SCHOOL OF MEDICINE

OFFICE FOR CONTINUOUS PROFESSIONAL LEARNING

Tips and Examples for the Education Planning Form

Thank you for committing to changing medical practice and medical education through the planning, design and execution of CME activities. Meaningful change in practice results from purposeful design and implementation, and this Education Planning Form sets you up to achieve the best possible outcomes.

CPL is here as your partner in achieving your educational plan, and we are always available to help you achieve your practice improvement goals. In addition to resources at the CPL website, please feel free to contact us at HSC-CPL@salud.unm.edu with your specific questions or for a consultation on completing the form and planning your CME activity.

Effective CME activities are purposefully designed to change competence and performance of individuals and the organizations where they work, leading to improved patient outcomes – and so doing meet the expectations of the AMS and ACCME. Deliberate planning and design set your activity up for success.

1. What is the planning process for your CME activity?

How did your planning committee determine the topics and speakers for your CME activity? Did you discuss professional practice gaps, needs, and assessment? Who was involved in the discussions and was racial, ethnic and gender diversity represented? Please upload notes or minutes from your planning discussions. Educational Planning Forms that do not describe the process used to determine the why, what, and how of the proposed activity will be returned for revision. Please consider the value of including residents/fellows on your planning committee and, perhaps, patients and representatives of other public health and healthcare organizations. Do you want to address gaps and needs in interprofessional collaborative care? If so, then consider the value of an interprofessional planning committee. CME activities must address gaps and needs and important opportunities may be identified by including your departments Quality and Safety Officer (QSO), vice chairs, and others who may be leading efforts to improve provider or educator practice, patient satisfaction or outcomes, or other aspects of learning that are important to your unit.

	Level 1 Does not meet requirements	**Level 2** Meets requirements for inclusion in an accredited CME program	**Level 3** Exemplar
Criteria	Planning is not clearly based on identified needs that can close professional practice gaps.	A described planning process connects professional practice gaps, needs, objectives, evaluation and assessment. Selection of topics and speakers is based on identified gaps and stated needs.	A planning committee identified the professional practice gaps and needs that drive the program. Meeting notes/minutes were uploaded to CPL. At least two of the following criteria were met: 1) relevant performance or process data were used in the planning process; 2) the committee is diverse; 3) residents, fellows, and/or students were engaged in the planning and delivery of the activity; 4) The QSO participated in the planning.
Example	A 3-member planning committee selects speakers for Grand Rounds based on faculty perception. Selected speakers provide new information to learners they can use to adjust practice patterns for better outcomes, both in their individual practice and as contributing members of the medical community at large. *Rationale: Although new information is intended to "adjust practice patterns for better outcomes," specific practice gaps and needs were not identified. Assessment of learners and evaluation of the program are not addressed.*	A 3-member planning committee solicits gaps and needs by surveying faculty once annually and consulting with the Chair, Division Chiefs, and the Quality and Safety Officer. This planning committee determines broad objectives for each identified educational theme and invites speakers that address these objectives. Regularly-scheduled assessments and evaluations will verify that learners are achieving the objectives and the grand rounds series is achieving its intentions. *Rationale: A process is defined. Gaps and needs are identified. Learning objectives are based on gaps and needs. Learning objectives are periodically assessed.*	A 4-member planning committee (including the Department QSO and Chief Resident) reviewed quality, safety, and patient-experience gaps revealed in Vizient and Press-Ganey data for the department. Goals were set for improvement in three areas and potential speakers (including a resident and a fellow) were identified along with the learning objectives. Updated data reports and lessons learned from the presentations are scheduled for review during periodic faculty meetings. Data-based assessment criteria were identified for the learners and evaluation criteria identified for the program. *Rationale: Gaps and needs are identified using data; the data source is identified. Improvement goals and learning objectives are based on the data. Plans to demonstrate change in learner performance and/or competence are data based. Measures of program effectiveness in reducing gaps are identified. Residents are involved in the planning and delivery of the activity.*

Why CPL asks: The School of Medicine, as a provider of accredited CME, must explain to the accreditors how gaps between current and desired performance are determined, how those gaps drive educational activities, and how educational activities are advancing the institutional mission "to advance the health of all New Mexicans by educating and increasing the diversity of health professionals, leaders and scientists…" Documentation of your planning processes allows us to meet that need.

2. Identify professional practice gaps

What are the professional practice gaps of your learners on which the activity is based? How did you identify the gaps? Clearly describe one or more professional-practice gaps that motivate your CME activity, such as patient care, competencies or performance in the role of researcher, teacher, administrator, or team-leader. In your Educational Planning Form, this gap is a description or numerical value representing the difference between actual performance and desired performance. The gap may be illustrated by quality improvement and patient safety metrics, CME-learner surveys that identify individual or collective gaps, department/division strategic planning goals, patient satisfaction data, practice guidelines, published research results, UME and/or GME learner surveys, etc. Please identify sources of data and information that led to identifying and prioritizing the gaps.

	Level 1 Does not meet requirements	**Level 2** Meets requirements for inclusion in an accredited CME program	**Level 3** Exemplar
Criteria	Professional practice gaps are not explicitly stated. Data/information for identifying the gaps are missing.	Professional practice gaps between actual performance and desired performance are stated, along with the sources of information used to identify the gaps.	Professional practice gaps are identified using quantitative data and an expectation is set for the amount of change to be achieved.
Example	Many residents are not involved in ACGME-mandated research activities until near the end of their second year, leading to a crunch at the end of residency and the completion of projects that are commonly not suitable for dissemination. Many GME faculty do not feel confident to supervise resident research. We need to improve faculty confidence to supervise research so that residents are involved in research by the midpoint of their second year. *Rationale: Although practice gaps are stated, the sources of information used to identify those gaps and the magnitude of the gap are not stated.*	According to student records, very few residents are involved in ACGME-mandated research activities by their second year, leading to a crunch at the end of residency and the completion of projects that are commonly not suitable for dissemination. About half of our GME faculty feel confident to supervise resident research according to a recent survey. We need to have all faculty confident to supervise research so that more residents are involved in research by the midpoint of their second year. *Rationale: Professional practice gaps between actual performance and desired performance are stated, along with the sources of information used to identify the gaps. Two related outcome measures are identified: 1) %residents involved in research by the midpoint of their 2nd year (from student records); 2) %faculty confident to supervise research (from survey results). The baseline of resident researchers is 20%; the target is 100%. The baseline of confident faculty is 50%; the target is 100%. The learning program is aimed at raising the confidence of faculty to supervise residents' research. The gap is defined and the means for assessing a change in the gap is identified.*	According to student records, only about 20% of residents are involved in ACGME-mandated research activities by their second year, leading to a crunch at the end of residency and the completion of projects that are commonly not suitable for dissemination. Surveys show that 45% of our GME faculty feel confident to supervise resident research (survey results attached). We need to have at least 75% of our faculty confident to supervise research so that every resident is involved in research by the midpoint of their second year. *Rationale: In addition to baseline and target data from identified sources aimed at raising confidence of the learners (faculty), the targeted amount of change is specified (from about 50% confident to all confident).*

Why CPL asks: Designing a successful educational activity begins with explaining why you are planning the activity. Gaps reveal targets you refer to when checking whether your plans are likely to help close the gap. When your application is reviewed, we look to see if your learning needs, learning objectives, assessment and evaluation activities are all aligned with your plans to close those gaps. The AMA also requires identifying and closing professional practice gaps as the purpose of CME. To learn more about professional practice gaps, watch this short video (2:38) by our accreditor, the ACCME.

3. Needs (knowledge, competence, performance)

What is needed to close the identified gaps? Do you need to increase knowledge and competence? Improve individual performance? Improve processes or systems? What does the target audience for your learning activity/program need? What do you, as the educational planner, need to do? Most improvement processes, especially for skills, competency, and performance, require ongoing actions beyond isolated formal education events. Be sure to include noneducational needs (e.g., practice and feedback, audit and feedback, refresher training, online resources, decision-support aids, or job aids). CPL welcomes opportunities to consult with you and collaborate toward meeting your educational and noneducational needs. Here is a brief explanation of the difference between knowledge, competence, and performance.

	Level 1 Does not meet requirements	**Level 2** Meets requirements for inclusion in an accredited CME program	**Level 3** Exemplar
Criteria	Needs, both educational and noneducational, are either lacking or not clearly related to closing the gaps.	Needs are explained for improving knowledge, competence, and/or performance in order to close the gaps. Explained needs distinguish between educational needs to be addressed by the learning objectives of the program/activity and noneducational needs that will be developed concurrently to support the learning objectives during and/or beyond the end of the activity. Sources used to determine the need, and noneducational strategies to address the need are all provided.	Learning needs are identified using process or performance data, population health data, evaluation or assessment data from previous educational activities or programs, surveys, requests from learners, patient care feedback, quality reports, M&M statistics, faculty perception, department/division program priorities, or some other identified source.
Example	(a) Needs explanation: Use of tPA (tissue plasminogen activator) is recommended for acute ischemic stroke. However, tPA is rarely used in rural hospitals. (b) Knowledge need: Rural clinicians need to know the criteria for administering tPA for suspected acute ischemic stroke. (c) Source: Faculty perception. (d) No additional educational intervention is needed. No non-educational strategies are planned. *Rationale: The statement of current status does not reveal a specific need (part a). The need is not simply to know the criteria, but to actually demonstrate the competence to administer tPA when indicated (part b). Noneducational needs are not addressed (part d).*	(a) Needs explanation: Rural clinicians need to learn to recognize the need for tPA (tissue plasminogen activator) and increase administration rates for suspected acute ischemic strokes seen in consultation. (b) Competence need: Rural clinicians need education to demonstrate competency for when to increase tPA administration for suspected acute ischemic stroke. (c) Source: Faculty perception. (d) Additional educational strategies needed: None Noneducational strategies needed: Follow up in 6 months on commitment-to-change statements provided in evaluation with reminders and recommendations for practice to assure eventual implementation. *Rationale: The need is specifically stated and appropriately connected to competency and the source that determined the need. Noneducational needs are indicated.*	(a) Needs explanation: Use of tPA (tissue plasminogen activator) for acute ischemic stroke in rural hospitals is 2-5% [Hassan et al., J Vasc Interv Neurol. 2016; 9(2):1-4]. Approximately 15% to 32% of patients presenting with ischemic stroke arrive within 3 hours of symptom onset; of these, about 40% to 50% are clinically eligible for tPA [Fang et al. *J Hosp Med*. 2010;5(7):406-409]. Therefore, there is a need to increase administration of tPA in rural hospitals. (b) Performance need: tPA administration by rural clinicians must increase for suspected acute ischemic strokes seen in consultation when indicated. (c) Sources: *Faculty perception* and *Other: journal articles*. (d) Additional educational needs will be determined by soliciting "next steps" needs from participants. Non-educational needs will include visual reminders posted in rural clinics in order to reinforce the performance expectation. *Rationale: In addition to stated knowledge and performance needs, a baseline and target are stated in terms of population data from identified sources. Public health officials are involved in the planning and/or delivery.*

Why CPL asks: Education alone is not usually going to close gaps, so determining needs is critical to why you are having your CME activity and what it should accomplish. By identifying noneducational needs, you can broadly plan for what is required to close the gap. The School of Medicine has to demonstrate that CME activities address the identified educational needs (knowledge, competence, or performance) that underlie the professional practice gaps of their learners. We compile this information from your applications and reports to help ensure your CME activity meets accreditation requirements and allows us to grant CME credits to your learners. If you would like to know more about professional practice gaps from the ACCME perspective, watch this short (2:29) video.

4. Design Criteria

4a. Expected Change

What are the targets for change that will help meet your needs identified in item 3 above and close the professional practice gaps described in item 2?

Your intended changes will be supported by the competencies you select next in item 4b and the learning objectives you state in item 4c. Be sure that your targeted change is measurable because you will describe how you plan to evaluate the changes in item 7. Competence is the ability to put into practice the knowledge gained as a result of the activity and can be assessed by asking how the learners intend to put new knowledge into action. Performance is the application of acquired knowledge in an authentic setting and is assessed through observing practice or reviewing data from actual practice.

Changes in performance and outcomes are both more difficult to achieve and to evaluate. Notably, change in competence is not the same as change in knowledge. Here is CPL's brief explanation of the difference between knowledge, competence, performance, and outcome.

	Level 1 Does not meet requirements	**Level 2** Meets requirements for inclusion in an accredited CME program	**Level 3** Exemplar
Criteria	None of the 4 change options are acknowledged, or the described change does not match the selected option(s), or the designed change is not related to the need(s).	The described targeted change(s) clearly relates to the needs, and is correctly matched to the selected change type(s).	Performance or outcomes (patient or learner) are targeted for change.
Example	Physicians need to learn the appropriate protocols for prescribing opioids. *Rationale: The statement implies a possible change in knowledge, but not a targeted change in competence.*	Designed to change competence: Yes In order to meet the need for improving treatment of chronic non-cancer pain, providers will change how they intend to prescribe opioids according to presented protocols. *Rationale: Targeting a change in intention (what would be done if it could be done), the statement matches the selected change in competence.*	Designed to change performance: Yes In order to meet the need for improving treatment of chronic non-cancer pain, providers will demonstrate changes in their recorded prescription of opioids in accordance with protocols. *Rationale: The target is to change practice, which aligns with the selection of a change in performance.*

Why CPL asks: Change is the purpose of education. In professional education, that means either providing the learner with the ability to change (competence), or a change in the learner's behavior in actual practice (performance), or a change in the outcomes of the patients (or other learners) as a result of the changed performance. The ACCME requires an accredited CME program to design educational experiences that change competence, performance, or patient outcomes; and to evaluate that change.

4b. Relevant Competencies (IOM, ACGME, IPEC, AoME, etc.)

Select the most relevant competency or competencies from the provided lists and briefly explain your choices. Please be thoughtful and deliberate because your choices must match with the stated needs (item 3) and objectives (item 4c) and be consistent with how you will assess your learners (item 6) and evaluate your activity (item 7). Click this link to obtain more specific information for each list.

	Level 1 Does not meet requirements	**Level 2** Meets requirements for inclusion in an accredited CME program	**Level 3** Exemplar
Criteria	Learner competencies are not selected or explained relative to the needs and objectives.	Selected learner competencies are appropriately aligned to the needs.	(There are no additional criteria for an exemplar response)
Example	Boxes are checked with no explanation of how the selected competencies relate to learning needs and objectives. *Rationale: Selected competencies do not align with stated needs, gaps, and learning objectives.*	The learning experience is designed to change learner competence; the selected competencies support changes to physician competence in prescribing opioids. The need to improve physician competence in prescribing opioids requires medical knowledge, patient care and procedural skills, patient-centered care, and evidence-based practice. Selected competencies: medical knowledge, patient care and procedural skills, provide patient-centered care, employ evidence-based practice. *Rationale: Selected competencies align with the goal of improving competence in prescribing opioids.*	

Why CPL asks: Activities designated for CME credit must be designed to use new knowledge or skills to change competence, performance or patient outcomes. Therefore, it is critical to define the competencies you intend to address and include these, along with your learning objectives, when planning your events.

4c. Learning Objectives

Learning objectives state what your learners will know and/or be able to do as a result of the activity/program – what learners will achieve through participation. Learning objectives are not a description of your activity (e.g., listen to a series of speakers, read and discuss the latest research, discuss recent problematic cases). Objectives must be specific and measurable. Objectives are the basis for learning assessment (item 6). The learning objectives include the knowledge and/or competence that learners will gain by the end of the full series of events and may include a performance expectation. Each constituent event (e.g., grand rounds presentation, journal club discussion, M&M presentation and debrief) will have its own learning objectives that support achieving the overall objectives that you list here. Two CPL resources provide guidance for writing learning objectives: the STAR model reference sheet with example objectives and the video (9:32) Creating & Aligning Learning Objectives.

	Level 1 Does not meet requirements	**Level 2** Meets requirements for inclusion in an accredited CME program	**Level 3** Exemplar
Criteria	Stated objectives are not specific and measurable; or objectives do not clearly address the educational need(s).	Stated objectives are specific, measurable improvements in learner knowledge, competence, and/or performance needed to reduce the performance gap described in item 2, and are clearly related to the educational need(s) identified in item 3.	Stated objectives are specific, measurable improvements in learner performance and/or patient outcomes.
Example	Clinicians need to know more about safely prescribing opioids and to access the PDMP database. *Rationale: Objectives are not specific and measurable.*	Objective 1: Learners will demonstrate competence in the use of the PDMP to access patient data needed to ensure safe opioid prescribing and pain management according to federal guidelines and state regulations. Objective 2: Learners will demonstrate competence through role-playing motivational interviews with patients around functional goals, drug screening, tapering, initiation of opioids, and the risks and benefits of different treatment options. Learners will receive feedback on their interviews. *Rationale: Objectives are specific, measurable improvements in learner competence needed to reduce the performance gap in assessing patient needs and safely prescribing opioids.*	In addition to objectives 1 and 2 (see level 2 example): Objective 3: Learners will demonstrate improved performance by showing a reduction in overlapping and concurrent prescriptions, co-prescriptions, proportion of high-dose prescriptions, or drug overdose deaths 6 weeks after the learning event. Objective 4: Learners will demonstrate a higher proportion of patients receiving PMP reviews 6 weeks after the learning event. *Rationale: Demonstration of improved performance in an authentic context is difficult to accomplish during the learning event. However, through follow up, it can be demonstrated once the learner has returned to normal practice.*

Why CPL asks: Objectives are the target that you are aiming for and indicate appropriate educational formats for each event or lesson. Additionally, the learning objectives are a way of translating the needs you identified in item 3 into specific outcomes of your programmed events that allow you to measure the extent to which you met the needs and closed the gap.

5. Learning Formats (small group discussion, case-based learning, panel, demonstration, role play / dramatization, virtual learning - synchronous, lecture, other)

What will your learners experience? How will the format(s) facilitate achievement of the stated objectives and targeted competencies? Case discussions, engagement of participants using audience-response systems, and other forms of interactivity or action among the participants are strongly advised. Didactics alone are unlikely to build competence. For an explanation of the most typical CME learning formats and their use, click here.

	Level 1 Does not meet requirements	**Level 2** Meets requirements for inclusion in an accredited CME program	**Level 3** Exemplar
Criteria	Formats are not clearly linked to educational needs and objectives. Formats will not likely lead to improved competence or performance.	Learning formats are consistent with needs and objectives and the activity type.	Applicant collaborates with CPL on the scope and content of learning objectives and activities; co-creates the necessary noneducational and educational interventions; and demonstrates creativity and innovation.
Example	Format selection: Lecture. Primary care has grown far more complex over the years with a need for ongoing, up-to-date, evidence-based support, especially for providing care to low-income patients who are commonly noncompliant with medications and life-style recommendations. These issues will be addressed in a series of lectures. *Rationale: There is no explanation for the selected format. The lecture format alone without additional noneducational supports, is not sufficient to improve competence of clinicians in providing care to low income patients.* *More information is needed to show how the chosen learning format (lecture) is consistent with the needs and learning objectives.* *Presenters/facilitators are not identified. [Note: identifying presenters/facilitators for the first 3 months is sufficient for a year-long RSS]*	Format selection: Lecture, small-group discussion, case-based learning. Primary care has grown far more complex over the years with a need for ongoing, up-to-date, evidence-based support, especially for providing care to low-income patients who encounter barriers to adhering to care plans. The background to evidence-based care will be provided by lectures, supplemented by small-group discussion where attendees will share their experiences and incorporate the speakers' key points into personal guidelines for communicating compliance with patients. Case-based learning will provide authentic cases for attendees to practice application of presented approaches. *Rationale: Several formats consistent with the learning objectives have been selected to provide a variety of learning experiences and the reasons for using them are explained.*	Primary care has grown far more complex over the years with a need for ongoing, up-to-date, evidence-based support, especially for providing care to low-income patients who encounter barriers to adhering to care plans. Incorporating advice from CPL, the background to evidence-based care will be provided by lectures, supplemented by small-group discussion where attendees will share their experiences and incorporate the speakers' key points into personal guidelines for care. Case-based learning will provide authentic cases for attendees to practice application of presented approaches. Reminder guidelines and tips will be periodically sent to attendees along with solicitation of reflections on successes and challenges in patient communication regarding compliance. *Rationale: The explanation of format goes beyond that provided in level 2 by including consultation with CPL to co-create a program that engages attendees in creative ways.*

Why CPL asks: What learners do determines what they learn. Learning formats, therefore, are critical to addressing the needs and gaps that motivate your CME activity. The AMA requires that selected learning methodologies match the needs and objectives. The ACCME further expects the formats to focus on changing competence and performance.

6. Assessment of learners' achievement of the learning objectives

How will you determine if your learners achieved the learning objectives? Common approaches include: direct assessment of knowledge or skill, retrospective pre-post self-assessment, commitment to change, and follow-up survey or phone call. These approaches to assessment are described further at this link [Note: participant satisfaction is not a measure of learning.] What you write here commits you to the data you will collect and report at least semiannually and you will also include in your annual Outcome Summary Report.

	Level 1 Does not meet requirements	**Level 2** Meets requirements for inclusion in an accredited CME program	**Level 3** Exemplar
Criteria	No learning assessment is planned/described.	Achievement of learning objectives is demonstrated by self-assessment, commitment to change, or both.	Learning is assessed directly by quiz (knowledge, competency) or observed/reported performance as appropriate for the learning objectives. Learners report how they have changed their performance and/or competence and what barriers to change they may have encountered. Learners demonstrate performance improvement with data.
Example	Learning objectives assessed by: Knowledge quiz For annual assessment/planning, faculty evaluate the effectiveness of the format and discuss ways to continue to improve learning formats, making adjustments as they deem beneficial. Learners fill out satisfaction surveys after each session. *Rationale: Although faculty evaluate the perceived effectiveness of the format, the requirement is to assess achievement of the learning objectives. Learner satisfaction is not a good indicator of having achieved the learning objectives and a satisfaction survey is not a knowledge quiz.*	Learning objectives assessed by: Retrospective pre/posttest. Participants will semi-annually complete a retrospective pre-post survey of their changing knowledge or skill proficiency for each learning objective. This survey will show the extent to which they are able (competent) to incorporate what they learned into their practice. *Rationale: A retrospective pre-post survey is an acceptable method for assessing increased competence. Each learning objective is indirectly assessed by linking the survey questions to each learning objective.*	Learning objectives assessed by: Knowledge survey; Direct follow up with learners Each attendee receives a 5-question quiz to respond to after each event to assess learning objectives related to knowledge and competence. Performance objectives will be assessed by a semiannual survey to learn about changes in practice, barriers to change (if any), and further information necessary to implement change. *Rationale:* The use of a quiz directly assesses learning.

Why CPL asks: No educational effort is complete without determining if the learning objectives were accomplished. The AMA requires that a CME activity provides an assessment of the learner that measures achievement of the educational purpose and/or objective of the activity. For regularly scheduled series such as grand rounds or journal club, learning can be assessed at or after each event in the series, periodically (monthly, quarterly, semi-annually; but at least twice per year), or following each topical group of events. You will analyze these assessment data in your annual *Outcome Summary Report*. Special note: A learning assessment must be administered following each instance of a conference, course, workshop, or other one-time event that is not part of a series. Learning assessment data are to be provided to CPL following each event.

7. Evaluation of the RSS program to meet educational needs

(Evaluation data are compiled and summarized at least annually, and uploaded to CPL)

How will you know if you met the needs and closed the gaps that led to the design of the activity? Refer back to item 3 where you selected the Type of Need (knowledge, competence, and/or performance) you were designing for. What data will you use for tracking changes in competence, performance, patient outcomes, and/or resident/student learning outcomes? It is often helpful to consult the same sources of information that you used to delineate your gaps (item 2) and to determine the evidence needed to show improvement. What you write here commits you to the data you will collect and report to CPL in your annual *Outcome Summary Report* for this activity.

	Level 1 Does not meet requirements	**Level 2** Meets requirements for inclusion in an accredited CME program	**Level 3** Exemplar
Criteria	Evaluation only includes collection of attendance and satisfaction data.	Applicant uses data to evaluate changes in competence and/or performance according to the learning objectives, and as a result of the program. Competencies identified in item 4b are also evaluated.	Applicant uses data to evaluate changes in patient or learner outcomes as a result of the program.
Example	At the end of each session, learners fill out a questionnaire indicating their degree of satisfaction with the topic, the presenter, and overall learning experience. The survey also asks for written suggestions. *Rationale: Learner satisfaction is not a measure of achievement of the learning objectives. Learner suggestions may be valuable feedback, but they do not provide sufficient evidence of meeting the learning objectives.*	Objective: Learners will demonstrate competence in the use of the PDMP to access patient data needed to ensure safe opioid prescribing and pain management according to federal guidelines and State regulations. a. During semi-annual meetings, the RSS curriculum is evaluated, including noneducational strategies, based on defined measures of learner competence identified in the learning objectives and assessed through pre/post self-reports. b. Relevant competencies are evaluated through pre/post self-reports. c. Changes in learner competence are evaluated through pre/post self-reports (i). Changes in learner performance (ii), patient outcomes (iii), and learning outcomes for residents/students (iv) are not evaluated. *Rationale: Item 4a indicates the activity is designed to change learner competence. The impact and effectiveness of the program is measured by changes in competence of the learners in relation to the learning objectives. Relevant competencies are also evaluated.*	Objective: Learners will demonstrate a higher proportion of patients receiving PMP reviews 6 weeks after the learning event. a. During semi-annual meetings, the RSS curriculum is assessed based on patterns of change in learner competence and performance identified in item 4a and in the learning objectives, and assessed through pre/post self-reports and follow up interviews. Competencies identified in item 4b are also evaluated. Improvement in quality indicators of clinical practice adapted from professional societies and peer-reviewed literature will demonstrate narrowing the gap between practice patterns and outcomes at advanced centers of excellence as described in item 2. *Rationale: The impact and effectiveness of the program is measured by changes in competence and performance of the learners in relation to the learning objectives. In addition, the impact of the program on patient outcomes is evaluated using quality indicators and comparing to the baseline as stated in item 2.*

Why CPL asks: Evaluation is how you determine if you met the needs and closed the gaps that motivated your CME activity. The AMA and the ACCME require that CME activities be purposefully designed to change competence and performance of individuals and organizations, leading to improved patient outcomes. Moore's Pyramid and Kirkpatrick's 4 Levels are useful tools for visualizing the relationship between evaluation and learning outcomes.

Resources linked within Tips and Examples

Addressing Professional Practice Gaps video (2:38)

Knowledge, competence, and performance PDF

Closing professional practice gaps video (2:29)

Relevant Competencies PDF

STAR Model of learning objectives PDF in Box

Creating & Aligning Learning Objectives video (9:32)

Learning Formats PDF

Learning Assessment Methods PDF

Moore's Pyramid and Kirkpatrick's Evaluation Levels PDF in Box

Supplementary Resources

A Practical Approach to Defining Professional Practice Gaps for Continuing Medical Education

Achieving Desired Results and Improved Outcomes: Integrating Planning and Assessment Throughout Learning Activities