Ask-the-Expert Meets Peer-to-Peer: Outcomes From the 3rd Annual Chair Summit

The Master Class for Neuroscience Professional Development, August 26–29, 2010, Chicago, IL

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About This Poster

Theme Related Area: Quality of care and patient health outcomes improvement

Competency Area: 2.9 – Provide interactive learning and opportunities to practice skills that lead to change in physician performance

Target Audience: Non-beginners

Member Section: All

Objectives

1. Evaluate pre- and post-survey data to assess differences associated with participation in the educational activity
2. Review data analysis results for Moore Level 5 outcomes measures to determine whether information and strategies learned at Chair Summit were applied to practice and had an impact on patient care

Background

Based on a strong commitment to the continuous professional development of clinicians, the annual *Master Class for Neuroscience Professional Development* ("Chair Summit") was developed as an innovative format to improve clinician practice and patient outcomes related to the practice of psychiatry and neurology. The *3rd Annual Chair Summit* expanded its psychiatry focus to embrace all of the neurosciences with additional topics and faculty.

Chair Summit is a unique, one-of-a-kind conference that features the leading teachers and mentors in the neurosciences. 163 neuroscience professionals attended the live, 3.5-day, 22.0-hour activity. The Chairs of the Departments of Psychiatry and Neurology of leading academic institutions gathered to not just present data but also to engage, interact, and share their practical, clinical insights with participants. They presented current research, the latest studies, and cutting-edge advances within these fields.

The educational formats were varied and involved didactic presentations, small-group "Ask-the-Chair" sessions, and Chart Review breakouts, which offered intimate settings that facilitated sharing and mentoring, and assisted in meeting the challenges of clinical practice, as well as one-on-one opportunities for interacting or networking with faculty and colleagues.[1,2] The Chair Summit is built on the concept of active learning, focusing on translation and application. Therefore, each session concluded with "clinical connections" to help clinicians translate the evidence to the care of patients.

An integral part of each Chair Summit has been to measure educational effectiveness. Thus, a Clinical Assertion model[3] and Moore's model of outcomes measurement[4,5] were used for this educational intervention to evaluate Level 5 outcomes (Performance).

Methodology

This study was designed to measure whether participants learned key concepts related to the treatment of a wide range of psychiatric and neurologic disorders and whether they applied this information within their practice setting. Based on content reviews and faculty interactions, specific areas of content within the neurosciences (e.g., sleep disorders, general psychiatry, MS) were selected for focus in this study. Specified focus areas were linked to the practice gaps, learning needs, and activity learning objectives identified for this target audience. In addition, key clinical strategies were identified and developed into statements to assess whether or not participants perceived that they gained new strategies to deal with important practice issues.[3] The Postgraduate Institute of Medicine (PIM) refers to these clinical strategy statements as Clinical Assertions.

Methodology cont'd

As an outcomes partner, PIM assessed Level 5 (Performance) approximately 7 months after the live activity, giving participants enough time to apply the vast amount of knowledge and strategies discussed at the 3.5-day Chair Summit. A total of 162 opted-in participants from the original activity with valid email addresses were sent an invitation to participate in an online survey consisting of 3 demographic questions, 4 clinical strategy statements or questions, and 4 performance-in-practice (PIP) questions relevant to the various psychiatric disorders.

The clinical assertion statements chosen for measurement reflected the practice area of the primary target audience. However, because not every participant may have had the professional authority or responsibility to implement the strategy under consideration, each participant could opt out of answering by indicating that the strategy was not within his or her scope of practice. The strategy chosen for measurement reflects the practice area of the primary target audience.

Clinical Assertion (Strategy) Statements Assessed:

1. Order polysomnography for patients in whom clinical findings suggest a primary sleep disorder.
2. Add a second-generation antipsychotic agent to SSRI therapy in patients with depression who have failed two trials of an SSRI.
3. Continually assess for treatment adherence in patients taking antipsychotic medications.
4. Develop a stronger therapeutic alliance with other clinicians in the health care provider system as part of treatment planning to improve adherence and continuity of care in patients.

Outcomes Measurement and Results

Demographics[†]

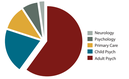
[†]Due to rounding, sums of percentages may not equal 100%

Respondents by Degree

Degree	Number of Respondents	Percentage of Respondents
MD/DO	33	73%
PA	4	9%
NP	2	4%
Social Work	4	9%
Other	2	4%

Respondents by Patients per Clinical Area

Clinical Area	Number of Respondents	Percentage of Respondents
Adult Psychiatry	27	60%
Child/Adolescent Psychiatry	9	20%
Primary Care	5	11%
Psychology	3	7%
Neurology	1	2%



Respondents by Years of Experience

Years of Experience	Number of Respondents	Percentage of Respondents
<5	3	7%
5 to 10	10	22%
11 to 20	6	13%
>20	26	53%

Level 4: Competence, Commitment-to-Change Assessment

The strategy of self-reported outcomes measurement has been found to be predictive of implementation of change in physicians' practice. It can stimulate reflection to institute change, plan new educational activities, and evaluate impact of education.[3]

Outcomes Measurement and Results cont'd

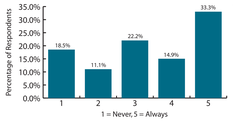
Therapeutic Track	Do you intend to change your practice based on this activity?
Sleep Disorders	83%
Geriatric Psychiatry	75.2%
ADHD/Child Psychiatry	64.4%
General Psychiatry (Session-specific topics—PTSD, borderline personality disorder, substance abuse, trauma, etc.)	63.7%
Bipolar Disorder	62.9%
Multiple Sclerosis	58.4%
Schizophrenia	50.5%
Depression/Anxiety Disorders	48.9%

Level 5: Performance

Of the 162 opted-in participants, 45 responded to the survey, for a 28% response rate. 82% of survey respondents were MDs, DOs, or PAs, with 80% listing adult or child/adolescent psychiatry as their primary clinical area. 58% of those surveyed had over 20 years experience. Because pre-test and post-test data from the original activity were not available, no statistical significance evaluations could be performed. Therefore, only the raw data for the results are reported.

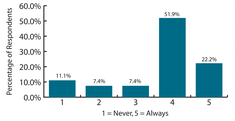
Clinical Assertion (Strategy) Statements (n = 27)

Strategy Statement 1: Order polysomnography for patients in whom clinical findings suggest a primary sleep disorder.



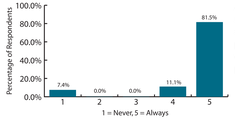
The widely diffuse response pattern indicates that many of the respondents are uncertain regarding the use of polysomnography for patients in whom clinical findings suggest a primary sleep disorder. Thus, this area of content may need to be emphasized if future activities are planned on this subject.

Strategy Statement 2: Add a second-generation antipsychotic agent to SSRI therapy in patients with depression who have failed two trials of an SSRI.



Knowing treatment strategies for patients who have an unsatisfactory response to SSRI therapy is critical for respondents because many patients will develop recurrent symptoms from this widely used class of drugs. Most of the participants indicated that, in the months after the activity, they added a second-generation antipsychotic agent to SSRI therapy in patients with depression who had failed two trials of an SSRI.

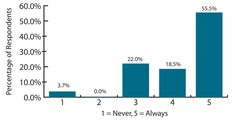
Strategy Statement 3: Continually assess for treatment adherence in patients taking antipsychotic medications.



Almost all of the respondents in the activity indicated that they continually assessed for treatment adherence in patients taking antipsychotic medications within their practice in the months after participating in this activity.

Outcomes Measurement and Results cont'd

Strategy Statement 4: Develop a stronger therapeutic alliance with other clinicians in the health care provider system as part of treatment planning to improve adherence and continuity of care in patients.



Most of the respondents made efforts toward developing a stronger therapeutic alliance with other clinicians in the health care provider system and actively implemented strategies aimed at enhancing adherence in patients with mental illnesses in the months after participating in the activity.

Performance-in-Practice (PIP) Questions (n = 45)

PIP Question #1: Did you change your clinical decision-making processes or any direct patient care as a result of participating in the 3.5-day Chair Summit activity?

62% of respondents said Yes; 18% said No; and 20% were uncertain. Of those respondents who said Yes, the survey asked about making changes in care for patients with specific disorders. Shown below are the percentage of changes made by participants in day-to-day practice.

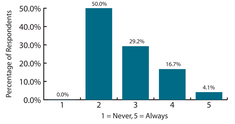
Condition	Change in care	Change in clinical decision making	Change in patient care practices	Changes had a beneficial effect on patient health	Changes are part of routine practice
ADHD (n = 21)	79%	81%	57%	100%	91%
Bipolar disorder (n = 22)	82%	82%	82%	100%	96%
MDD (n = 23)	85%	65%	83%	100%	96%
Schizophrenia (n = 19)	70%	63%	90%	100%	90%
Sleep disorder (n = 11)	41%	73%	82%	91%	100%
MS (n = 6)	22%	83%	67%	100%	100%
Alzheimer's (n = 9)	33%	89%	78%	100%	100%

PIP Question #2 was omitted due to space limitations. Please refer to the handout for full detail.

PIP Question #3: What barriers to initiating changes in clinical decision-making processes or direct patient care practices did you encounter after returning from the Chair Summit?

Response	Number	Percentage
one	9	33%
Need for more information	6	22%
Lack of equipment or staff resources	12	44%
Inadequate community resources	10	37%
Poor patient/family cooperation	10	37%
Inadequate reimbursement	2	11%
Recommended treatment not affordable or accessible to patients	10	37%
My practice already conformed to the information presented	2	7%
None	2	7%
Other (denials from insurance companies and prescription programs)	1	4%

PIP Question #4: How difficult was it to resolve or accommodate these barriers to practice implementation?



Conclusions and Implications

This study demonstrated the effectiveness of the activity in conveying information to professionals in a manner that promoted application of learning to practice and demonstrated improved performance as a result of participation in the activity. *The 3rd Annual Chair Summit, The Master Class for Neuroscience Professional Development* ("Chair Summit") in 2010 improved performance using the Moore model, and met Level 5 Outcomes – Performance.

Key Points:

- The results to Strategy Question #4 suggest that this activity was successful in contributing to the continual assessment for treatment adherence in patients taking antipsychotic medications.
- 62% of respondents to the performance-in-practice survey indicated that changes were made in clinical-decision making or direct patient care as a result of their participation in this activity.
- The effectiveness of the activity is evident in that participants overcame barriers to implement the strategies discussed.

As a result of participation in Chair Summit:

- The strategy that was most widely adopted by participants was the continual assessment for treatment adherence in patients taking antipsychotic medications. Adherence to treatment is a very important clinical issue because nonadherence can have serious consequences, such as relapse. It is not surprising that these mental health professionals would embrace a strategy that lies at the core of their scope of practice.
- When asked whether changes in practice were made regarding specific disorders, participants responded that the most changes were seen in the treatment of ADHD, bipolar disorder, major depression, and schizophrenia.
- The respondents who made changes in decision-making or patient care indicated that the greatest barriers to implementing strategies were the lack of equipment/staff resources, poor patient/family cooperation, inadequate community resources, and unaffordable/inaccessible treatment options.
- The respondents who did not make changes identified barriers such as lack of time and professional conflict as reasons for lack of strategy implementation. The lack of application to practice may be a result of external factors, not a reflection of the effectiveness of the activity.

References

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ADHD = Attention-Deficit/Hyperactivity Disorder; MDD = Major Depressive Disorder; MS = Multiple Sclerosis; PTSD = Posttraumatic Stress Disorder

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