

January 2011



*“Education,
Collaboration,
Fellowship,
Networking.”*

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IACME ANNUAL NETWORKING EVENT

IACME will once again host its Annual Networking Event during the ACME Annual Conference in San Francisco on Thursday evening, January 27th from 6:15-8:15pm. Based on feedback from our members, the format for the evening will be an informal meet and greet, casual dress, with drinks and hot hors d'ouerves. The price for this event is \$40.00 for members and \$50 for non-members and we encourage all of you attending the ACME Conference not already registered for this Reception to come and join us.

Members, please note that if you know any colleagues, associates and/or friends who are non-members of IACME please invite them to attend this informal event and see what the IACME is all about!

MARK YOUR CALENDAR!!! IACME Annual Conference

May 20, 2010

Please hold the date! The IACME Annual Conference will take place on May 20, 2011 at the Metropolis Theatre in Arlington Heights. Additional details will be coming soon!

GOING GREEN

Do you have ideas on how to “Go Green CME!” Please e-mail ilalliance@aol.com or join the discussion on LinkedIn. Go to: http://www.linkedin.com/groups?gid=1903150&trk=myg_ugrp_ovr

Choosing the appropriate formats in CME: Based on Standard 2.1, which comprises three of the ACCME’s Criteria for Accreditation (C4, 5 and 6)

Part 2: one provider’s approach to choosing a format

Criteria:

4. The provider generates activities/educational interventions around content that matches the learners’ current or potential scope of professional activities.
5. The provider chooses educational formats for activities/interventions that are appropriate for the setting, objectives and desired results of the activity.
6. The provider develops activities/educational interventions in the context of desirable physician attributes (e.g., IOM competencies, ACGME

Competencies).

The original case:

Target Audience:

- Physicians and advanced practice clinicians employed by a large statewide managed care group serving incarcerated individuals in 100 facilities.

Current/Potential Scope of Practice:

- Physicians staff clinics at different facilities and provide 20-30 visits in a day.
- Physicians are all board certified in internal medicine or family practice.
- Inmates are often transferred to different facilities.
- Inmates therefore see multiple physicians for their care.
- Clinicians are expected to follow system algorithms and policies for treatment as closely as possible.
- All treatment algorithms are authorized by a single infectious disease physician who leads the virology practice.
- Telemedicine consults are available on limited basis with the infectious disease physician or his staff of NP's and PA's to address
- The system has a fully operational and integrated electronic health record that allows clinical entry from anywhere in the system.

Professional Practice Gaps:

- The prison system population is known to have a hepatitis C seroprevalence of 30-40% of its total population of 125,000 individuals.
- 10 % of patients identified with hepatitis C in the prison system are being screened for hepatitis B.
- 20% of the patients identified as hepatitis B negative are being vaccinated against hepatitis B.
- 70% of clinicians surveyed as part of a recent training were aware that the hepatitis B vaccine is provided as a series of three.

Solution:

1. What types of gaps are these?

The gaps are as follows:

- The prison system population is known to have a hepatitis C seroprevalence of 30-40% of its total population of 125,000 individuals. While this data is important in terms of understanding the importance of this disease within the target healthcare system, it is not a professional practice gap. The clinicians cannot impact the health of those entering the system. It does point out the tremendous prevention opportunity for the system to educate all of the inmates on what risk behaviors are and how to avoid them.
- 10 % of patients identified with hepatitis C in the prison system are being screened for hepatitis B. This is a performance gap. The clinicians should be screening 100% of the patients. The guidelines for the prison healthcare system clearly state that screening of 100% of patients with hepatitis C for hepatitis B is necessary.

- 20% of the patients identified as hepatitis B negative are being vaccinated against hepatitis B. This is also a performance gap; all negative patients should be vaccinated. The guidelines for the prison healthcare system are also clear on the need to vaccinate all hepatitis B negative inmates.
- 70% of clinicians surveyed as part of a recent training were aware that the hepatitis B vaccine is provided as a series of three. This is a knowledge gap, as the survey is based on a clinician response to a direct question.

2. What is the educational need?

- The provider felt that there was a tremendous educational need for the clinicians to be made aware of their own data and their overall patient health status as it relates to viral hepatitis.
- There was a modest need found to provide direct traditional education on HBV vaccination and on how to communicate with patients regarding risk behavior.
- The provider felt that the most important thing that could be done in this situation was to engage all of the clinicians in the drive to improve viral hepatitis prevention and care across the system. Given the difference in prevalence in this community versus the outside world, viral hepatitis was essentially incubating within the healthcare system. The greater the focus on identification, staging, treatment and prevention of hepatitis, the more the system could help to impact the population health regarding this viral epidemic.

3. What competencies should be addressed?

Given the broad scope of this problem, it was felt that an activity that covered all of the core competencies was essential to put into place. Here is how each of the ABMS core competencies were addressed in the ensuing activity:

- Patient Care: examination of systems that reflect how viral hepatitis is addressed at all stages, including intake, general screening, prevention education, testing, follow up counseling and discussions, treatment discussions, treatment recommendations, treatment adherence, side effect management, pre-release counseling, post release connection to community care,
- Medical Knowledge: development and distribution of literature and education regarding viral hepatitis, with an emphasis on treatment of HCV and prevention of HBV.
- Practice-based Learning and Improvement: review of individual and clinic wide data on all patients with known viral hepatitis. Assessment of how protocols for staging and treatment of hepatitis are followed. Interventions must not only address how the individual patient is supported, but also what the impact of that patient's care is in the context of the larger health system (e.g.: the impact of side effects on a patient's mood in the context of the other inmates with whom he/she must have mandatory daily interaction, the ability for the system to provide the support necessary for maintaining adherence to treatment, etc.)

- Interpersonal and Communication Skills: scripts for discussing risk behavior, treatment options, correctional specific issues in treatment pertaining to viral hepatitis.
- Professionalism: the learners need to work in a highly confined, low privacy setting, while supporting patient confidentiality and working with a very diverse population. The activity must address this and incorporate the sharing of institutional best practices.

4. What format would be appropriate to close the gaps?

The provider recommended to the leadership of the managed care organization that a performance improvement CME activity focused on internally driven professional practice gaps be implemented. The CEO of the organization (a physician) agreed and mandated participation by all clinicians in the program.

5. Do you see any obstacles that need to be overcome?

Like any new project that is untested, there were numerous issues that arose that were completely unforeseen in the planning. The primary obstacles to implementing the activity in its initial stages included:

- Education of clinical leadership on PI CME
- Lack of Internet Access to clinicians while inside the facilities
- Delay in pulling electronic data and obtaining individual clinic/clinician data

6. Are there any non-educational strategies that should be utilized?

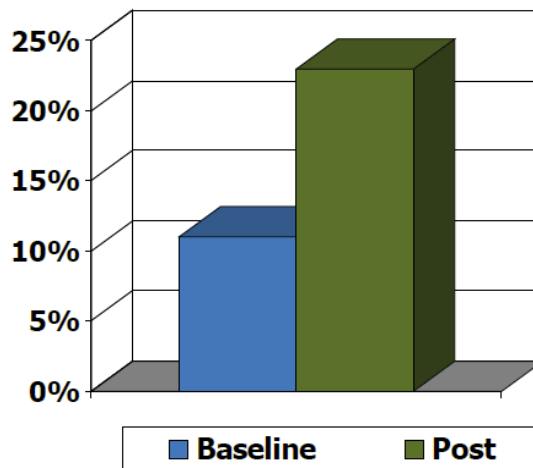
Many of the strategies (interventions) were essentially non-educational strategies, as many of the causes of the gaps were systemic as opposed to knowledge or competence based. One example was the inclusion of an APRI calculation as a method of initial staging of liver disease using liver enzyme testing results. The inclusion of a simple calculator in the electronic record helped the utilization of this screening test go from 4% at the outset to 72% at the completion of the activity.

7. What outcomes methodology makes sense to use to assess the success of this educational intervention?

The nature of a PI CME activity provides data at the performance and/or patient level if the activity is completed properly. In this case, the outcomes were measured on a system level, as 100% of the target audience was reached therefore having a significant impact on the patient care system-wide. The provider was able to compare the pre activity data for each performance measure selected to the post activity data. All data was system wide and aggregate. The provider did not collect any individual patient data, thereby avoiding any HIPAA or patient privacy concerns. Sample outcomes from the activity included:

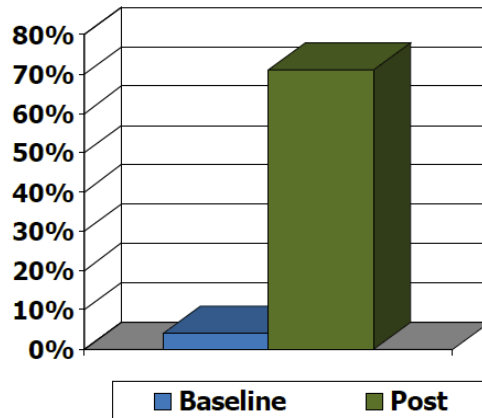
Persons who have had recommended HAV and HBV serologic status completed with 6 months of HCV diagnosis

Numerator	Persons who have had recommended HAV and HBV serologic status completed within 6 months of HCV diagnosis
Denominator	HCV positive persons with a new diagnosis after April 1 2009 who are in TDCJ for at least 6 months after diagnosis
Exclusions	For HBV serology: Previous documented chronic hepatitis B, resolved acute hepatitis B, or a completed series of HBV vaccines For HAV serology: History of hepatitis A or documented immunity. Valid medical reason(s) for not administering HAV or HBV vaccine series.



Persons with facility-calculated APRI within 6 months of diagnosis of HCV

Numerator	Persons with facility-calculated APRI within 6 months of diagnosis of HCV
Denominator	HCV positive persons with a new diagnosis after April 1, 2009 and in TDCJ for at least 6 months after diagnosis
Exclusions	Most recent AST and ALT within normal limits and HCV-PCR negative



The results speak for themselves, this format was the right choice for this case. All performance measures improved in a similar way.

We invite you to take the time to answer one or all of these questions for yourself or on the IACME LinkedIn Discussion group, <http://www.linkedin.com/groups?mostPopular=&qid=1903150>. This case will be posted as a fresh discussion for you to join now. Tune in next month for our provider's answers as to how they developed an activity based on the above information!