UNMC College of Medicine

Continuing Medical Education (CME) Committee

January 29, 2021 via Zoom

The meeting was called to order by Kelly Caverzagie, MD, and all were welcomed. The presence of seven full members established a quorum at this meeting

Present:

Kelly Caverzagie, MD
Chair
Lisa Bally, Director, CCE
Jeffrey S. Cooper, MD
Susan K. Evans, MD
Katherine C. Finney, MD
Andrew Gard, MD
Shaun C. Horak, PA (ex-officio)
Heidi Keeler, PhD, RN
Don Klepser, PhD, MBA (ex-officio)
Kim Latacha, PhD
Maureen McElligott, MD (Resident)
Amber McMahon, BS, MS
Lucy Muinov, MD
Frank Pietrantoni, MS (ex-officio)
Brenda Ram, Director, CCE
Justin C. Siebler, MD

Absent:

Micah W. Beachy, DO (ex-officio)
Danish Bhatti, MD
Chris A. Cornett, MD
Jason M. Johanning, MD

1. Review of minutes from October 23, 2020 meeting
   The minutes from the last meeting were sent with the agenda and were approved without dissent.
   Heidi Keeler, PhD, RN introduced herself to the team.

2. Update on Joint Accreditation (JA) and discussion

Through the combined efforts of UNMC's CNE and CCE leadership and teams and after a year's pursuit, UNMC achieved Joint Accreditation. This means that UNMC's College of Nursing Continuing Nursing Education and the College of Medicine's Center for Continuing Education can now award continuing education credit for a variety of healthcare professions (i.e., nursing, medicine, pharmacy, psychologists, social work and optometry).

This is a first step toward what continuing education will look like in the future. It also signifies the collaboration of UNMC's Colleges of Medicine and Nursing over the course of the past five+ years, and sets the stage for the future of continuing education for the university.

Heidi Keeler PhD, RN, introduced herself in her roles as the Director of Continuing Nursing Education Office, UNMC's College of Nursing Faculty, UNMC's Director of the Office of Community Engagement, and as part of the metrics team of NETEC. In the past four years, there has been a huge shift in continuing education with changes in directorships, with CCE and CNE joining hands to support faculty across campus. Not only in regard to education, but in how we provide the credits. Our focus is efficiency and ease of use for learners, by also having the ability to award a variety of continuing education credit.

These entities recognize that we need to look at continuing education not only as addressing skills/practice gaps, and learning needs; but also to consider other factors that impact practice and the functioning of the health care team. This focus is how joint accreditation was born.

We want to be influential. Not just provide a "piece of paper" at the end of training, but instead collaborate to improve patient outcomes and team performance. Not only is the benefit of joint accreditation the ability to offer many different types of credit, but also to address IPECs. As UNMC is recognized as being a leading place where IPEC is fostered, we want to be contribute to this as well. JA means new criteria for us, some which is actually easier to meet; it also has elevated the mission to become more outcomes based, driven by metrics.

Where do we go from here? The committee should consider not only continuing education needs in the way of practice, but also in the way of inter-professional competencies. Also, it should collaborate regarding the roles of healthcare providers, communication, and opportunities. One such inter-professional education competency is in the area of values and ethics. The College of Medicine just brought Shirley Delair, MD, MPH on board for DEI initiatives, a huge area of opportunity to promote education and change.

What does this look like for day-to-day operations? At this point, the operations are still proceeding in much the same manner for both CCE and CNE . We get ideas from this community and others and partner with practitioners to create education, as we continue to offer the same capabilities in assisting with logistics assistance and planning. One change in the planning will be more questions to address related not just the practice gap, but also to assess IPEC in the content. There will be differences in the metrics. The plus side of this is that with better metrics comes better data, and opportunities to put the analysis of this data out into the

literature. Please share ideas as more thinking on this by this committee is encouraged.

Our achievement of Joint Accreditation, has encouraged us to achieve the goal of Joint Accreditation with Commendation, as both offices had previously held this accreditation level separately. JA just published a list of criteria for commendation and on which are twelve criteria that we will start on now. *(NOTE: Dr. Keeler distributed this document to the committee after the meeting).* Other goals are increased efficiencies between the two offices, addressing barriers to higher team functions achieve and better outcomes, and meeting these commendation criteria.

Higher collaboration in the health care team is vital to avoid the tendency to become 'silo-ed". This includes efforts to accommodate diverse planning committees as we move forward to make multi-profession focus standard practice, not an afterthought. Analysis of the data generates opportunities for scholarship, but also contributes toward the attainment of non-pharmaceutical, practice driven grants.

This will be a real opportunity to advance the way our education looks, For example, we will consider rolling Health Disparity into our education, with purposeful intent.

Dr. Caverzagie acknowledged his great appreciation for Dr. Keeler, Brenda Ram, and Lisa Bally for their significant efforts in this achievement.

3 Conversation regarding Continuing Professional Development and Faculty Readiness

The next discussion is about the role of this committee to address continuing professional development. The committee's physicians, colleagues, and residents are not necessarily required to be experts on continuing education and how it works. Instead, the committee can lend expertise to what is needed to impact practice in the future of the health care team. Inter-professional content should focus on what practice looks like and what needs to occur among ALL of our professions for education within the university, and all stakeholders. (Example, what does this like for rural education – not just our various faculties, but across the board, statewide and beyond?) What should your faculty being doing that they are not? This committee is tasked to think not just about continuing education, but also practice gaps, IPE, and brainstorming on needs.

Teams – There is some training and education being done on TeamSTEPPS, which lends itself well to the clinical environment and practice. The institution is focusing intently on the whole team dynamic. Part of the OHPE team presented TeamSTEPPS training for College of Pharmacy. The curriculum is built and could be a benefit to the whole continuum for students to clinical practice.

DEI – This is a priority at UNMC, with additional resources now added to examine our curriculum for appropriateness. *(For example, dermatology and care of all demographics, being intentional in knowledge and language)*. Also, addressing training gaps to improve our ability to meet DEI standards of care.

Principles of change management - This applies to any roles from nursing to pharmacy across the board. CCE and CNE have become well versed in change during the JA process!

What are the gaps in working together as teams, both within a team and between teams? Issues exist within silos between departments, and even between nursing, MDs, techs. 21st century medicine is becoming more team dependent. Any opportunity to address the team dynamic is very important, such as with stimulation training, ERs, ORs, etc., with some real-life challenge built in. The Crew Resource Management for safety education was one such program. It was developed in the aviation industry, but has since has become less standardized. TeamSTEPPS was considered, but at present Zero Harm is the branded safety reinforcement offered. It offers an opportunity to meet existing gaps for multiple professions, while providing continuing education.

Davis Global Center – The suggestion to add a Davis Global Center representative to this committee was met with enthusiasm. There is room for collaboration and their global presence would be of great value.

Radiology – The separation due to technology and circumstances is a challenge to teamwork, and to bringing all professions together and IPE. This will continue to be a factor in the digital world.

Outpatient education COVID-19 - An opportunity exists to better educate CMAs, LPNs, RNS, etc. in the best practices in outpatient care in Covid19.

Some of the low-hanging fruit would be to collaborate with nursing and others for required credit for accreditation, such as comprehensive stroke credits. The departments could tap into those 'must-dos' for all, and make them more inter-professional offerings. Within discipline-specific areas for licensing boards, such as diabetes, stroke there is definitely room for growth. This has potential to extend further. OB-GYN also has requirements for credentialing, such as electronic fetal monitoring which extend across departments, and are dependent on other departments. Examples include joint education opportunities for radiology/OB GYN, and inter-professional education in women's health care to address diversity and the uniqueness of each patient.

All of these things could be leveraged for JA continuing education. In the past, we have all had separate circles of accreditation. Joint accreditation will allow for the credits within those circles, but with special emphasis on the intersection of the circles as its focus. In fact, 25% percent of our offerings will need to be within these intersections. This is definitely the direction we should be headed.

All are educators and all have materials available, and all want our teams to be better. What can this group do to leverage education to be easily transferable to other hospital areas? Not easy to do, but perhaps possible with the right people and logistics. How can we leverage content that already exists? Curriculums do vary, but what can be done practically speaking to share? People need the knowledge and the ability to locate and access the content.

Residents and students rotate through many departments. How do I get involved in education and obtain access to resources? What would benefit the patients overall? For example, for different patient emergencies on the floor, examine the management techniques of sub-specialties and how they compare. (Example - ACLS vs stroke management)

With the quick rotations in medical training, how does the medical student discern their role within each rotation? Other than residents - who trains, leads and fills in the practice gaps and communication? For example, the Nebraska Medicine daily shout-out is an effective way to disseminate information as efficiently as possible. What can be done inter-professionally to communicate?

Billing coding decision making is another hot topic, as is global health. Another suggestion is to encourage Preceptor participation with a reward of some sort. (Grand Round participation has been considered but some HIPAA constraints apply).

What we can do for our state and play to our strength by helping rural communities? How do we development a mechanism for rapid response and disseminate information quickly? It is noteworthy that the patient is part of the team in Joint Accreditation, and the Office of Community Engagement is available to assist.

The goal of today was to tap into the resources of the committee for ideas. Thank you for the many useful suggestions that can be taken to the healthcare system to go forward. Your engagement and participation today is much appreciated.

The next committee meeting is scheduled for **April 23, 2021**.

CME Committee Membership (2020-2021)

Kelly J. Caverzagie, MD – Chair	Lisa Bally (ex-officio)
Danish Bhatti, MD	Micah W. Beachy, DO (ex-officio)
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Amber McMahon (Medical Student)	