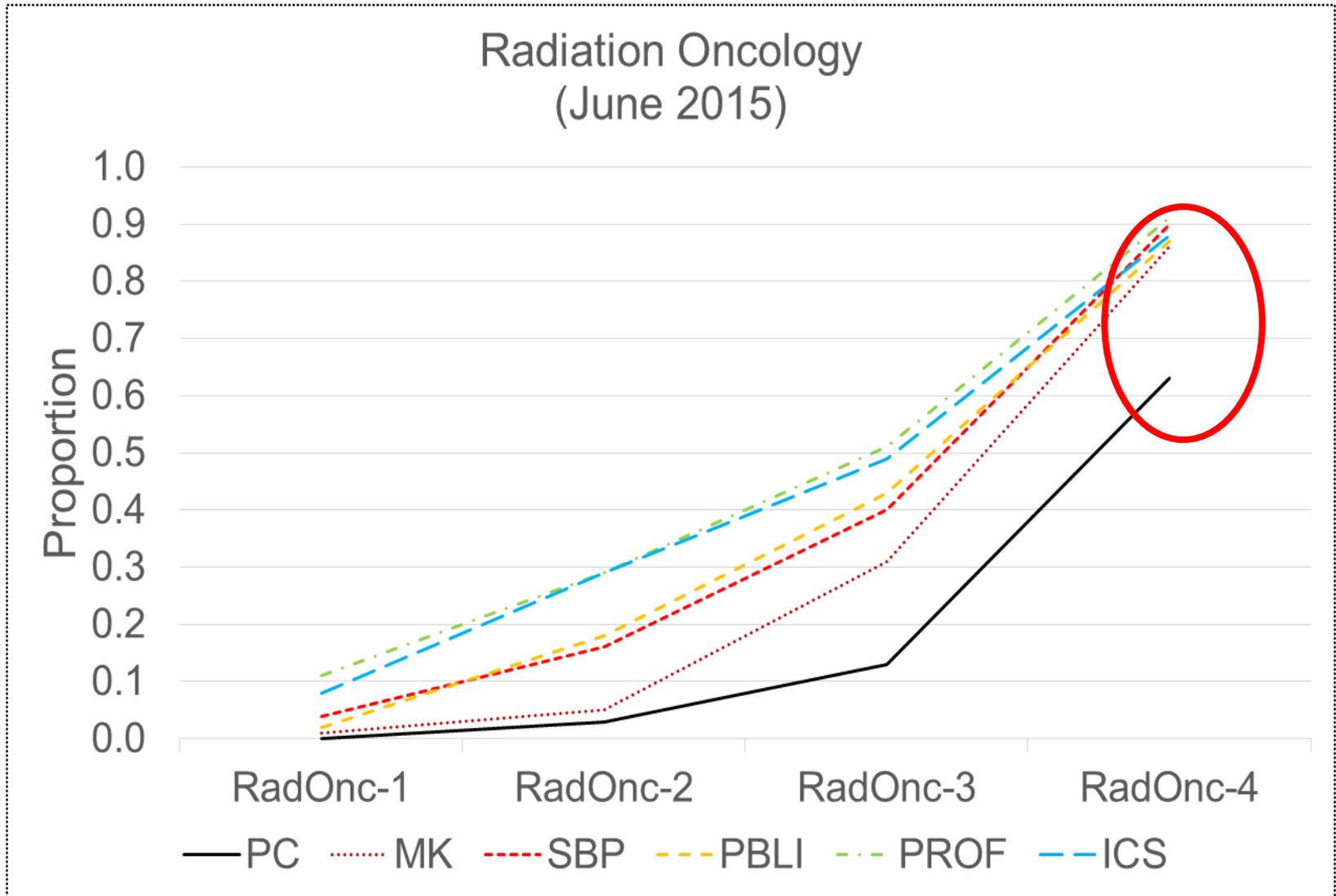
Residents Attaining Level 4 or Higher
for PC Sub-Competencies

Radiation Oncology
(June 2015)

	Achieved most
PC04	Palliation
PC11	Stereotactic Radiosurgery/Stereotactic Body Radiotherapy

	Achieved least
PC07	Gynecologic
PC10	Brachytherapy

Legend: PC04, PC11, PC08, PC05, PC09, PC02, PC06, PC01, PC03, PC07, PC10

X-axis: RadOnc-1, RadOnc-2, RadOnc-3, RadOnc-4
Y-axis: Proportion (0.0 to 1.0)

ACGME
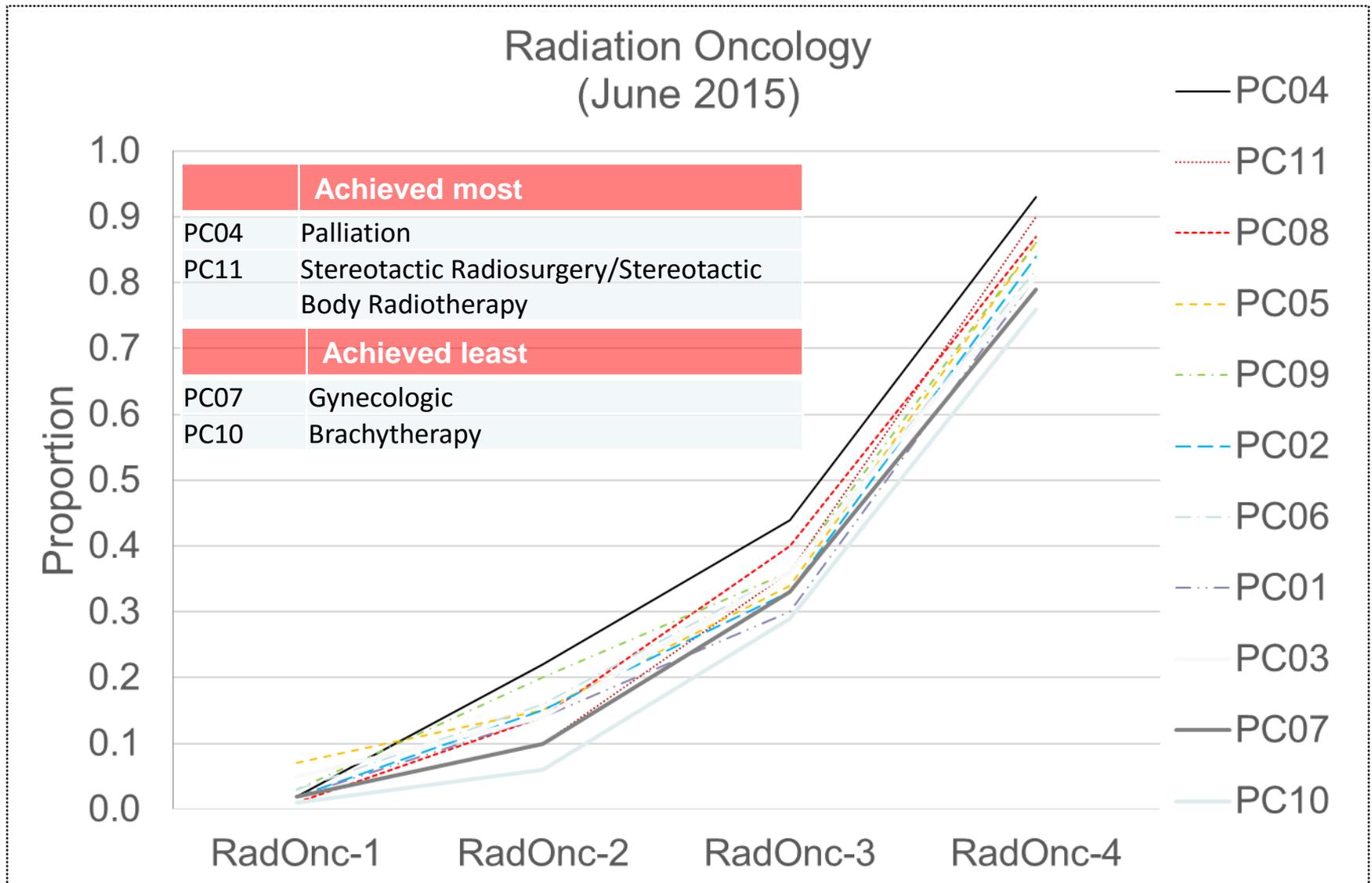
Residents Attaining Level 4 or Higher
in All Sub-Competencies

Neurological Surgery - 2014
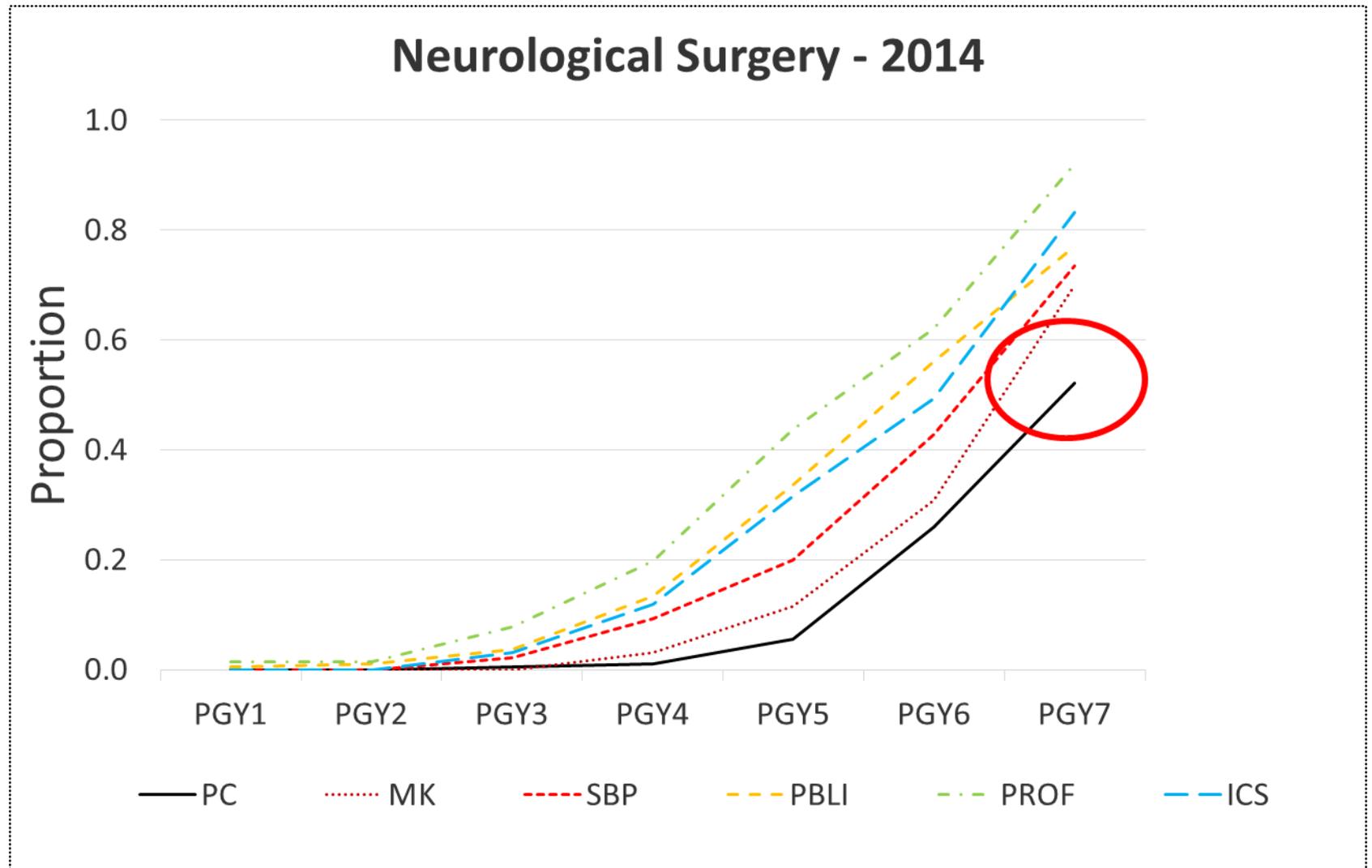
Neurological Surgery, June 2014
Level 4 Attainment per Patient Care Sub-Competency
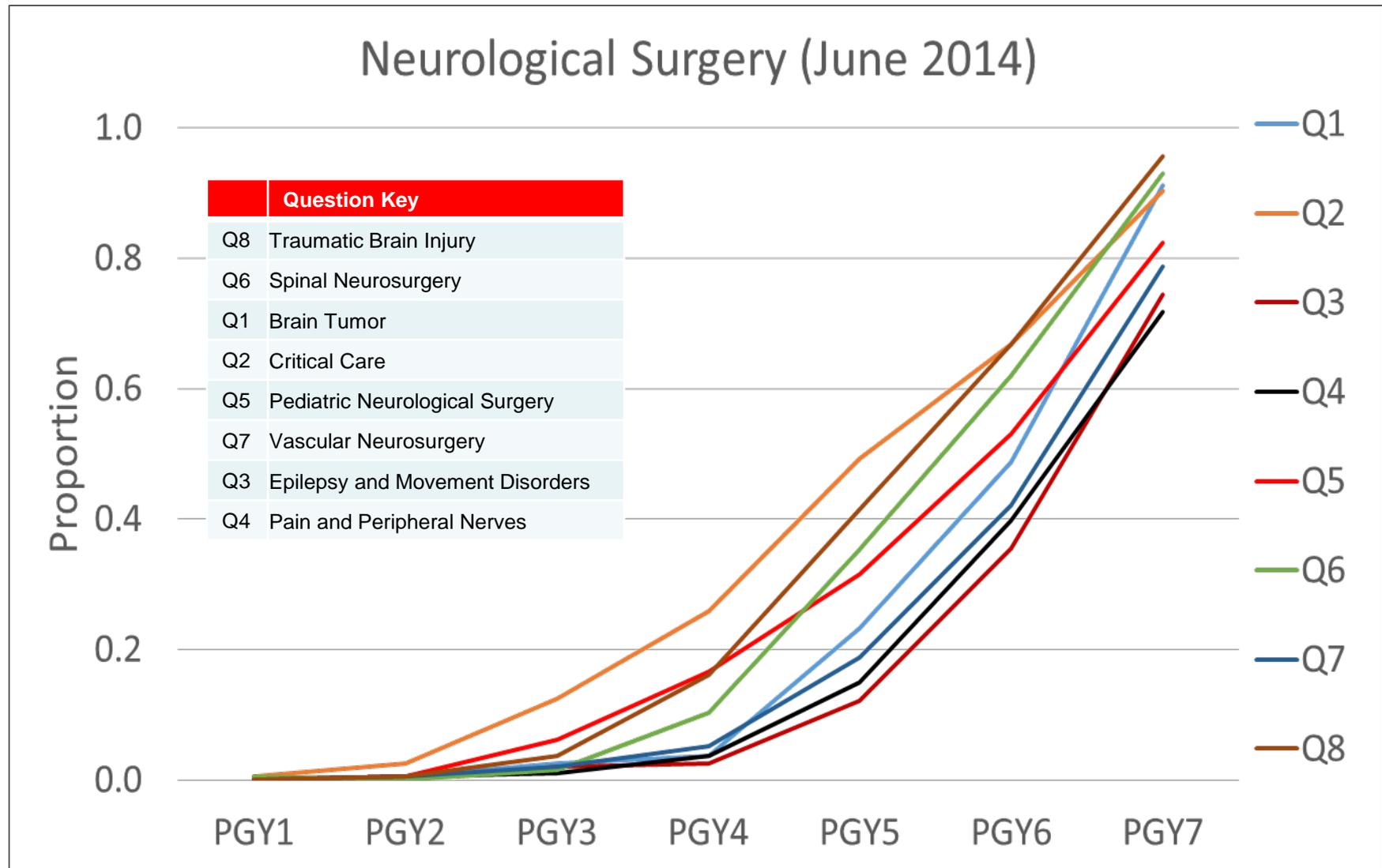
Neurological Surgery (June 2014)

Question Key	
Q8	Traumatic Brain Injury
Q6	Spinal Neurosurgery
Q1	Brain Tumor
Q2	Critical Care
Q5	Pediatric Neurological Surgery
Q7	Vascular Neurosurgery
Q3	Epilepsy and Movement Disorders
Q4	Pain and Peripheral Nerves

Neurological Surgery, June 2015
Level 4 Attainment per Patient Care Sub-Competency

Neurological Surgery, June 2015
Level 4 Attainment per Patient Care Sub-Competency

Question Key

Q8	Traumatic Brain Injury
Q2	Critical Care
Q1	Brain Tumor
Q6	Spinal Neurosurgery
Q5	Pediatric Neurological Surgery
Q7	Vascular Neurosurgery
Q4	Pain and Peripheral Nerves
Q3	Epilepsy and Movement Disorders
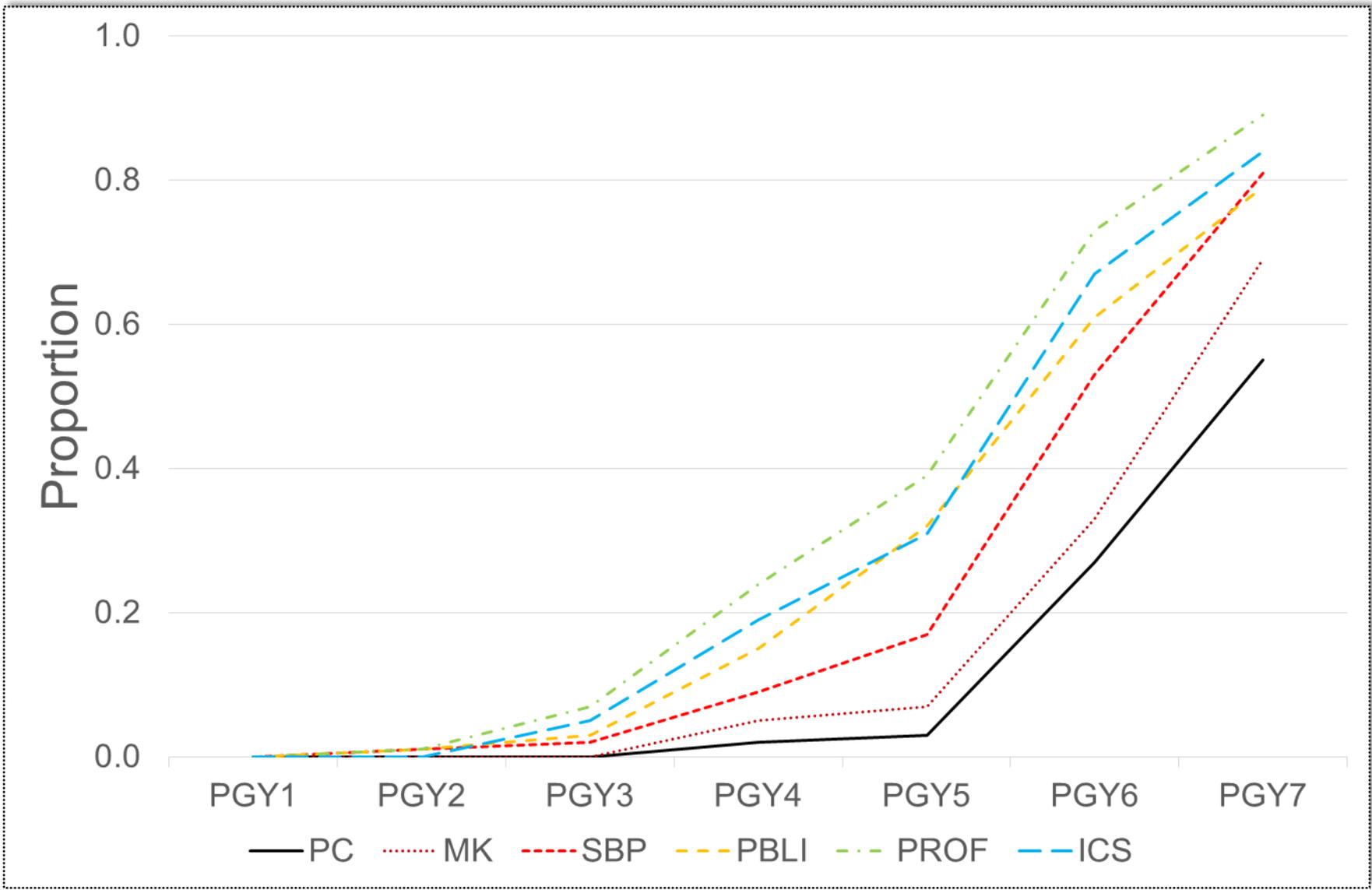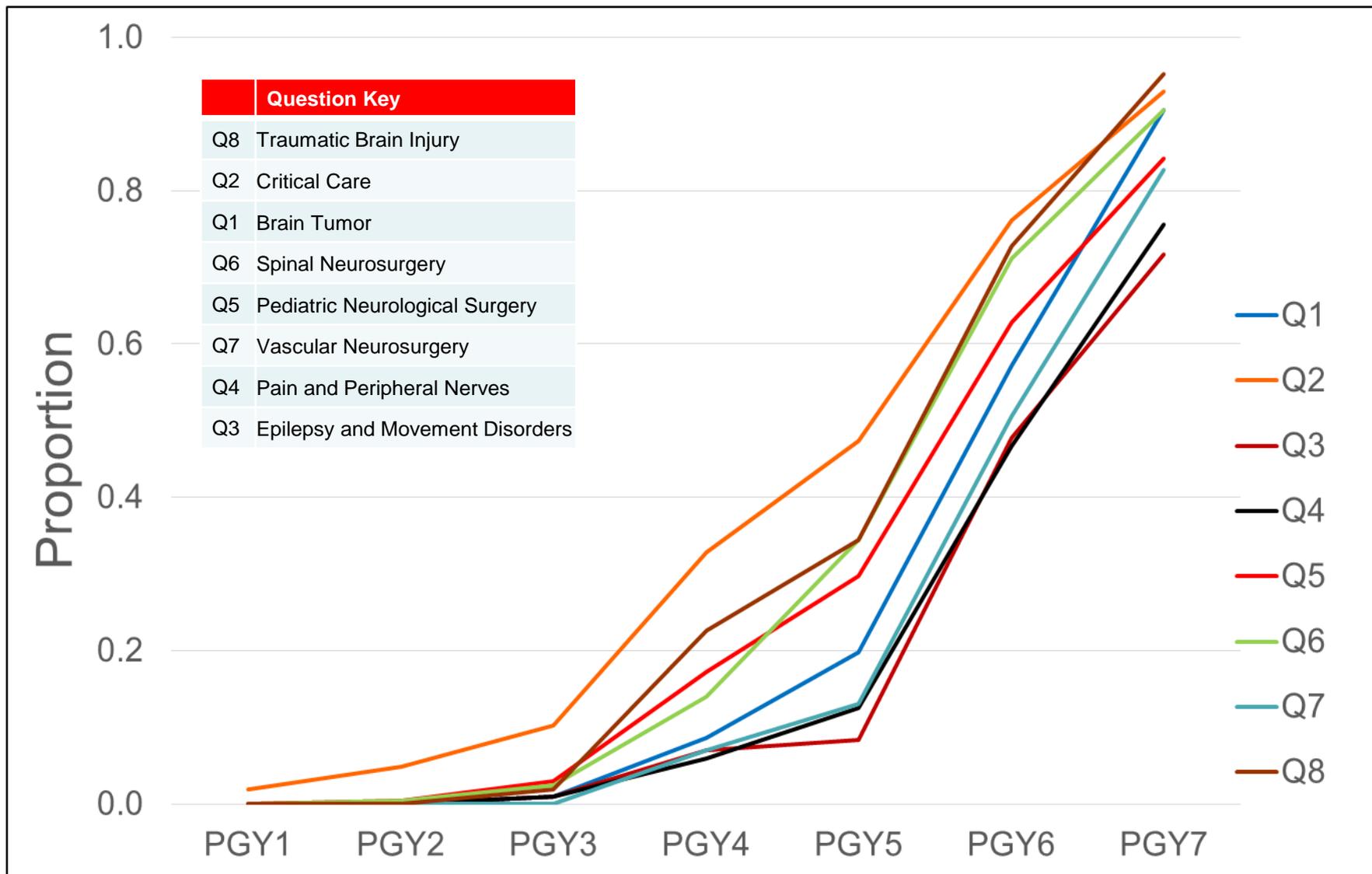
All Pathology Residents, May/June 2015
Overall Competency Assessment
*n=2351**
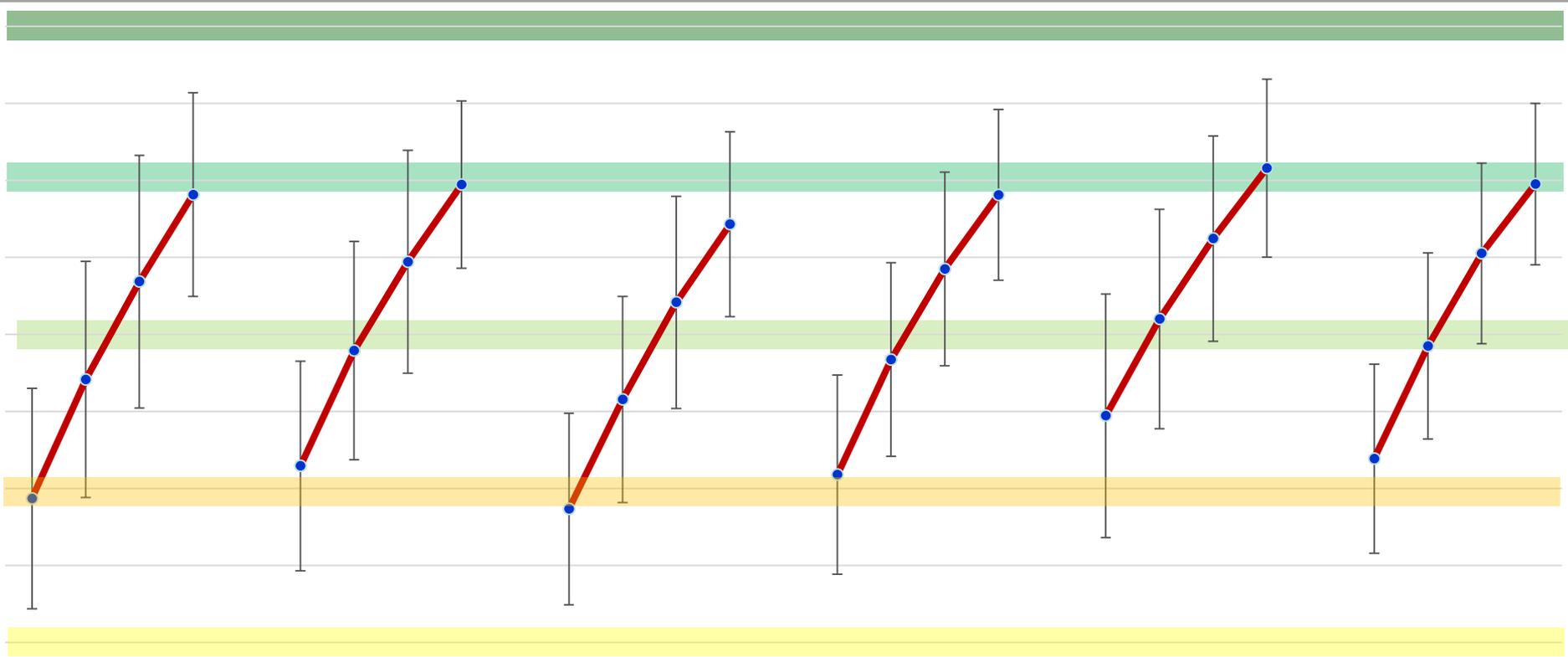
Year1	Year2	Year3	Year4	Year1	Year2	Year3	Year4	Year1	Year2	Year3	Year4	Year1	Year2	Year3	Year4	Year1	Year2	Year3	Year4	Year1	Year2	Year3	Year4
Patient Care				Medical Knowledge				Systems-Based Practice				Practice-Based Learning and Improvement				Professionalism				Interpersonal and Communication Skills			

n* = Year 1, 626; Year 2, 617; Year 3, 574; Year 4, 534.

Graduating Pathology Residents, 2015
n = 534 (100%); 27 Sub-competencies
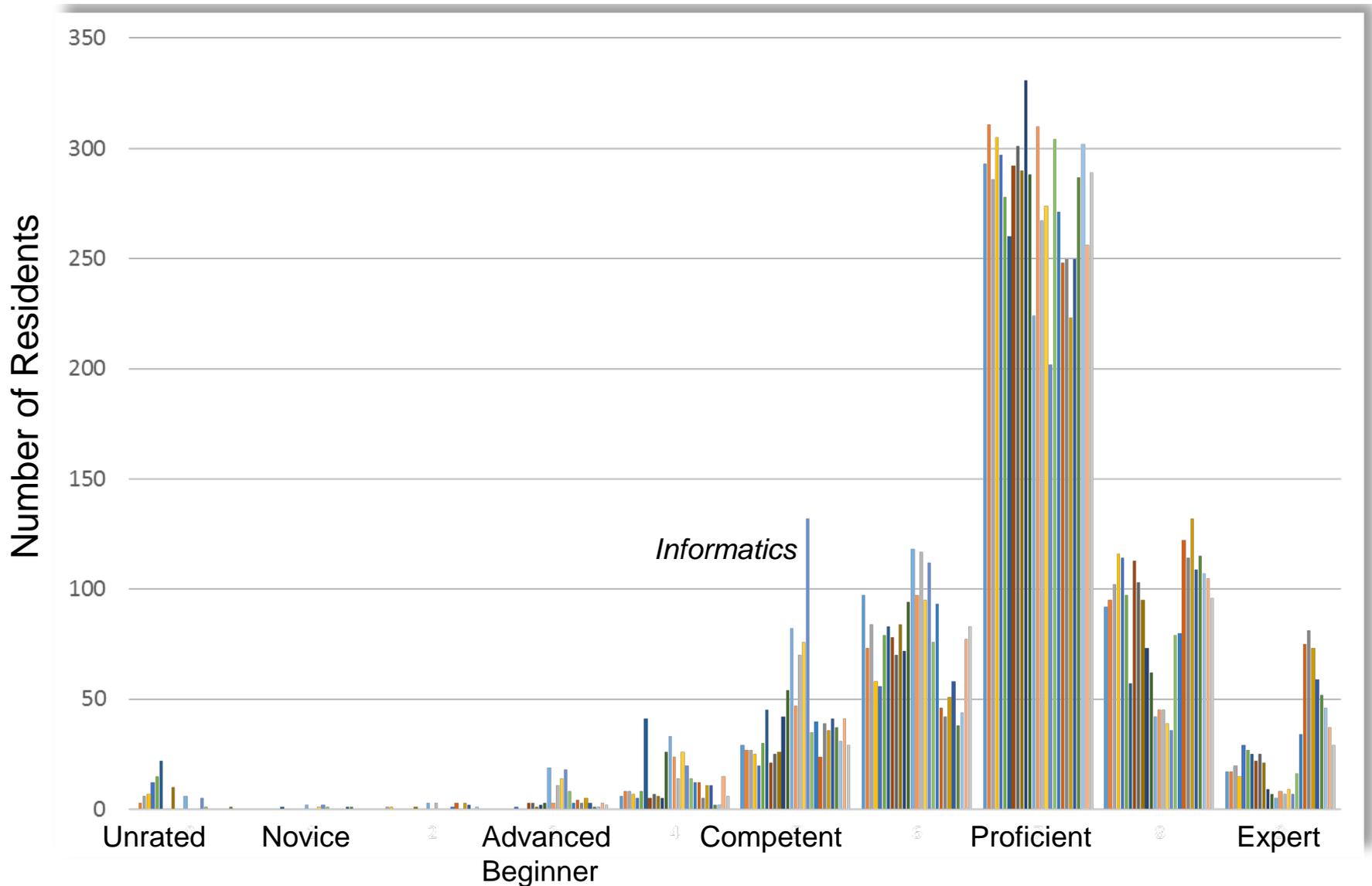
Orthopaedic Surgery 2014
System Based Practice Subcompetencies*

n* = Year 1, 726; Year 2, 735; Year 3, 711; Year 4, 704; Year 5, 691

ACGME
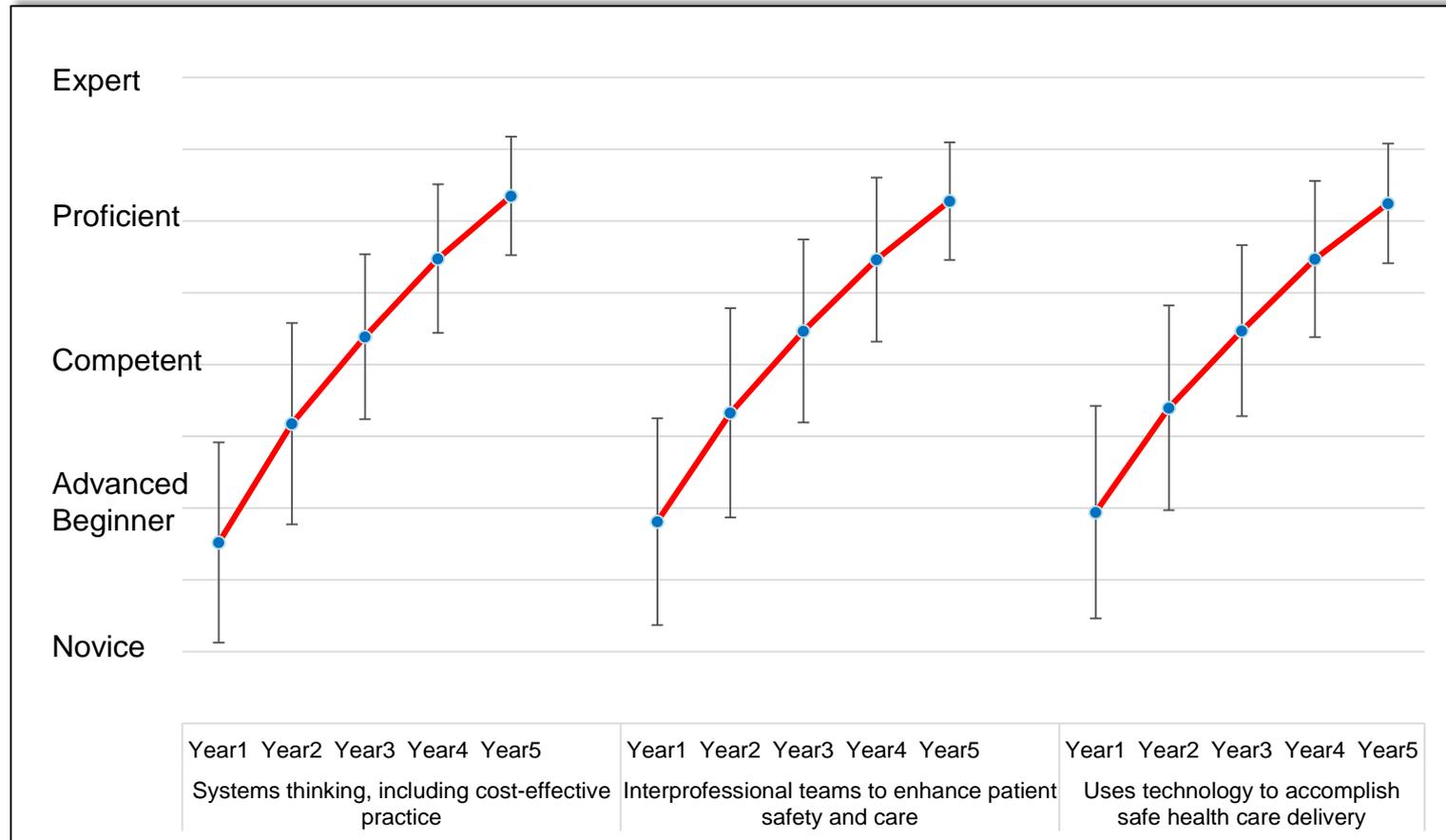
Orthopaedic Surgery 2014
Interpersonal and Communication Skills Subcompetencies*
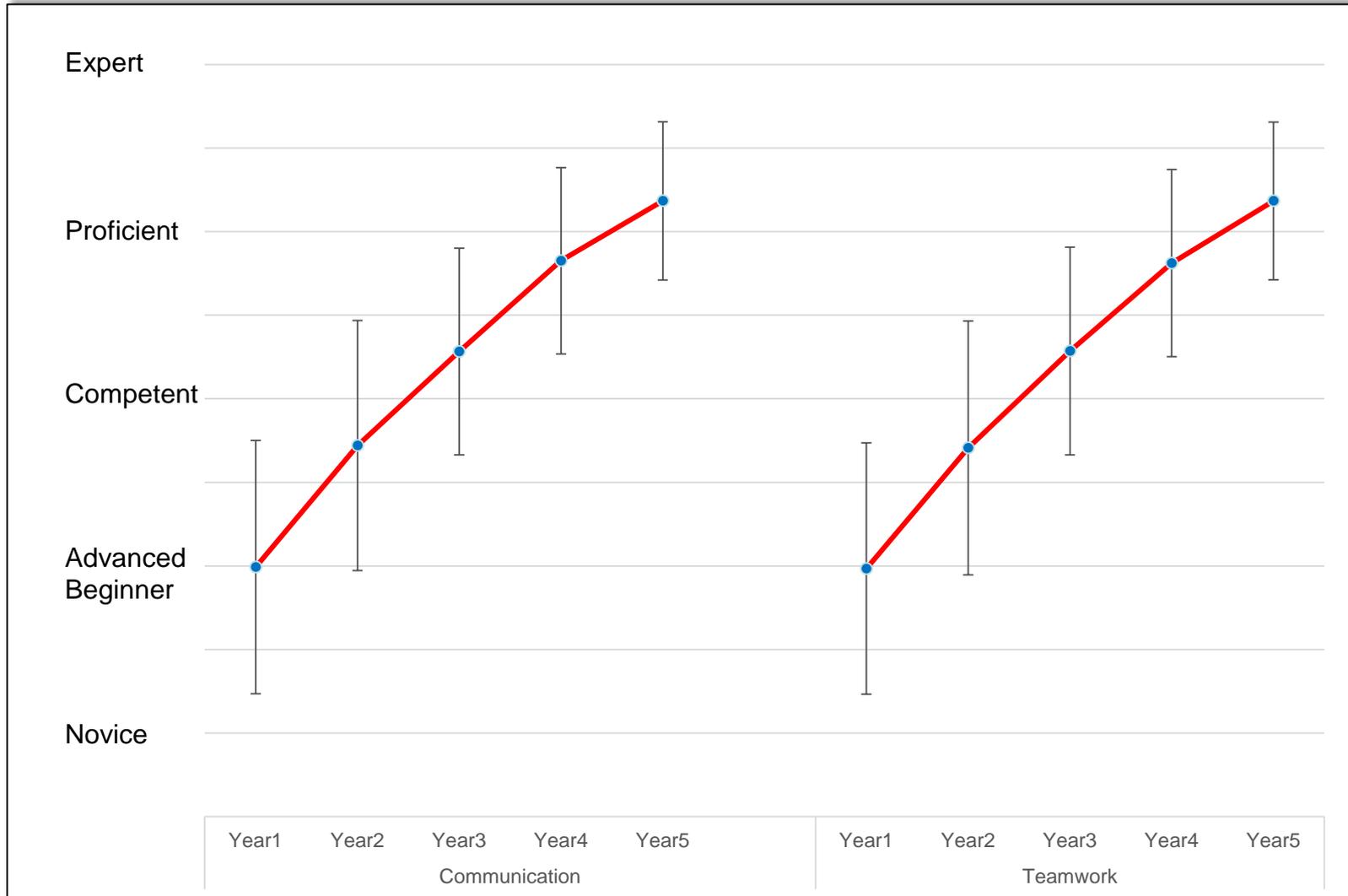
n* = Year 1, 726; Year 2, 735; Year 3, 711; Year 4, 704; Year 5, 691

Summary

- Positive Developmental Trajectory observed across System Based Practice and Interpersonal and Communication Skills in all specialties

- These observations are likely influenced by current definitions of "Teamwork" in each Clinical Learning Environment

- Structural dimensions of programs/institutions must be examined/modified to manifest opportunities for residents to experience "Optimal Teamwork"

- CLER data would suggest that current conceptualization of teamwork, at least around quality and safety, are less than ideally implemented in some CLE's

Thank You!

Current and Future Uses of Milestones

- Systematically improve outcomes through national study (research), linking educational outcomes to clinical outcomes of graduates in practice

- Correlate outcomes with attributes of programs and clinical learning environments – to further inform future standard setting

- Provide national comparisons and concrete descriptions of levels of performance for residents, enhancing formative feedback and mentored practice

Current and Future Uses of Milestones

- Provide direct feedback to program directors and faculty to improve their educational efforts.

- Aid in the development of individual physician competence

- Move from idiosyncratic satisfaction of minimal standards to a *"Decentralized but coordinated national educational effort to achieve excellence in preparing the next generation of physicians."*

- Provide national accountability for our outcomes (*aggregate*) to the Public, justifying ongoing support of our collective efforts

The Accreditation System *After* the "Next Accreditation System"

Thomas J. Nasca, MD, MACP, Kevin B. Weiss, MD, James P. Bagian, MD, PE, and Timothy P. Brigham, MDiv, PhD

Abstract

The Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties and its member boards introduced the six domains of physician competency in 1999. This initiated a national dialogue concerning the elements of competency of the physician, and incorporation of these elements into the framework of evaluation of residents and fellows, as well as the educational programs within which they are trained. The next step in this process will be the ACGME's Next Accreditation System, which the authors describe in this commentary. Recognizing that there are already developments in the assessment of medical education that will influence future models of accreditation, the authors consider some of these innovations and discuss how they may shape the next accreditation system *after* the Next Accreditation System.

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) described six domains

certification (IC) and maintenance of certification (MOC) processes in the six competencies, and the ACGME required residency and fellowship programs to configure curricula and evaluation processes in the rubric of the six competencies under the umbrella of the Outcome Project.[1] The implied goal of these tandem efforts was to establish desired outcomes of physician training and to maintain and enhance

next accreditation system *after* the Next Accreditation System.

The NAS

Coincident with the efforts of the Outcome Project and an increased focus on physician performance over time, the ACGME has redefined the accreditation process, moving to a model of continuous oversight of key parameters, while

The Challenges in Moving from Time-Based to Competency-Based Medical Education (CBME) at the GME level

- Need for well-defined and agreed upon outcomes

- Rigorous Pilot studies to examine feasibility

- Must address "deceleration as well as acceleration" in CBME

- Must address attainment of Mastery, not merely Proficiency

- Must first address heterogeneity in Clinical Learning Environment

- ACGME's CMBE Pilot Process

Issues with "Competency Based" Threshold Decisions for Completion of Training

Continued *Mentored* Deliberative Practice

Expert Performance
Continue Deliberative Practice
Continue Complex Cognitive/Associative Development

Arre...
Cease...
Auto...

Cognitive/...

Performance

EXPERIENCE

Violinists
- Professionals
- Best Experts
- Good Experts
- Least Accomplished Experts

Pianists
- Amateurs

Estimated Accumulated Practice (Hours)

Age of the Musicians (Years)

ACGME
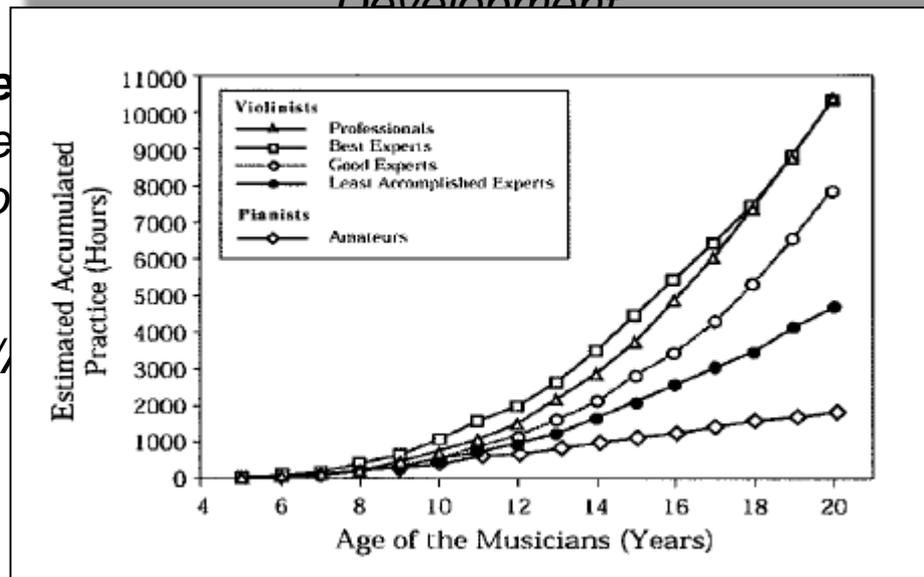
US Hospital Comparisons on Quality and Resource Use
(Higher scores represent better performance)

Non-teaching (N= 997)   ◆ *Teaching (N=186)*

Resource use Composite Score

Quality Composite Score

Exemplary Teaching Hospitals

Expensive High Quality Teaching Hospitals

ACGME

Optimism

"What lies behind us
and what lies before us
are tiny matters compared to
what lies within us."

Oliver Wendell Holmes

"The Future ain't what it used to be!"

Yogi Berra

Philosopher, New York Yankees Catcher

Deliberative Practice in the Development of Professional Violinists

from K. Anders Ericsson. Deliberate Practice and the Acquisition and Maintenance of Expert Performance in Medicine and Related Domains. Acad. Med. 79(10), S70-S81, 2004
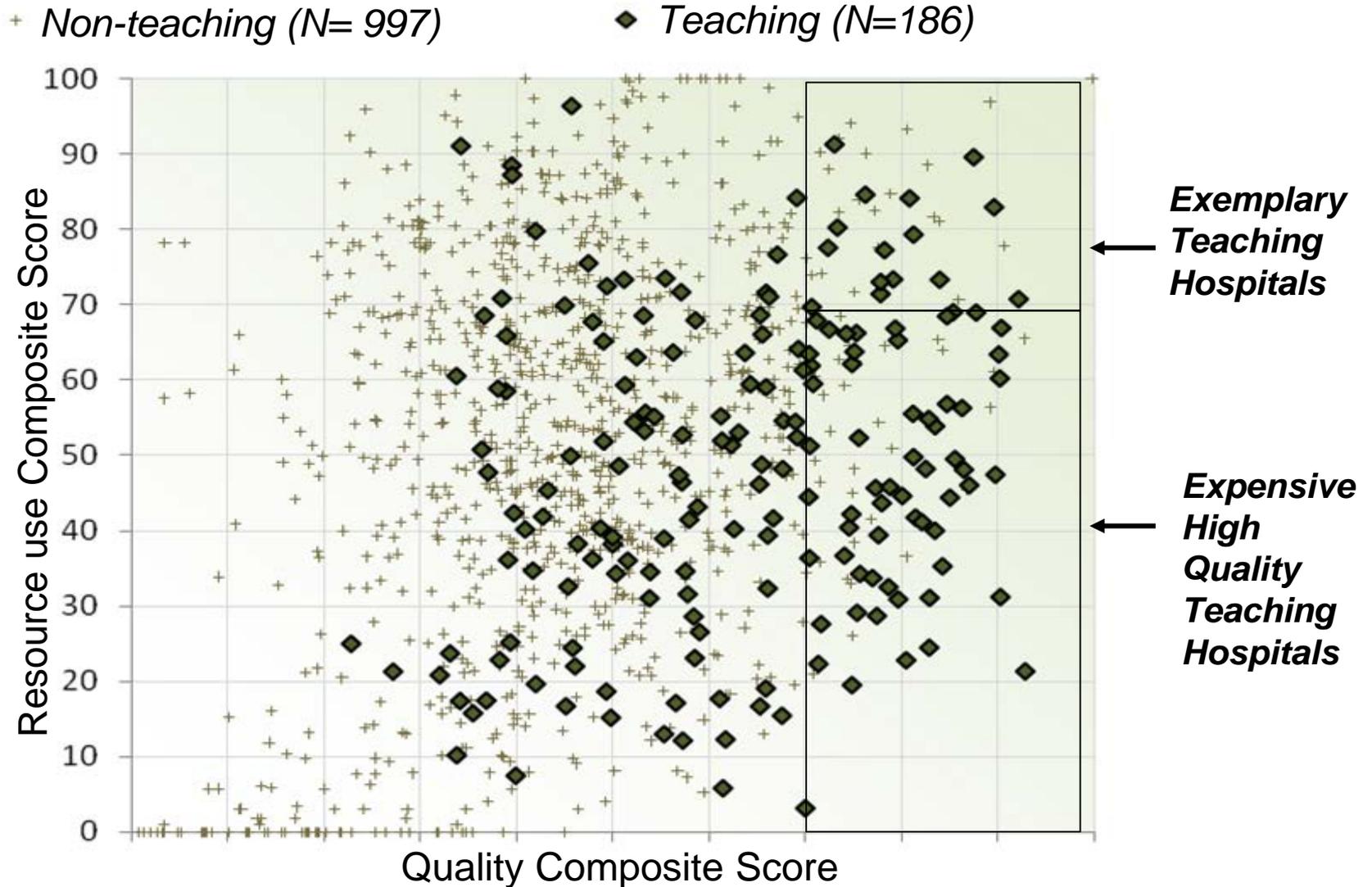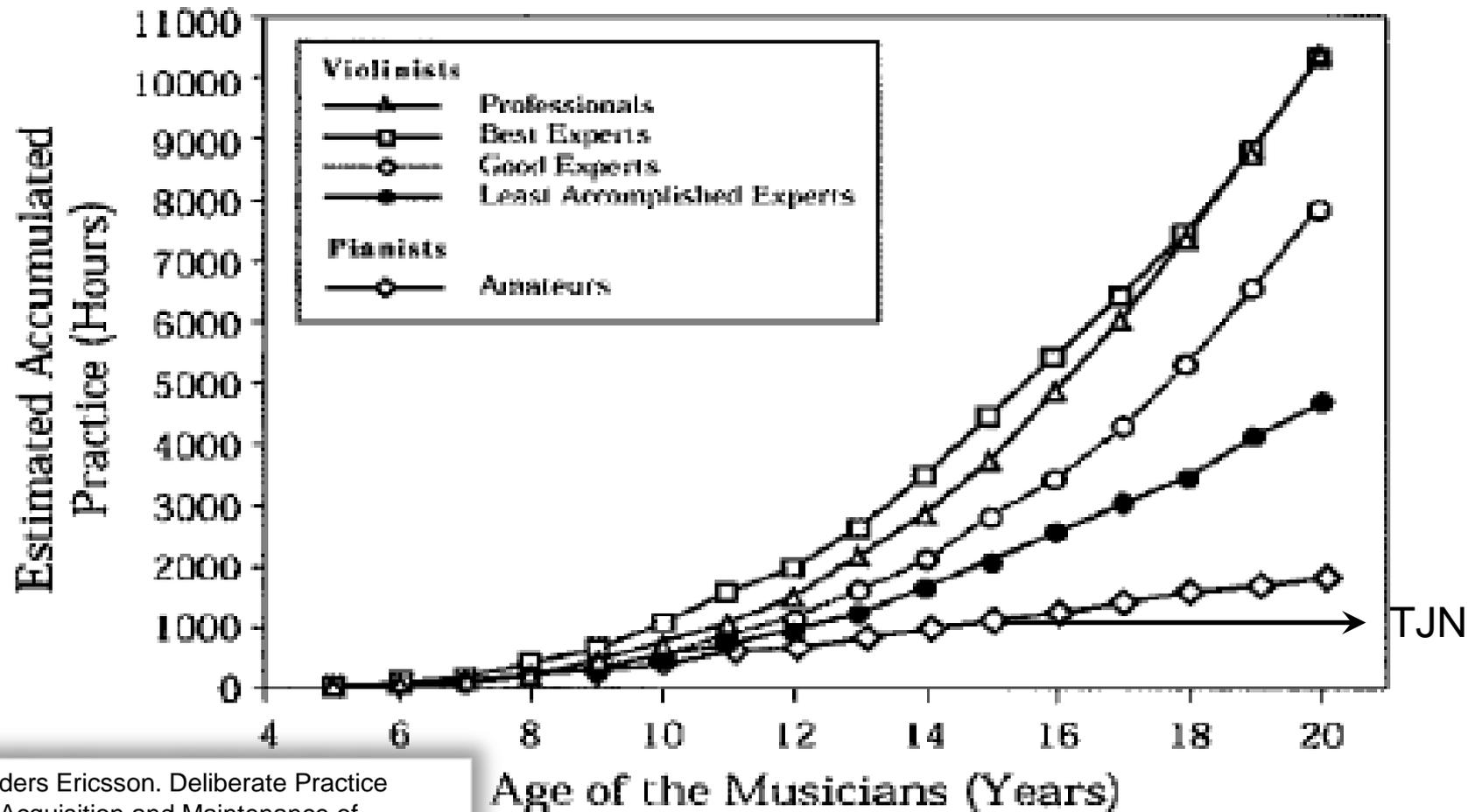
Reliability Across Evaluation Methods
Slide derived from that created by Cees van der Vleuten, 2010
as presented by Brian Hodges, ACGME Annual Educational Conference, 3/2/2013

Testing Time (hrs)	Multiple Choice Questions[1]	Case Based Short Essay[2]	Patient Management Problems[1]	Oral Examination[3]	Long Case[4]	Objective Structured Clinical Evaluation (OSCE)[5]
1	0.62	0.68	0.36	0.50	0.60	0.47
2	0.76	0.73	0.53	0.69	0.75	0.64
4	0.93	0.84	0.69	0.82	0.86	0.78
8	0.93	0.82	0.82	0.90	0.90	0.88

<u>**Review Article Reference**</u>**: van der Vleuten, CPM, Schuwirth, LWT. Assessing professional competence: from methods to Programmes. Medical Education 2005; 39: 309–317**

[1] **Norcini JJ.** Reliability, validity and efficiency of multiple choice question and patient management problem item formats in assessment of clinical competence. Medical education. 1985;19(5):238-47.

[2]**Stalenhoef-Halling et al.,** 1990

[3] **Swanson, David B.** A measurement framework for performance-based tests. In: Hart I, Harden R, eds, Further Developments in Assessing Clinical Competence. Montreal: Can-Heal publications 1987;13–45.

[4]**Wass, V., Jolly, B.** Does observation add to the validity of the long case? Medical Education 2001;35:729±734

[5]**Petrusa, ER.** Status of Standardized Patient Assessment. Teaching and Learning in Medicine, *16*(1), 98–110 and: Clinical performance assessments. In International handbook of research in medical education. Dordrecht, The Netherlands: Kluwer Academic, 2002.

Reliability of Oral Examinations[1]
Slide derived from that created by Cees van der Vleuten, 2010
as presented by Brian Hodges, ACGME Annual Educational Conference, 3/2/2013

Testing Time (hrs)	Number of Cases	Same Examiner for All Cases	New Examiner for Each Case	Two New Examiners for Each Case
1	2	0.31	0.50	0.61
2	4	0.47	0.69	0.76
4	8	0.47	0.82	0.86
8	12	0.48	0.90	0.93

[1] **Swanson, David B.** A measurement framework for performance-based tests. In: Hart I, Harden R, eds, Further Developments in Assessing Clinical Competence. Montreal: Can-Heal publications 1987;13–45. *See also*, **Swanson, DB.** Arch Intern Med 1987;147:1981-1985.

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Traditions Contributing to the American Concept of Professionalism

Hippocratic Tradition
"Medicine as a Moral Enterprise"

Hippocrates
Aristotle
Maimonides
Thomas Aquinas
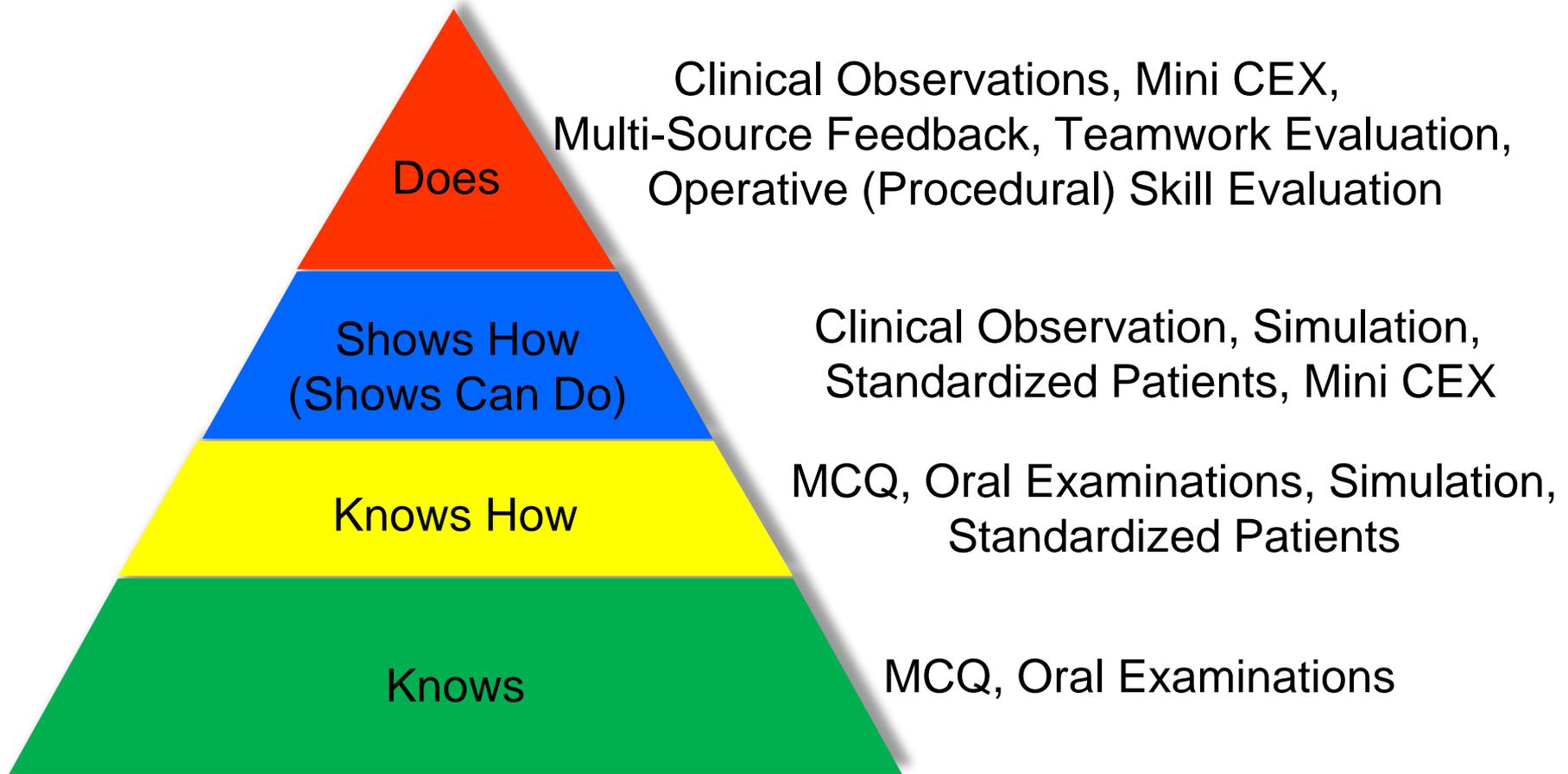*Edmund Pellegrino*

Physician as a Moral Actor

- Character
- Altruism Guiding Virtue
- Ethical Decision-Making

Guild to Profession
"Medicine as a Public Trust"

Francis Bacon
David Hume
John Gregory
Thomas Percival
AMA, ABIM Charter

Physician as a Professional

- Competency
- Altruism
- Education of the next generation to serve

Social Justice
"Medicine as a Social Good"

John Rawls
Ruth Faden
Madison Powers
ABIM Charter

Physician as a Participant in the Social Contract

- Just distribution of the Good of Health Care
- Well Being

Physician Voluntary Oath To Society and Each Other

Individual Physician

Medical Profession

Trusting Relationship between Patient and Physician

Social Contract between Society and the Medical Profession
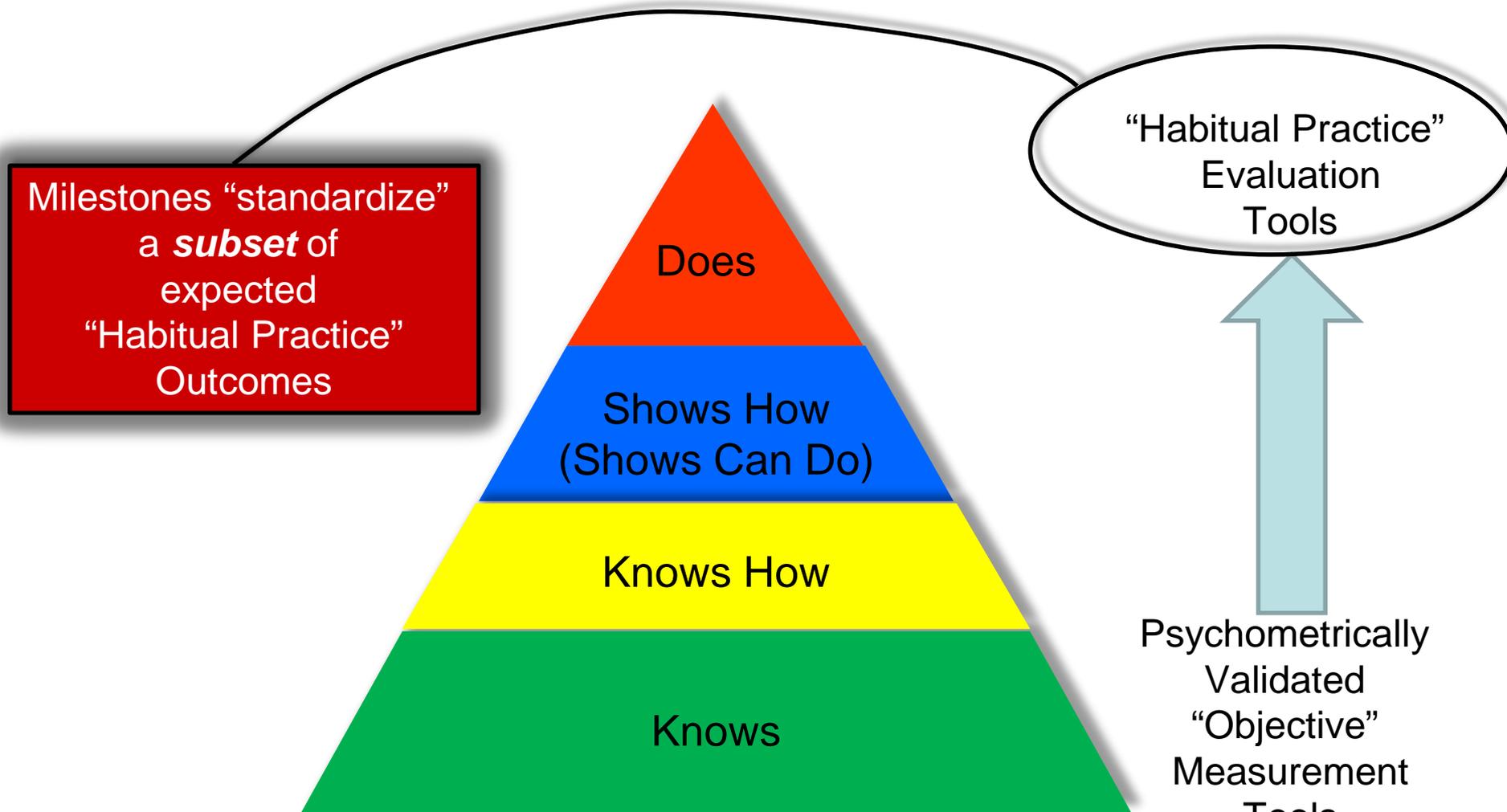
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Miller's Pyramid of Clinical Competence[1]

[1]Miller, GE. Assessment of Clinical Skills/Competence/Performance.
Academic Medicine (Supplement) 1990. 65. (S63-S67)

Does — Clinical Observations, Mini CEX, Multi-Source Feedback, Teamwork Evaluation, Operative (Procedural) Skill Evaluation

Shows How (Shows Can Do) — Clinical Observation, Simulation, Standardized Patients, Mini CEX

Knows How — MCQ, Oral Examinations, Simulation, Standardized Patients

Knows — MCQ, Oral Examinations

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Miller's Model of Clinical Competence

Milestones "standardize" a **subset** of expected "Habitual Practice" Outcomes

"Habitual Practice" Evaluation Tools

Does

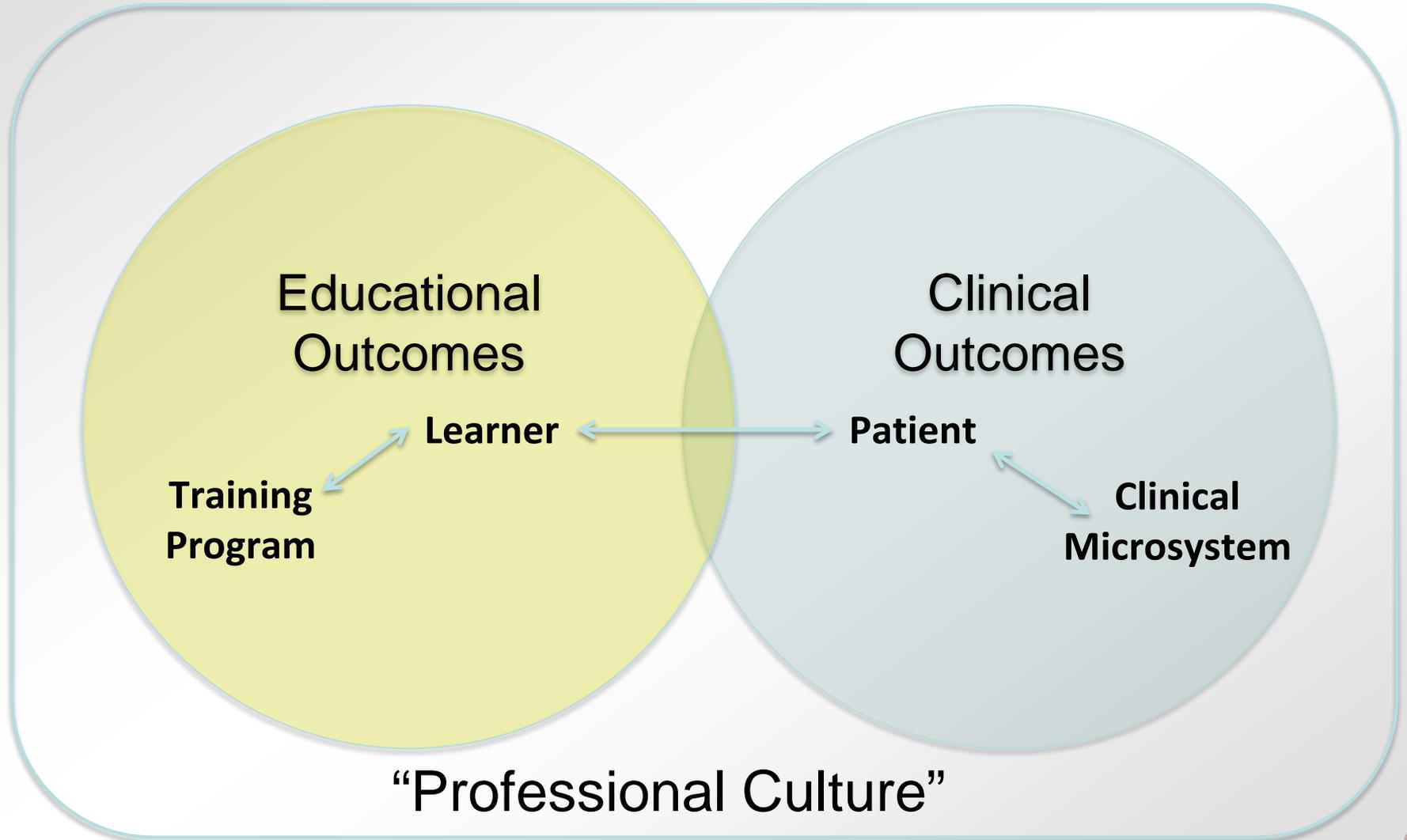Shows How (Shows Can Do)

Knows How

Knows

Psychometrically Validated "Objective" Measurement Tools

Miller, GE. **Assessment of Clinical Skills/Competence/Performance.**
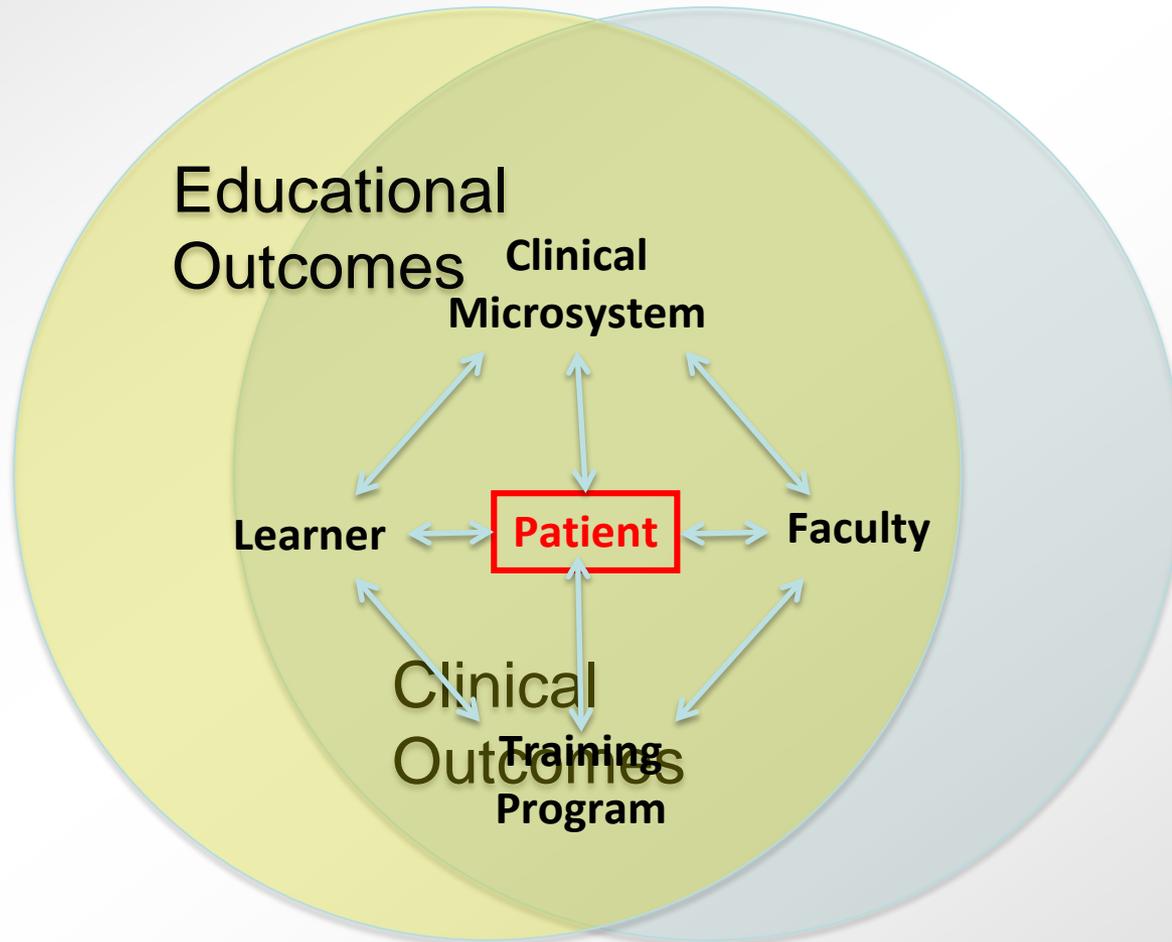Academic Medicine (Supplement) 1990. 65. (S63-S67)

van der Vleuten, CPM, Schuwirth, LWT, Scheele, F, Driessen, EW, Hodges, B.
The assessment of professional competence: building blocks for theory development.
Best Practice & Research Clinical Obstetrics and Gynaecology 24 (2010) 703–719
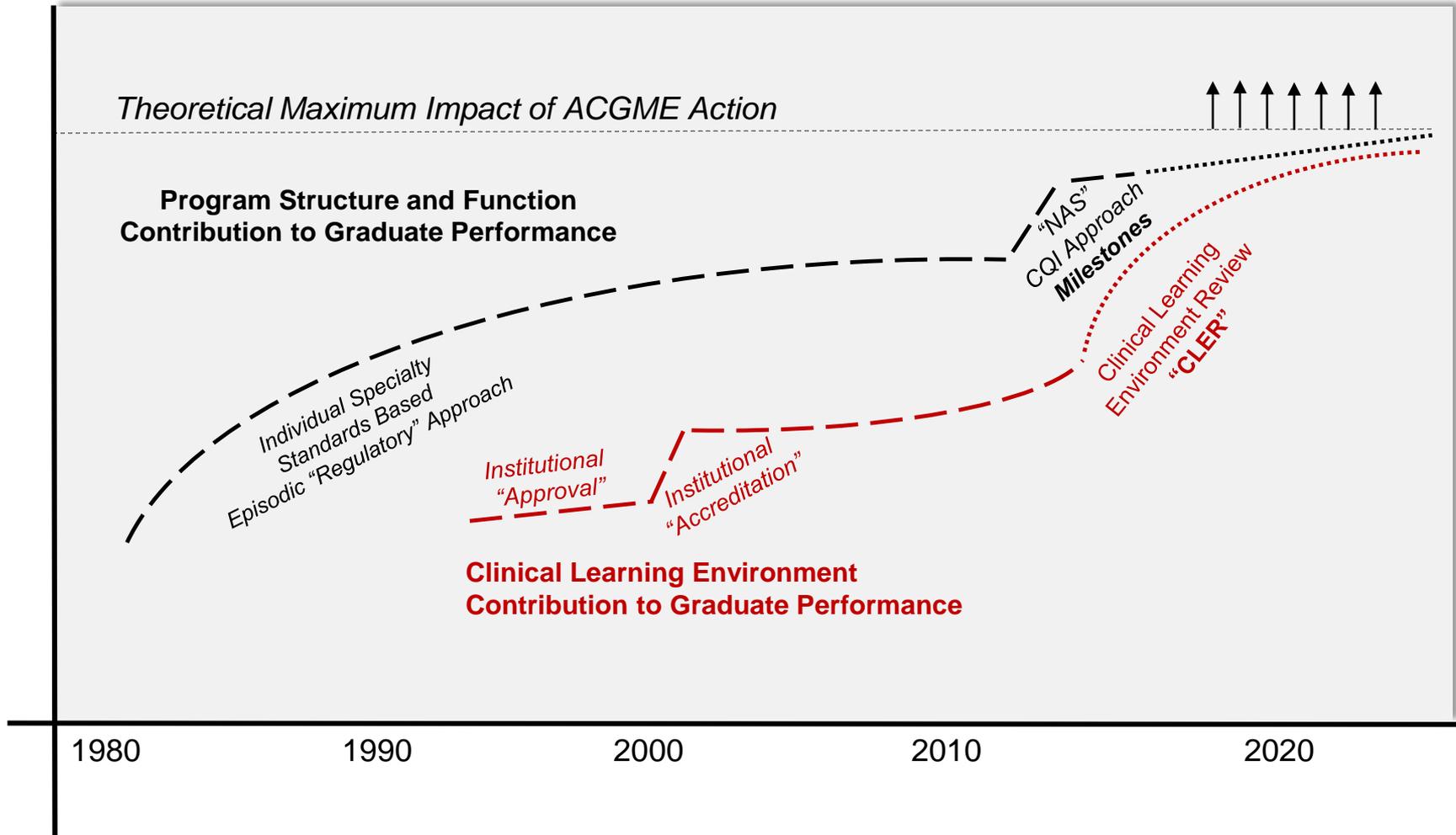
Traditional Medical Education Perspective

Educational Outcomes

Clinical Outcomes

Learner → Patient

Training Program

Clinical Microsystem

"Professional Culture"

Needed Perspective

Institutional and System Professionalism

Educational Outcomes

Clinical Microsystem

Clinical Outcomes

Learner ⟷ **Patient** ⟷ Faculty

Training Program

Elements of ACGME Accreditation
Contribution to Graduate Performance

Theoretical Maximum Impact of ACGME Action

Program Structure and Function
Contribution to Graduate Performance

Individual Specialty
Standards Based
Episodic "Regulatory" Approach

"NAS"
CQI Approach
Milestones

Institutional
"Approval"

Institutional
"Accreditation"

Clinical Learning
Environment Review
"CLER"

Clinical Learning Environment
Contribution to Graduate Performance

1980   1990   2000   2010   2020

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The Way Ahead Is Difficult But Not Impossible

©Heidi Baikie

Thank You!

Disclosure of relevant financial relationships

- **Nothing to disclose**

Scope of the Enterprise

2014 Reporting Year

Physician Interactions	Other Learner Interactions
13,599,687	11,587,518

Activities	Hours of Instruction
147,024	1,033,615

Providers:
1,225 SMS-accredited
683 ACCME-accredited

Types of Activities in 2014

	Activities
Courses	71,047
Regularly scheduled series	23,427
Internet (live)	4,063
Test-item writing	87
Committee learning	575
Performance improvement	470
Internet searching and learning	82
Internet (enduring materials)	34,006
Enduring materials (other)	8,452
Learning from teaching	149
Journal CME	4,596
Manuscript review	70

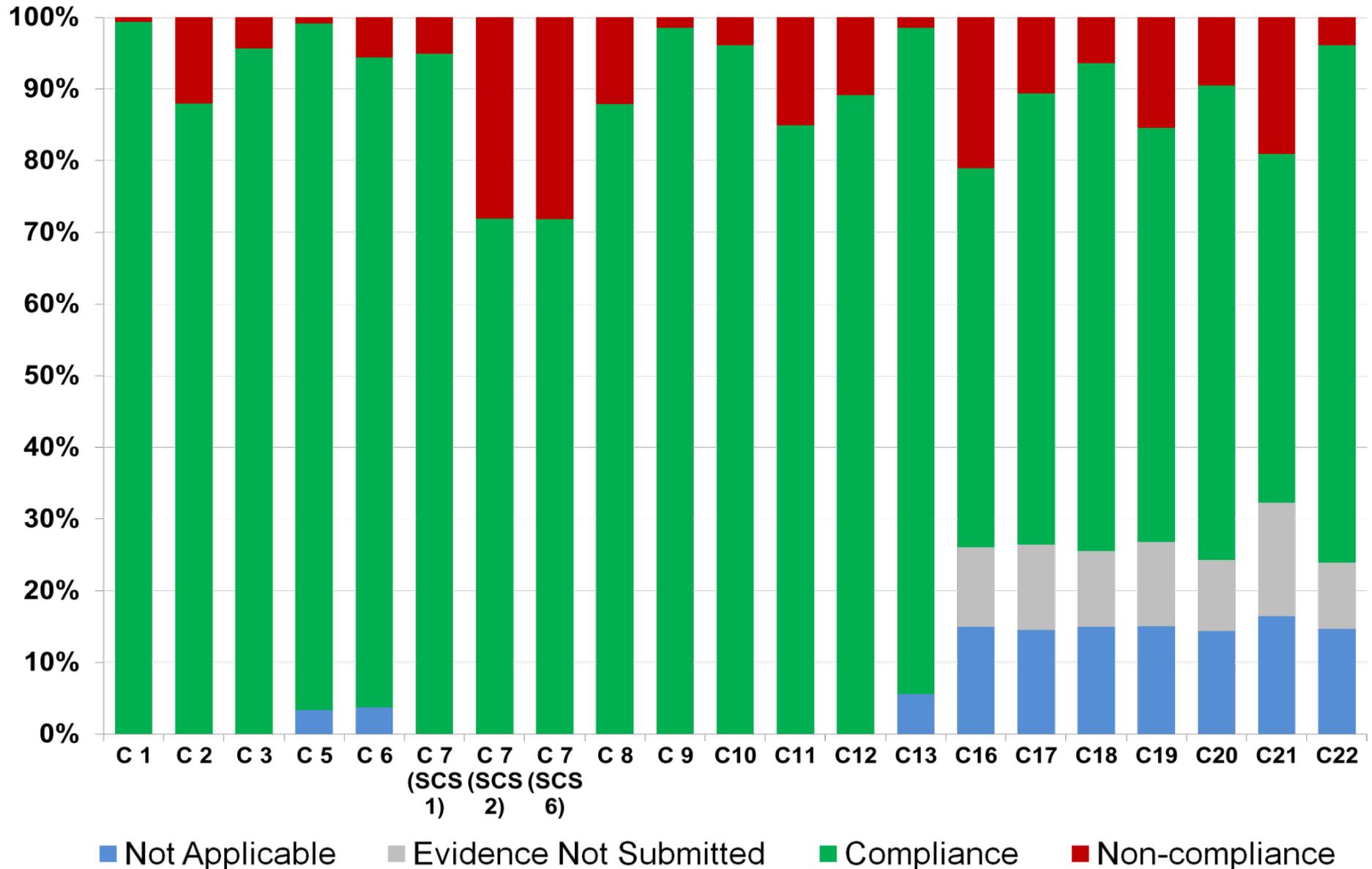# CME Presented by Providers Accredited in the ACCME System - 2014
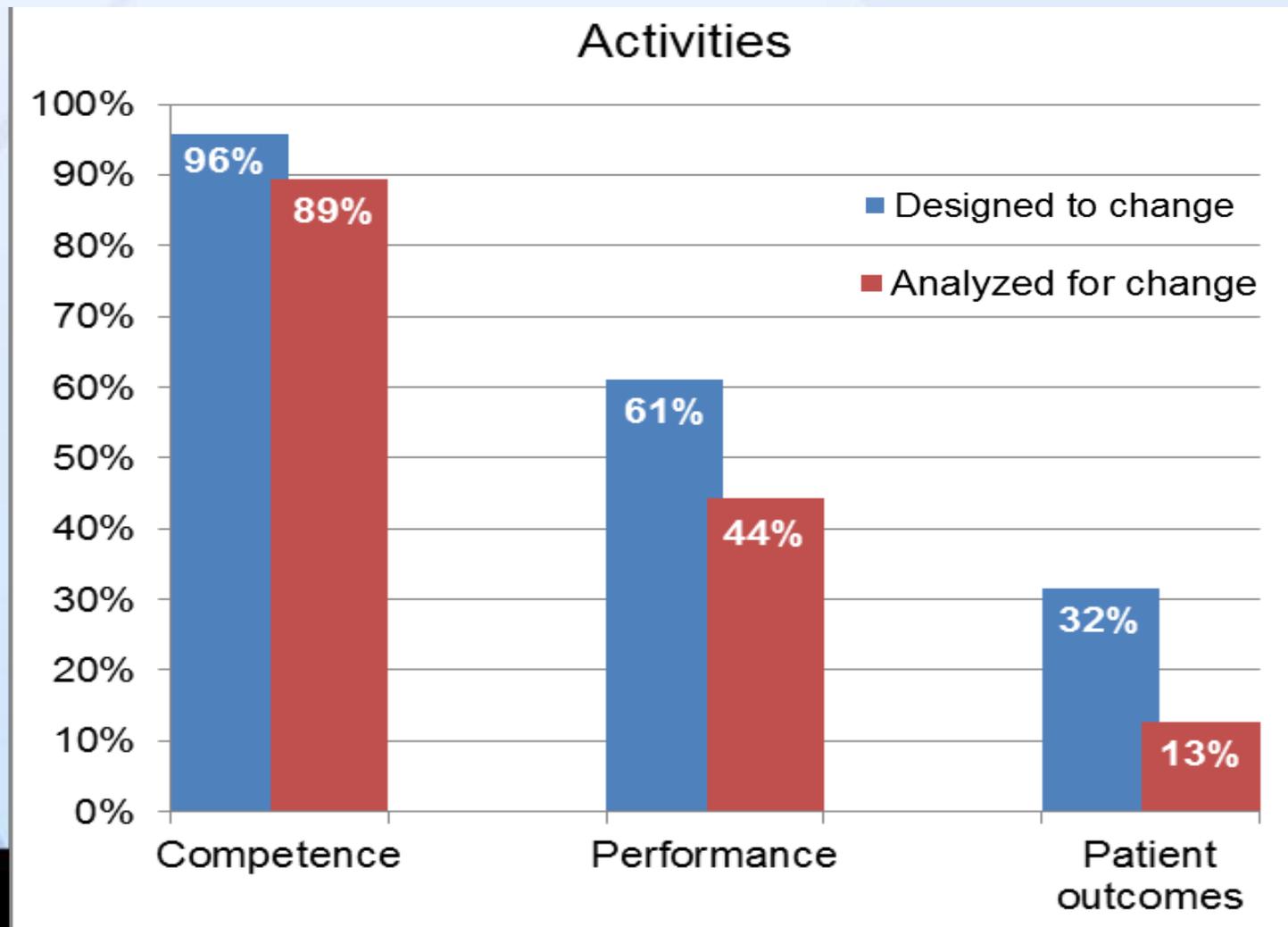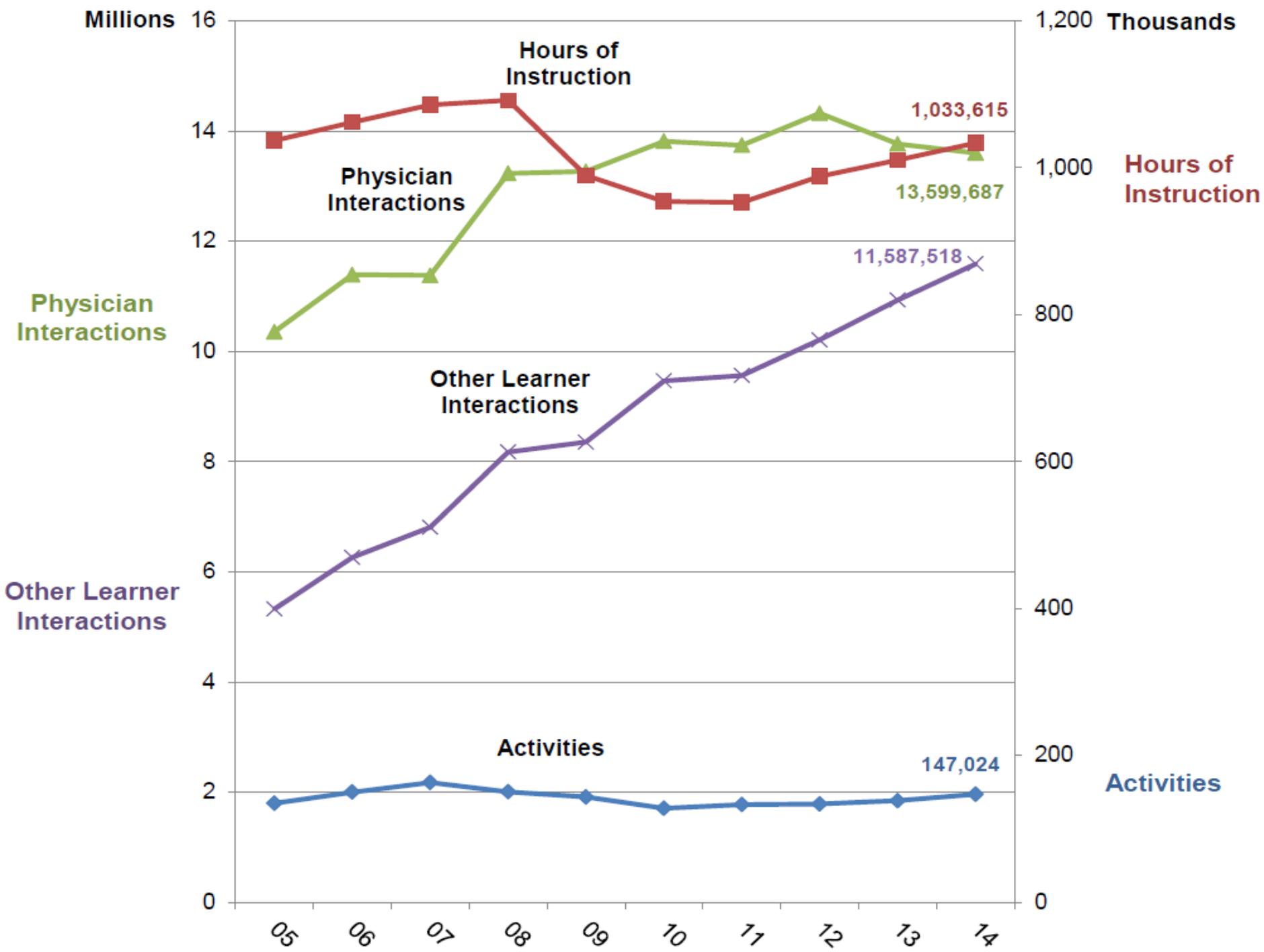
Overall Compliance Results for
November 2008 through July 2015 (n=1,123)

Legend: Not Applicable, Evidence Not Submitted, Compliance, Non-compliance

Accreditation Decisions
November 2008 to July 2015
(n=1,123)

July 2015 (n=43)

- Accreditation with Commendation — 50%
- Accreditation — 29%
- Accreditation with Progress Report — 12%
- Provisional — 3%
- Probation / Nonaccreditation — 6%
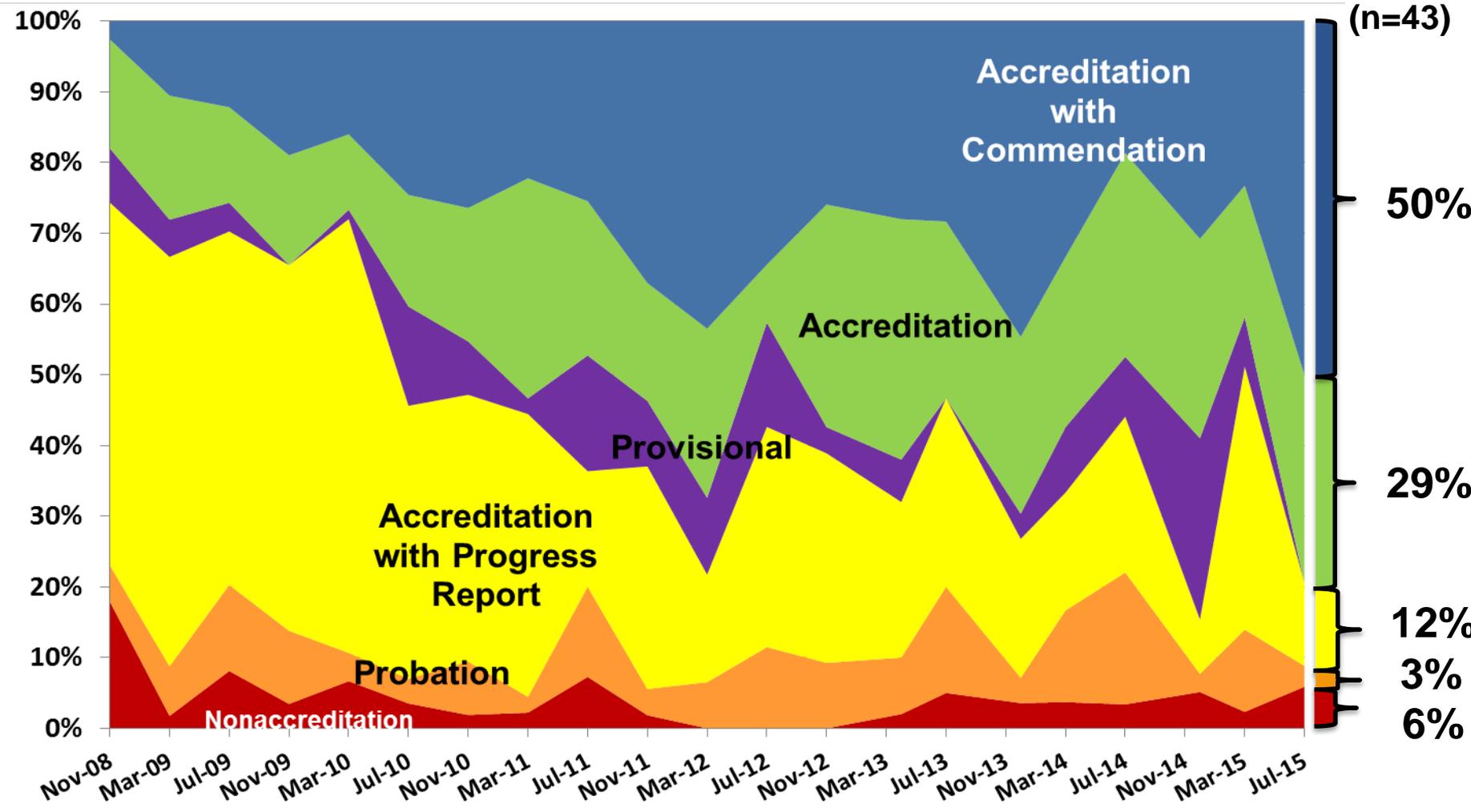
A new approach…

Revised Accreditation with Commendation Criteria: A work in progress…

CME That Counts for MOC

"By collaborating with ACCME, ABIM will open the door to even more options for physicians engaged in MOC and will allow them to get MOC credit for high-quality CME activities they are already doing."

Richard J. Baron, MD

President and CEO

American Board of Internal Medicine

ACCME-ACGME Alignment

- Integration with CLER (Clinical Learning Environment Review);
- Share milestone data
- Wellness curriculum
- Educational leadership/CLO
- Operational alignment

ACCME-AMA alignment

- Commitment by ACCME and AMA governance to move forward on alignment process
- Preliminary review of AMA PRA format with stakeholders
- Agreement on principles of alignment
- Listening sessions
- Forming a "Bridge Committee"

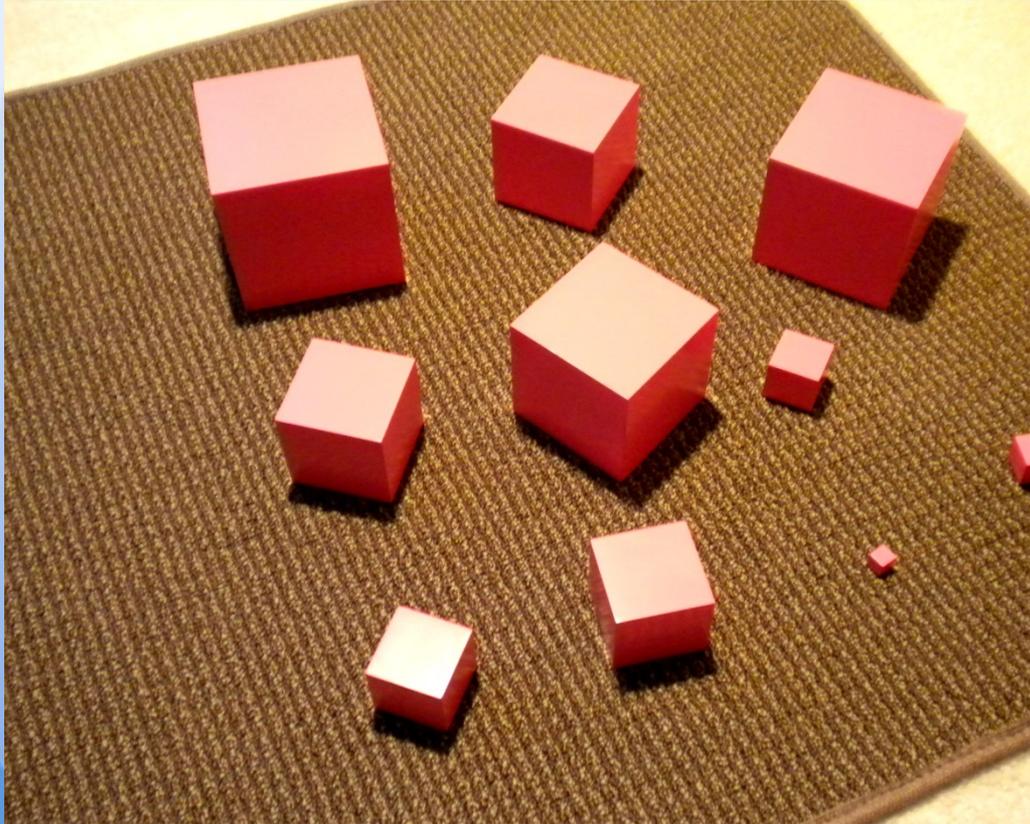# Interprofessional Continuing education (IPCE)

www.jointaccreditation.org

vs.

Meeting Learners' Needs

Health professionals want a learning system that is:

Personalized

Rewarding

Effective
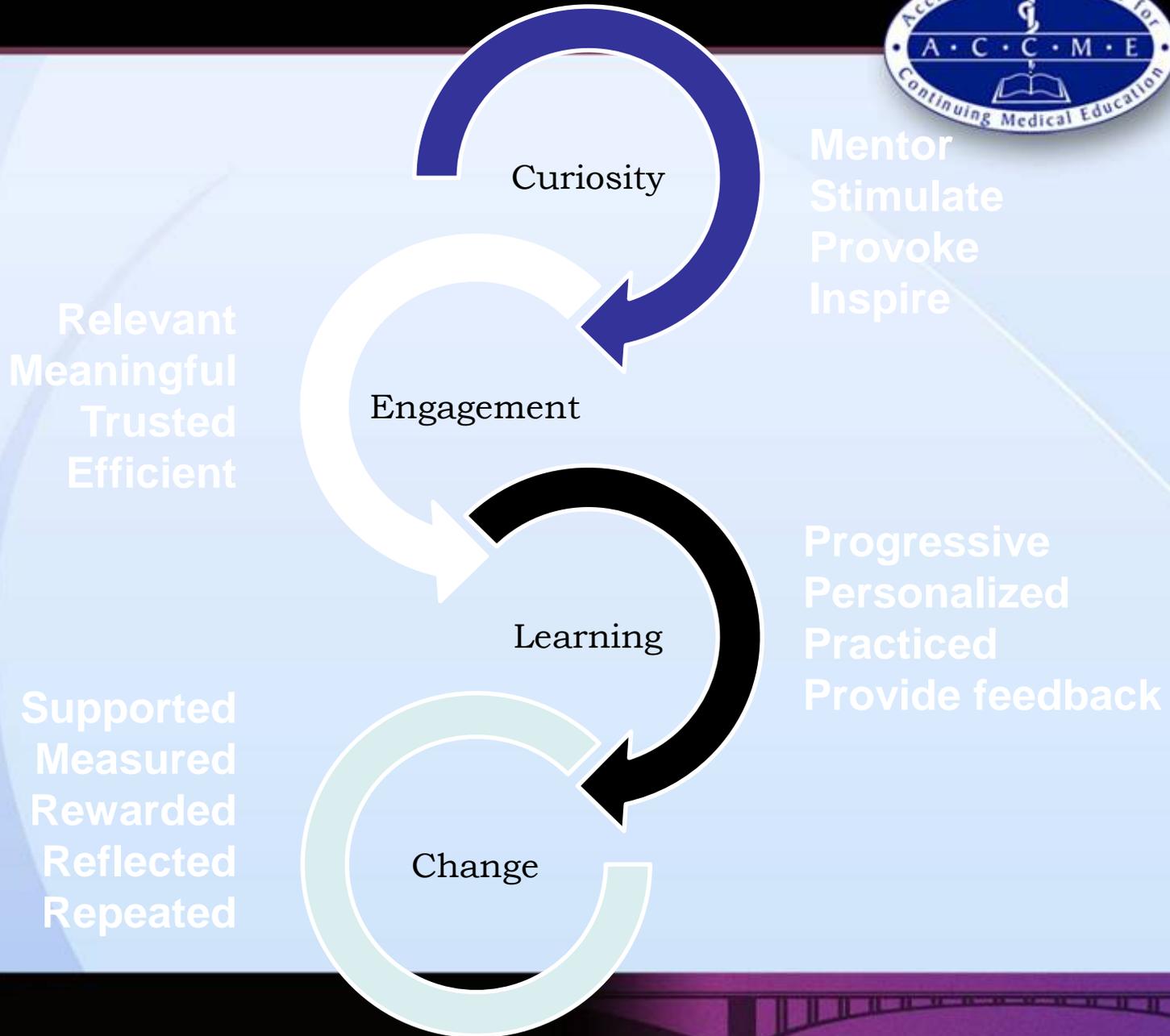
Efficient

Relevant

Emerging Changes in Post-Graduate Education

- Passive → Active Learning
- Single interaction → Series of interactions
- Physician → Team
- Attendance → Participation
- Single modality → Blended learning
- Satisfaction → Higher level outcomes

Evolution for Learners

- Become more self-aware
- Deliberately choose activities
- Avoid promotion & marketing
- Balance online and peer learning
- Actively participate
- Complete evaluations

Evolution for Health Institutions

- Appreciate the strategic power of education
- Recognize the ROI with local CME
  - quality, efficiency, teams, burnout, turnover
- Ensure clinicians have the time and resources to engage in CME
- Nurture teachers and CME professionals

Evolution for Providers

- Change passive to active learning environments
  - Include simulation opportunities
- Involve patients
- Focus on institutional quality goals
- Collaborate with system leadership
- Generate long-term relationships with learners and other organizations

Evolution for Regulators

- Focus on outcomes rather than process or time spent

- Recognize wide diversity of learning approaches

- Encourage and facilitate innovation

- Align regulators and systems

- Provide services to the community

Thank you

Contact me:
gmcmahon@accme.org