WAKE FOREST
UNIVERSITY
SCHOOL *of* MEDICINE

OFFICE of CONTINUING MEDICAL EDUCATION

Certification Request for Sponsorship of a Regularly Scheduled Series (RSS) and AMA PRA Category 1 Credit(s) ™

Introduction

The Wake Forest University Health Sciences (WFUHS)/Wake Forest University School of Medicine (WFUSM) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The ACCME requires that accredited Providers maintain high standards of quality and documentation in the development and provision of continuing medical education (CME). This *Certification Request* is intended for WFUHS/WFUSM faculty and their departments, sections, divisions, institutes, offices, and centers developing regularly scheduled series (RSS) who agree to support and abide by these standards. RSS are defined as daily, weekly, monthly, or quarterly CME activities that are primarily planned by and presented to an organization's own professional staff; examples include grand rounds, teaching conferences, tumor boards, and journal clubs. Each section of this *Certification Request* is specifically designed to link with the ACCME's *Updated Accreditation Criteria* (http://www.accme.org/dir_docs/doc_upload/b03aa5cc-b017-4395-a41f-8d5d89ac31ca_uploaddocument.pdf).

The Office of Continuing Medical Education (OCME) is responsible for maintaining the CME accreditation granted to WFUHS/WFUSM. RSS for which CME sponsorship is sought must be reviewed and approved by the institutional CME Committee. Appropriate CME credit is awarded if sponsorship is approved. Credit can be withdrawn from previously certified activities if actions by the faculty, staff, planning committee members, or teachers/authors threaten WFUHS'/WFUSM's accreditation.

As set forth in the core mission statement of WFUSM, the OCME is committed to providing superior, ethical, timely CME to healthcare professionals, specifically physicians, thereby supporting them in constant self-evaluative improvement and lifelong learning of biomedical knowledge and better enabling them to provide optimal, safe patient care leading to the improved health and well-being of the general public. All certified CME activities must help fulfill this mission. In addition, when developing CME activities, it is important to: 1.) build bridges with other stakeholders through collaboration and cooperation and 2.) participate in a framework for quality improvement.

The OCME uses the American Medical Association (AMA) House of Delegates' definition of CME – "educational activities that serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is the body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of healthcare to the public." All content must promote improvements in patient care and not a specific proprietary business or commercial interest. (*Criterion 10 and the Standards for Commercial Support*) Recommendations involving clinical medicine must be based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in the care of patients. In addition, all scientific research referred to, reported, or used in support or justification of a patient care recommendation must conform to the generally accepted standards of experimental design, data collection, and analysis.

Instructions

- Departments/sections that are new applicants should contact/meet with the OCME RSS Program Coordinator.
- Complete the following *Certification Request* and return it to the OCME with all required documentation, including completed *Full Disclosure Statements* and resolution of conflicts for the Activity Director, Staff Coordinator, and all planning committee members.
- Material for newly proposed RSS should be submitted to the OCME three months in advance of the planned start date.
- No accreditation, sponsorship, or credit statements can be used in publicity materials unless approved by the OCME.
- The *Certification Request* review fee is non-refundable.
- All sections of the *Certification Request* must be completed in order to be accepted for review. Incomplete applications will be returned.

Certification Request for Sponsorship of a WFUHS/WFUSM Regularly Scheduled Series (RSS) and AMA PRA Category 1 Credit(s)™

Regularly Scheduled Series (RSS) Title: **Emergency Medicine Continuing Medical Education Lecture Series**

Sponsoring WFUHS/WFUSM Department/Section: **Emergency Medicine**

Start Date: **July 1, 2010** End Date: **June 30, 2011** Location (*Building & Room* #): **Comprehensive Cancer Center Room 1A/B**

Frequency & Time(s) (*e.g. 3rd Monday of the month, 10:00-11:00 am*): **1st Tuesday of the month, 8AM-Noon**

Faculty Activity Director: **Cedric Lefebvre, MD** Phone: **336-716-4648** Fax: **336-716-5438**

E-mail Address: **clefebvr@wfubmc.edu**

Staff Coordinator: **Kristy Spear** Phone: **336-716-1902** Fax:

E-mail Address: **kspear@wfubmc.edu** Department Chair/Section Head: **James Hoekstra, MD**

List other internal departments, sections, divisions, institutes, offices, centers, etc., if any, that are co-hosting.

A.) Planning Committee Structure:
In addition to the above individuals, list all persons responsible for planning, designing, developing, and implementing this CME activity. Include names, degrees, and titles. [Note: No employee of a commercial interest may serve on the planning committee nor be allowed to influence educational content (nuanced or direct). All decisions must be free of the control of commercial interests including: (a.) identification of needs; (b.) the determination of educational objectives; (c.) the selection and presentation of content; (d.) the selection of all persons and organizations in a position to control the content; (e.) the selection of educational methods; and (f.) the evaluation of the activity. *(Criterion 7 and the Standards for Commercial Support)*]

Name: **David Manthey, MD**	Title: **Professor, Grand Rounds/Activity Co-Director**
Name: **Nancy Holliday**	Title: **Residency Coordinator, Staff Coordinator**
Name:	Title:
Name:	Title:

OFFICE USE ONLY X RSS ☐ EM X Renewal

Date Received: **5/10/10** Date Reviewed: **6/15/10** Date Approved: **6/22/10** OCME Program Coordinator: **AS**

Approved for **4.0 (*per individual activity*)** *AMA PRA Category 1 Credit(s)™* Activity #: _____

Disapproved (*description*): _____

B.) Professional Practice Gaps, Educational Needs, Desired Results, & Learner Objectives:

As outlined in its mission statement, the OCME helps physicians and other healthcare providers to identify professional practice gaps – to recognize the difference between current practice patterns and those potentially achievable, leading to practice improvement and thus better, safer care for patients.

1. A professional practice gap is the difference between healthcare processes and outcomes currently in practice and those potentially achievable. Put simply, it is actual practice (what learners *currently* know and/or do) vs. best practice (what they *should* know and/or do). These gaps are measured in terms of:
    - Knowledge – being aware of what to do
    - Competence – knowing how to do it
    - Performance – actually doing it

    a.) Describe the identified professional practice gaps to be addressed during this year's RSS. What patient care (clinical) and/or healthcare system (non-clinical) issues will be the focus over this next year? What does the department/section need to improve in order to provide better, safer patient care? What does the data (internal or external) say? Compare the current care being provided to what needs to be improved. (*Criterion 2*)

    The education committee of the Department of Emergency Medicine (EM) and the residency leadership have determined that resident physicians require formal didactic instruction on the practice of emergency medicine. Furthermore, EM faculty benefit from educational activities so they can remain up to date on the latest practices and new innovations in an ever-changing field. In the setting of new medical therapies and advancing diagnostic modalities, a practice need/gap is inevitable. EM faculty require access to relevant and up-to-date, evidence-based medical information. To address this practice gap, the EM training program has established a regularly scheduled didactic component of resident medical education and EM physician training. This lecture series aims to provide both basic and late-breaking evidence-based information to EM resident and attending physicians. This information is delivered by the regularly-scheduled EM lecture series which serves to close the practice gap as identified. This improves patient care and enahnces resident education.

    The department of Emergency Medicine continues to be a model in meeting practice standards and providing quality care for its many patients. Performance measures are frequently monitored within the department of Emergency Medicine. Although the department continues to perform well in these areas, there is always room for improvement. (see below). One of the methods by which improvement of practice performance can be achieved is enhancing awareness by education and dissemination of knowledge. We feel this can be accomplished through regularly scheduled educational conference events, such as the one described above.

    Current Practice:

    Pneumonia management – The department of Emergency Medicine and other hospital services adhere to clinical guidelines and practice standards to improve the care of patients with pneumonia. According the latest "pneumonia variance report", the ED and in-patient services continue to perform admirably in these areas (85-94% compliance rates between October 2009 and March 2010). However, a compliance rate of 100% is the goal. Learners should know: (1) optimal timing of antibiotic administration; (2) the need for collecting blood cultures prior to giving antibiotics and why this is important; and (3) the circumstances in which special attention must be paid to antibiotic selection (e.g., immunocompromised patients and ICU-bound patients). Given the dynamic process of clinical medicine and the ongoing changes related to quality care measures, core measures, and provider compliance, the establishment of EM-specific Grand Rounds allows for continued performance improvement, an avenue to address ongoing quality care changes, and an educational environment from which both residents and faculty can learn.

    Myocardial infarction management – Core measures for the treatment of acute myocardial infarction (AMI) are tracked at NCBH. Since most AMI patients are treated by the departments of EM and Cardiology, this data is particularly relevant to EM practice standards. According to the ACTION Registry GWTG™, this institution performs admirably in the treatment of AMI. In the Q4 2009, adherence to the core measure of obtaining an ECG within 10 minutes of arrival was sub-optimal (57.5%, 65.2%). Aspirin administration within 24 hours of arrival of AMI patients and anticoagulation in NSTEMI patients was 98.6% and 94.8% respectively. Over the past 12 months, door-to-balloon time in non-transferred STEMI patients was <90 minutes in 95% of eligible cases. For patients with STEMI who were transferred to this facility, 41% had a door-to-balloon time of < 120 minutes. The overall AMI performance composite for AMI at this facility was 98% with overall "defect-free care" posted at 89%.

To maintain this rate of success and to improve performance in these core measures, continuing education of practitioners must take place. The proposed EM regularly scheduled series (RSS) aims to help accomplish this task. Learners should understand the importance of administering aspirin to all MI patients unless there is a contra-indication to doing so. Learners should know that an ECG should be obtained within 10 minutes of arrival for chest pain patients and that coronary angiography with intent to perform intervention should be performed as soon as possible in STEMI patients (ideally < 90 minutes). Understanding the resources available at NCBH is critical to coordinating this expedited care. A dissemination of current practice guidelines and new evidence-based data on the spectrum of acute coronary syndromes will take place at the proposed EM lecture series.

Patient satisfaction – Patient satisfaction is an important component of service excellence and patient care. In light of the hospital-wide initiative to improve patient satisfaction, faculty must be knowledgeable about all aspects of patient satisfaction. Data about patient satisfaction is collected throughout the year. Since May 2009, patient satisfaction scores out of the ED have ranged from 82.4% to 86.9%. It is important for ED faculty to understand the importance of patient satisfaction, to be aware of current trends in patient satisfaction scores, and to develop ways of improving these parameters in an effort to improve patient care. This will facilitate the benchmark goal of > 90% satisfaction among patients. These issues will be presented and discussed during EM Grand Rounds.

Trauma alerts – The process by which trauma alerts are issued from the ED impacts patient care. Guidelines have been established to help guide EM faculty on their decisions to activate trauma codes. Data on performance in this area are collected and analyzed. This process requires EM faculty to be aware of the importance of trauma code activation, the criteria for trauma code activation, and the need for documentation during these events. The percentage of trauma codes with supporting documentation of why the trauma alert was issued has recently fallen to about 87%. Historically, EM faculty members have performed at a rate of > 90% in this area. This represents a practice gap that requires attention. Regularly scheduled lecture series, joint EM/Trauma conferences and EM Grand Rounds will address these issues in an effort to improve performance and patient care.

b.) The gap is in (*check all that apply*):
- ☒ Knowledge
- ☒ Competence
- ☒ Performance

2. CME activities incorporate the educational needs (knowledge, competence, or performance) that underlie the professional practice gaps. Done prospectively, needs assessments look at gaps from various points of view, showing current practice vs. ideal practice. For RSS, additional needs assessments can be performed for a specific session to further define a professional practice gap. A need can be addressed in more than one session, and new needs can be incorporated over time into a series as long as they are appropriate to the target audience.

a.) Indicate the needs assessments used for this CME activity (*check all that apply*) *and attach supporting documentation*. How was the need brought to the attention of the planning committee? Accreditation guidelines require that planning committees look outside themselves, e.g. beyond attendance records and past evaluation data when conducting needs assessments. (*Criterion 2*)

- ☐ Review of Previous Evaluation Data
- ☐ Focus Groups
- ☐ Identification by Internal Medical Staff
- ☐ Community Health Needs Assessments
- ☐ Referral Data
- ☒ Internal Quality Initiatives
- ☐ Expert Opinion
- ☐ Research Findings
- ☐ P&T Committee
- ☐ Internet Searches
- ☐ Patient Chart Audits
- ☒ Institutional Requirements or Strategic Plans
- ☐ National or Specialty Society Guidelines
- ☐ Literature Reviews
- ☐ New Medical Information
- ☐ Translational Science Institute (TSI) Research
- ☐ Feedback from 3rd Party Payers and Regulators
- ☐ Joint Commission Standards
- ☐ Legal, Government, or Regulatory Requirements
- ☐ Maintenance of Certification (MOC) Requirements
- ☐ IOM, ACGME, and/or ABMS Core Competencies/Requirements
- ☐ Requests from Affiliated Institutions, Groups, or Community Organizations
- ☐ Interviews
- ☐ Survey Results
- ☐ Committee Findings
- ☐ Library Requests
- ☒ Practice/QI Data

☐ Other (*describe*)

The needs assessments used for this CME activity include internal quality initiatives, external quality monitoring processes, and institutional strategic planning. The needs noted above were brought to the attention of the education committee and event organizers during faculty meetings, internal memorandums, hospital-wide meetings (town-hall meetings), and internal Q/A processes.

The needs assessment tools used for this CME activity include external performance assessments such as the ACTION registry GWTG™, internal quality initiatives such as the Quality Resource Center, and institutional performance review data. Full reports of these registries and data repositories are considered confidential. See attached documents for available examples (appendix 1).

b.) Based upon the identified professional practice gap (*Question #1*) and the above listed needs assessment tools, state the educational need(s). In other words, what information and skills need to be shared, taught, learned, or communicated in order to improve the unsatisfactory patient outcomes listed in Question #1?

The goal of this CME endeavor is to address the practice gaps noted above. The educational needs within these practice gaps include knowledge of :(1) evidence-based information regarding the treatment of common emergency medical conditions; (2) existing core measures for improving the quality of care for patients presenting to this facility with pneumonia, acute myocardial infarction, sepsis, trauma and other life-threatening conditions; and (3) methods by which care for these emergency medical conditions can be improved. The proposed EM lecture series will: (1) apply an evidence-based approach to the diagnosis and treatment of select emergency medical conditions; (2) promote the use of current/up-to-date medical techniques at this facility and surrounding communities; (3) foster an environment in which education and discussion about these innovative trends in patient care can take place; (4) improve the access of relevant and ground-breaking medical knowledge to emergency medicine practitioners; and (5) pursue safe, cost-effective and sound medical care for patients of NCBH and nearby hospitals.

Quality assurance (Q/A) measures are an important part of medical practice within the department of EM and NCBH. The department of EM exercises on-going Q/A methods to improve its efficacy and safety. This includes, but is not limited to, quarterly "morbidity and mortality" conferences, quarterly "practice improvement conferences," joint departmental panel discussions, tracking of core measures (e.g., door-to-balloon time, antibiotics for pneumonia, etc.), research project Q/A newsletters, and evaluations of lecture series. Measuring the effect of this CME activity can be included in a pre-existing Q/A activity and/or will be measured directly by evaluations to be completed by attendees. Such evaluations will pose the question, "Did the information presented during this CME activity change your practice?" The education committee and CME director(s) will evaluate the effect of CME activities by requesting direct feedback fom attendees.

3. Based on the identified gap/need (*Questions #1 & #2*) the CME activity is intended to address, what are the desired results? What is the impact on the learner? What is the CME activity designed to change? (*Criterion 3*)

This CME activity is designed to change (*check all that apply with explanations and measurement plans for each*):

☒ Competence (give physicians new abilities/strategies/knowledge): **See above.**

How do you intend to measure these changes? Possibilities include evaluation questions, audience response system, pre-tests, post-tests, surveys, etc. Measuring the competence of learners at this CME activity will be performed in a number of ways. **Pre- and post-presentation quizzes or tests will be administered during several CME presentations to gauge attendees' knowledge before/after the educational event. Some presentations will include interactive case presentations during which the audience will be polled for their experiences in certain areas, their perceptions about certain topics, and how they might manage certain clinical scenarios given new information provided during the lecture. Measuring the effects of this CME activity may include a pre-existing Q/A activity and/or will be measured directly by evaluations to be completed by attendees. Such evaluations will pose the question, "Did the information presented during this CME activity change your practice?" The education committee and CME director(s) will evaluate the effect of CME activities by requesting direct feedback from attendees during faculty meetings and internally distributed memos/e-mails.**

☒ Performance (help physicians modify their practices): **See above.**

How do you intend to measure these changes? Possibilities include adherence to guidelines, interviews, focus groups, chart audits, peer review, direct observation, etc. **We will continue to measure changes in practice by following adherence to guidelines (noted in section B.1.a.) and tracking changes in performance measures (such as patient satisfaction rates, pneumonia treatment measures, etc). Furthermore, we will continue a peer review process in the form of monthly "morbidity and mortality" conferences, practice improvement conferences, and joint departmental conferences (e.g., joint EM/Trauma Surgery/Pathology conference), during which open discussion about patient care issues can be held among peers.**

☒ Patient Outcomes (help improve patient outcomes): **See above.**

How do you intend to measure these changes? Possibilities include patient feedback, patient chart audits, hospital QI data, etc. **Quality assurance and improvement measures are an important part of medical practice within the department of EM and NCBH. The department of EM exercises on-going Q/I methods to improve its efficacy and safety. This includes, but is not limited to, quarterly "morbidity and mortality" conferences, quarterly "practice improvement conferences," joint departmental panel discussions, tracking of core measures (e.g., door-to-balloon time, antibiotics for pneumonia, etc.), research project Q/A newsletters, and evaluations of lecture series.**

4. Learner objectives should connect the identified educational need(s) (*Question #2*) with the desired result(s) (*Question #3*) and are framed in terms of the expected changes in competence, performance, and/or patient outcomes. Based on the desired results (*Question #3*), list the learner objectives for this CME activity. What should the attendees know or be better able to do as a result of participating? Use the attached list of action-oriented verbs. Global learner objectives are acceptable at this stage; more detailed, specific objectives can be created later for each individual RSS session. The number of objectives is not as important as being sure they adequately reflect what is to be achieved.

At the conclusion of this CME activity, the learner should be better able to (*list learner objectives*):

- **Identify the signs and symptoms of life-threatening medical conditions.**
- **Initiate stabilizing medical treatment for severe medical illnesses and/or traumatic injuries.**
- **Learn (choose different action verb) which treatment modalities are available at their facility and which conditions require patient transport to NCBH.**
- **Be more mindful about medical and traumatic conditions that are time-sensitive and require expedited care.**
- **Investigate the barriers that patients often encounter to securing the medical treatment they require and how these barriers can be overcome.**
- **Discover new, ground-breaking information from medical trials and evidence-based sources about common and unusual life-threatening conditions and therapeutic modalities to treat these problems.**
- **Recognize the importance of professional medical societies and the role they play in professional advocacy and patient care.**

C.) Target Audience:

The content of a CME activity should be designed to match learners' current or potential scope of professional activities. (*Criterion 4*)

5. In addition to the sponsoring WFUHS/WFUSM department/section, indicate which additional specialties of medicine will be targeted (*check all that apply*):

☐ Anesthesiology	☐ Biochemistry	☐ Cancer Biology	☐ Cardiology
☐ Cardiothoracic Surgery	☐ Dermatology	☒ Emergency Medicine	☐ Endocrinology/Metabolism
☒ Family & Community	☐ Gastroenterology	☐ General Internal Medicine	☐ General Surgery
☐ Gerontology & Geriatrics	☐ Hematology & Oncology	☐ Infectious Diseases	☐ Microbiology/Immunology
☐ Molecular Medicine	☐ Nephrology	☐ Neurobiology & Anatomy	☐ Neurology
☐ Neurosurgery	☐ Obstetrics & Gynecology	☐ Ophthalmology	☐ Orthopaedic Surgery
☐ Otolaryngology	☐ Pathology	☒ Pediatrics	☐ Physiology & Pharmacology
☐ Plastic & Reconstructive	☐ Psychiatry & Behavioral	☐ Public Health Sciences	☐ Pulmonary/Critical Care/ Allergy/Immunologic Disease
☐ Radiation Oncology	☐ Radiology	☐ Regenerative Medicine	☐ Rheumatology

☒ Surgery ☐ Urology ☐ Others:

6. Will medical students, residents, and/or fellows be included? ☒ Yes ☐ No

7. Is the target audience multidisciplinary, e.g. targeted to both physicians and non-physicians? ☒ Yes ☐ No
   If yes, list other healthcare providers/practitioners that are part of the target audience.
   Nurse practitioners, physician assistants

8. Are non WFUBMC employees invited to attend, e.g. community practitioners? ☒ Yes ☐ No

9. What is the estimated attendance size? **35**

10. If additional types of continuing education credit, e.g. American Academy of Family Physicians (AAFP), American College of Obstetrics & Gynecology (ACOG), Accreditation Council for Pharmacy Education (ACPE), American Nurses Credentialing Center (ANCC) are needed, list them. (*Note: Additional fees are associated with these credit applications. See CME Financial Agreement for specifics.*) **American College of Emergency Physicians (ACEP)**

D.) Core Competencies:

11. A CME activity should be developed in the context of desirable physician attributes. (*Criterion 6*) Indicate which of the Institute of Medicine (IOM), Accreditation Council for Graduate Medical Education (ACGME), and/or American Board of Medical Specialties (ABMS) core competencies will be addressed by this CME activity (*check all that apply*).

☒ Quality Improvement
☒ Evidence and Practice-Based Learning & Improvement
☒ Patient-Centered Care
☒ Medical Knowledge
☐ Systems-Based Practice
☐ Use of Informatics
☒ Working in Interdisciplinary Teams
☒ Interpersonal Communication Skills
☒ Professionalism

E.) Barriers to Change, Collaborations, & Non-Educational Strategies:

12. Often times, factors exist outside the control of the learner that can impact patient outcomes. Indicate *at least one* potential or real non-educational barrier facing the department/section and its faculty/staff for this gap/need to be addressed. (*Criterion 18*)

☒ Lack of Time to Assess/Counsel Patients
☐ Insurance/Reimbursement Issues
☐ Larger, Healthcare System-Type Issues
☐ Costs
☒ Too Few Resources or Administrative Support
☐ Lack of Consensus on Practice Guidelines
☐ Patient Compliance
☐ Others:

13. Describe the educational strategy that will be used to help remove, overcome, or address the barrier(s) listed in Question #1. If you do not plan to address them, why not? (*Criterion 19*) **The Emergency Department is an area in which care is administered on an urgent or emergent basis. Due to large volumes of patients, the severity of illness or injury, and the physical practice environment of the department, time available to talk to patients is limited. Furthermore, since the EM physician usually does not encounter a patient again in the near future, an opportunity to re-evaluate them in a reliable and scheduled manner is impossible. This limits the amount of follow-up and counseling that can occur between patient and EM physician. This problem is inherent to the practice of Emergency Medicine. Although this problem cannot be changed, it will be discussed as a non-educational barrier facing the department and discussions on how it affects patient care and how to minimize these barriers will be held.**

With regard to limited resources, some of our affiliate sites (e.g., Wilkes Regional Emergency Department) do not have all the resources necessary to care for all types of emergencies. This requires transfer of patients to NCBH or other sites. During this regularly scheduled education event, we will discuss specific medical conditions/injuries which require additional care and which require immediate transfer to NCBH. Included in this discussion will be a description of which services are available at NCBH, which conditions require immediate transfer, and which conditions are time-dependant. These considerations will be included in lectures about specific medical/traumatic conditions, available diagnostic and therapeutic options, and methods by which patient transport can be facilitated (e.g., air-medical transport, pre-hospital treatment, etc). This information is critical for physicians at these affiliate sites to acquire so they may care for their critically ill patients. Responsible for coordinating patient transfers between facilities, NCBH EM faculty must be privy to this information so they may be aware of which services are available to incoming patient transfers and which patients need expedited transport.

14. Indicate other internal or external stakeholders with whom collaboration or cooperation is possible in order to build bridges to quality. Could they help address any of the potential or real barriers listed in Question #12? (*Criterion 20*)

☐ Other Clinical Departments/Sections	☐ WFUP	☐ Risk & Insurance Management
☐ Community Health/BestHealth	☐ Center for Applied Learning	☐ Pharmacy/P&T Committee
☐ Maya Angelou Center for Health Equity	☐ Food & Nutrition Services	☐ Office of Global Health
☐ Church & Community Relations	☐ Legal Department	☐ Life Support Education
☐ Medical Coding	☒ Nursing	☐ Patient Relations/Service Excellence
☐ Northwest Community Care Network	☐ Public Health Sciences	☒ Physician's Access Line (PAL)
☐ Quality Resource Center	☐ Six Sigma	☐ Translational Science Institute (TSI)
☐ Women's Health Center of Excellence	☐ Coy C. Carpenter Library	☐ Infection Control
☐ Information Services/Academic Computing	☐ Compliance Office	☐ Managers of Institutional Initiatives
☒ Government Agencies	☐ Local or National Societies	☐ Community Organizations
☒ Regional/Affiliated Healthcare Organizations	☐ Patient Organizations	☐ Others:

The above checked stakeholders are entities involved with the NCBH Emergency Department in patient care. Some of these groups are actively involved in addressing the barriers noted above. These groups are often, and will continue to be, an integral part of patient care in the ED and as such, will be involved in efforts to improve awareness of the above issues and addressing them.

15. Indicate any non-educational strategies to be used to enhance/reinforce change. (*Criterion 17*)

☐ Post RSS Reminders to Attendees	☐ Patient Feedback or Surveys	☒ Protocols
☒ Patient Education Materials	☐ Algorithms	☐ Order Sets
☐ Flow Sheets	☐ Personal Patient Outcomes Data	☐ Newsletters
☐ Display Posters	☐ Forms	☒ Handouts
☐ Chart or Electronic Record Reminders	☐ Others:	

F.) Adult Learning Principles & Educational Methodology:

16. Adult learning is a complex, multistage process that incorporates the learner into the planning and evaluation process. Learning is problem-centered rather than content-oriented; experience provides the basis for learning, which is focused on material that has immediate relevance. Adults learn by solving genuine problems (reviewing their own issues and daily encounters); reflecting via analogy/comparison (comparing their own experiences to others); practicing and applying new knowledge and strategies; and developing a framework for application (creating plans for implementation). There are five stages of physician learning. Indicate the appropriate stage(s) of learning for this CME activity (*check all that apply*).

    ☒ Recognizing a need for learning – when a physician becomes aware that something in his/her practice needs improvement

    ☒ Searching for learning resources, which is driven by cognitive dissonance (the difference between what is and what should be)

    ☒ Engaging in learning – when learning (formal or informal) becomes more intentional and focused on the problem at hand

☒ Trying out what was learned – when a physician begins to use newly acquired knowledge or skills and looks to confirm the benefits

☒ Incorporating what was learned – when a physician integrates the new knowledge or skills into daily practice

17. Educational formats should be appropriate for the setting, objectives, and desired results of the CME activity. (*Criterion 5*) Indicate what educational design(s)/format(s) will be used (*check all that apply*).

☒ Lecture/Didactic	☒ Panel Discussion	☒ Question & Answer	☐ Videoconference
☐ Live Webcast/Webinar	☐ Archived Webcast/Webinar	☐ Live Demonstration	☐ Interact. Workshop
☐ Simulated Patient	☐ Tumor Board	☐ Journal Club	☐ Pro/Con Debate
☐ Lab Exercise	☒ Hands-On Practicum	☐ Podcast	☐ Academic Detailing
☐ Roundtable Discussion	☒ Case Study	☐ Other (*describe*)	

G.) Evaluation:

18. Describe the planned evaluation process, including frequency. Explain how the results will be used, including determining the effectiveness in meeting the educational need and creating changes in competence, performance, and/or patient outcomes. (*Criterion 11*)

Results of this evaluation process will be used to:

1. Direct type, scale, length, announcement, and organization of future CME activities.

2. Determine the most effective teaching modalities for each topic and tailor this for subsequent CME events.

3. Explore the characteristics of each CME activity that generate the most positive feedback and provide the highest impact to its attendees.

4. Determine which activity leaders (lecturers) generate the highest satisfaction scores among attendees and focus on these teaching styles as a guide for other activity leaders. This will improve the effectiveness of subsequent CME activities.

This evaluation process will take place quarterly.

H.) Funding Sources:

19. Indicate what funding sources will be used (*check all that apply*).

☒ Department/Institutional Funds
☐ Government Funds
☐ Foundation Grants
☐ Pharmaceutical/Medical Device Educational Grants (*Criterion 8 and the Standards for Commercial Support*)
☐ Exhibit Fees (*Criterion 9 and the Standards for Commercial Support*)
☐ Other (*describe*)

20. Will teachers/authors be paid an honorarium? ☐ Yes* (Amount: $) ☒ No

*WFUSM policy states honoraria higher than $1500 per day must be approved by the Associate Dean for Faculty Services. Planners, teachers, and authors may be reimbursed for out-of-pocket expenses consistent with WFUHS policies. If teachers or authors are listed on a CME activity agenda as facilitating or conducting a presentation or session, but participate in the remainder of the activity as a learner, their expenses can be reimbursed and honoraria can be paid for their teacher or author role. No other payment, apart from those paid by WFUHS, shall be given to the Activity Director, planning committee members, teachers, authors, or others involved with the CME activity. *(Criterion 8 and the Standards for Commercial Support)*

I.) Required Attachments:

- *Full Disclosure Statements* for Activity Director, Staff Coordinator, and additional planning committee members
- *Resolution of Conflict of Interest Forms* documenting how conflicts will be managed
- Signed *CME Financial Agreement*

- Current/Planned RSS Schedule

By submitting this Certification Request, the Activity Director and his/her staff understand that the proposed RSS must be consistent with the overall CME mission and policies of WFUHS/WFUSM and follow all ACCME *Essential Areas, Policies,* and *Updated Accreditation Criteria*, including the *2004 ACCME Standards for Commercial Support*. In addition, the listed Department Chair/Section Head is aware and approves of this submission.

Submitted by: **Cedric Lefebvre, MD** Date: **5-10-2010**

Deduct application fee from the following WFUHS Chartfield: **02150100112107070000**

Appendix 1

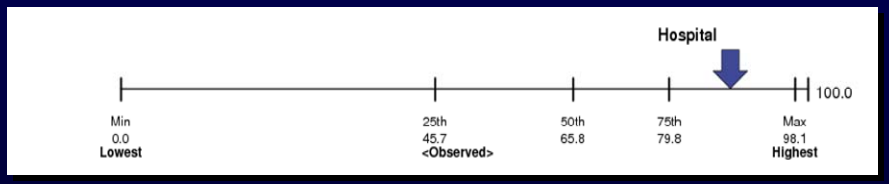
Pneumonia Variance Report	November 2009			Pneumonia			Octol
December 2009							
Number	Compliance	Variance	Number	Compliance	Variance	Number	C
23	22	1	23	19	4	32	28
33	29	4	17	15	2	23	22
35	33	2	38	35	3	36	36
15	15	0	11	11	0	14	14
21	21	0	24	24	0	26	26
Antibiotic Received w/in 6 hours of arrival	32	32	0	35	34	1	41
Initial ABX selection immunocompetent ICU	1	1	0	2	1	1	3
9	9	0	13	13	0	9	9
Antibiotic Timing Median Minutes			128.5		116		115
64	58	6	64	55	9	66	60
90.91%			Composite Score		90.63%		85.94%

January 2010			Community Acquired Pneumonia			March 2010			Febru
Number	Compliance	Variance	Number	Compliance	Variance	Number			C
30	27	3		35	34	1			
23	21	2		19	19	0			
43	41	2		38	37	1			
11	11	0		11	10	1			
26	26	0		26	26	0			
Adult Antibiotic Timing (Received ABX w/in 6 hours of arrival)	39	39		0	37	37			
Initial ABX selection immunocompetent ICU	3	1		2	1	1			
16	15	1		19	18	1			
Antibiotic Timing Median Minutes			128				142		
76	67	9		71	67	4			
Composite Score		94.37%			#DIV/0!				88.16%

NCDR

ACTION Registry-GWTG

Overall Defect Free Care

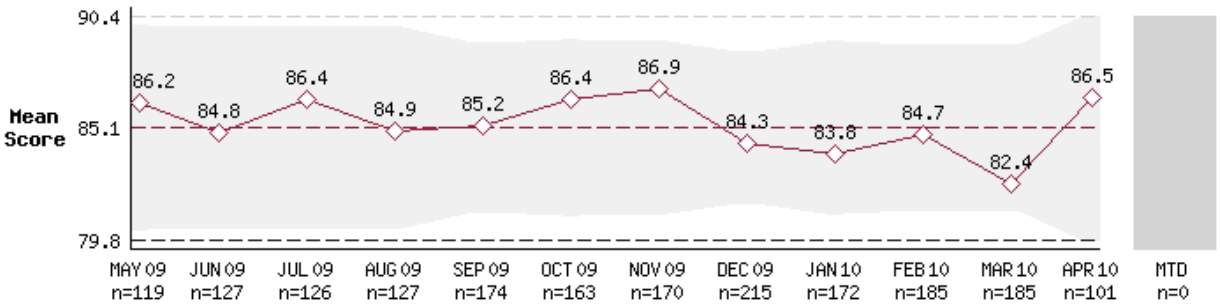


Hospital's...		
Opportunities (N)	Score	Rank
485	89%	19

American College of Cardiology Foundation | American Heart Association | Society of Chest Pain Centers

Wake Forest University Baptist - Emergency Department

Control Chart
Overall Mean Score



Discharge/Service Date

Greatest Increases and Decreases

Question	03/07/2010 04/03/2010 n	Mean	04/04/2010 05/01/2010 n	Mean	Change
Concern blood draw comfort	87	83.3	27	90.7	7.4
Waiting time for radiology test	101	79.0	37	85.8	6.8
Likelihood of recommending	166	79.4	77	85.4	6.0
Adequacy of info to family/friends	109	82.1	61	87.7	5.6
Courtesy shown family/friends	118	85.2	64	90.6	5.4
Courtesy during pers/insur info	153	85.0	70	85.0	0.0
Nurses attention to your needs	159	87.9	78	87.8	-0.1
Courtesy of radiology staff	100	87.3	37	87.2	-0.1
Courtesy of front desk nurse	155	86.0	68	84.9	-1.1
Privacy during pers/insur info	151	84.4	70	83.2	-1.2

Top 10 Priorities

1 Staff cared about you as person
2 Informed about delays
3 Likelihood of recommending
4 How well pain was controlled
5 Overall rating ER care
6 Adequacy of info to family/friends
7 Doctors concern for comfort
8 Information about home care
9 Waiting time to see doctor
10 Doctor informative re treatment