Des Moines University Application for Credit

Activity Information

Date of application: October 7, 2020

Organization: University of Northern Iowa

Activity title: End-of-Life Care Mini Summit

Date: Saturday, March 24, 2018

Location: Gallagher Bluedorn Performing Arts Center at the University of Northern Iowa, Cedar Falls, IA

Time: 4 – 9 pm

Activity director: Amy Hunzelman

Phone: 319-273-3660 **Email:** Amy.hunzelman@uni.edu

Activity director: Keyha Levy

Phone: 319-273-2250 **Email:** keyah.levy@uni.edu

Activity coordinator: Deanna Shafer

Phone: 319-273-6249 **Email:** dshafer@uni.edu

Format: *ACCME C5; CPME Standard 3.2, 9.0*

☒ Live
☐ Journal-based CME
☐ Online/Enduring materials
☐ Grand Rounds/Regularly scheduled series (RSS)
☐ Remote site teleconference
☐ Other:

Frequency of activity:

☒ Once
☐ Weekly
☐ Monthly
☐ Quarterly
☐ Annual
☐ Other:

Type of credit requested: (additional requirements and fees may apply)

☒ American Osteopathic Association (AOA) credit
  ☐ Category 1-A
  ☐ Category 1-B
  ☒ Category 2-A
  ☐ Category 2-B
☒ Nursing credit (IBON)
☒ American Academy of Family Physicians (AAFP) Prescribed credit ***Additional fee
☒ *AMA PRA Category 1 Credit™* through the Iowa Medical Society
☐ Podiatry credit (CPME)
☒ Certificates of participation
☐ Other:

Planning Committee

Identify below members of the planning committee who have input into the planning process and selection of content. To comply with national CME standards, Des Moines University requires all planners and developers of content for an educational activity to complete and submit a financial conflict of interest form. It's the responsibility of the activity director to ensure that no conflicts of interest occur during the planning and content delivery process. If needed, attach separate documentation. *AOA Standards 2.2.4.2, 3.3, 3.5; ACCME C7, SCS 1.1, SCS 6.1-6.5, C9, SCS 2.1-2.3, SCS 4.2-4.5, C10, SCS 5.2; CPME Standard 1.3, 1.6, 5.2, 5.3*

Name, Credentials, Title	Phone	Email	COI
Amy Hunzelman *Director of Education Special Projects, University of Northern Iowa*	319-273-3660	Amy.hunzleman@uni.edu	None
Keyha Levy *Assistant Director – Multicultural Education, University of Northern Iowa*	319-273-2250	keyah.levy@uni.edu	None
Deanna Shafer *Social Work Graduate Student, University of Northern Iowa*	319-273-6249	dshafer@uni.edu	None

Target Audience

AOA Standards 2.1.8, 3.1.1, 3.1.2, 3.2; ACCME C3; CPME Standard 3.2

☒ Physicians
☒ Mid-level providers
☒ Nurses
☐ Ancillary Staff
☒ Residents
☒ Medical Students
☒ Non-Medical Students
☒ General Public
☐ Other:

Number of proposed attendees: 100 - 150

Purpose and Mission

Describe the purpose and mission of this CME activity. Must be in harmony with the Des Moines University CME mission statement. *AOA Standard 2.2.2.1; CPME 1.1*

The purpose of the mini-summit is to provide community conversations between medical professionals, social workers, and the general public as they explore and share experiences with end-of-life care. Each of these three identified groups offer a unique perspective of relieving and lessening pain in someone with a life-limiting condition. The mini-summit will also provide compassion and empathy for other people as they cope and experience grief and loss.

Educational Format

AOA Standard 2.1.7; ACCME C5; CPME Standard 3.2

☐	Case presentation	☐	Interactive response system
☐	Skills demonstration	☐	Simulated patient
☒	Lecture	☐	Laboratory session
☒	Panel discussion	☐	Mentoring/coaching
☒	Small group discussion	☒	Question and answer session
☐	Seminar	☐	Workshops
☒	Round table	☒	Other: Live theatrical performance

How was it determined that the format chosen was the best for delivery of activity?

Given the topic “End-of-Life Care,” we felt it was best to provide an informal environment throughout the day with sessions and round table discussions at dinner, allowing participants to feel comfortable in an uncomfortable topic.

Identifying Professional Practice Gaps

The CME planning process begins with identifying professional practice gaps(s). The practice gap is the difference between what actually occurs and what the ideal or evidence-based practice should be. Describe below what practice gap(s) this CME activity will address. How do you know there is an educational need from the target audience? What clinical problems or opportunities for improvement will the activity address? What types of gaps in the target audience did you identify? (e.g., for clinical care: patient outcomes to improve, new methods of diagnosis or treatment to implement, better ways to deliver care) *ACCME C2, C3; AOA Standards 2.1.8, 2.2.3.3.1; CPME Standards 2.0, 3.0*

The practice gap being addressed during end-of-life care is empathy and compassion between the patient, care-giver, and medical team. Ethical challenges are also common in end-of-life care, creating confusion and conflict about the balance between benefits and burdens experience by patients. As indicated by research, physician trainees experience significant moral distress when they felt obligated to provide treatments at or near the end-of-life that they believed to be futile. Some trainees developed detached and dehumanizing attitudes towards patients as a coping mechanism, which may contribute to a loss of empathy.

End-of-Life Care: Core Competencies for Physicians

On August 17, 2011, the Iowa Board of Medicine amended the Iowa Administrative Code 653 Chapter 11, requiring physicians to complete continuing medical education on end-of-life care management. This administrative rule was changed in an effort to improve end-of-life care for patients. Based on this information, it has been concluded that physicians are in need of training regarding caring for patients at the end of their lives.

https://www.legis.iowa.gov/docs/iac/chapter/653.11.pdf

Educational Need

Is the identified educational need of the target audience related to: (select all that apply) *ACCME C2, C3; CPME Standard 3.0, 3.1, 9.5*

- ☒ Knowledge (facts and information acquired by a person through experience or education)
- ☒ Competence (having the ability to apply knowledge, skills, or judgment in practice if called upon to do so)
- ☒ Performance (what the participant actually does in practice)
- ☒ Patient outcomes (actual outcomes in individual patients and/or patient populations)
- ☐ Community (change in population health status)

Barriers

What factors outside of the provider's control have been identified that would have an effect a change in patient outcomes. Include examples of identified factors outside of your organization's control that will have an impact on patient outcomes. *ACCME C18*

In general, access to care is an outside barrier for providers. This includes legislation, both Medicaid and Medicare, financial barriers such as patients who might not be covered, transportation for patients, and geographical location to services.

What potential or real barriers are physicians faced with if this gap is to be addressed? Describe the educational strategies that have or are being implemented to remove, overcome or address these barriers to change? *ACCME C19*

Essentially, physicians might face a quantity verses quality gap of service and care with patients. Continuing Education opportunities for physicians are being implemented throughout the nation, state, and region to address End-of-Life Care and the ability to provide compassion and empathy for other people as they cope and experience grief and loss. Other strategies include lobbying, patient advocacy, and physician self reflection.

Collaboration with Stakeholders

If your organization is engaged in collaborative or cooperative relationships with other stakeholders, describe these relationships. *ACCME C20; CPME 1.6*

The Mini-Summit provides short term partnerships between the performing arts center, UNI students, staff, and faculty, as well as community organizations, in a non-traditional environment (surrounding the play, Mercy Killers).

Sources of Professional Practice Gaps

Check the procedures you will use to identify the CME needs of the intended target audience. AOA credit is requested, for a multi topic activity, each presentation must have an evidence based needs assessment source. *AOA Standards 2.1.2, 2.1.3, 2.2.3.1; ACCME C2, C21; CPME 2.1*

☐	OMT/OPP as part of the profession. No additional documentation necessary.
☐	Core competencies that are non-clinical (professionals, communications, system based practice, etc.)
☐	Faculty development programs. No additional documentation necessary.
☐	Evaluation results from previous CME activities. Attach past evaluation summary with relevant suggestions highlighted.
☐	Request of medical staff or administration. Attach documentation or emails with relevant suggestions highlighted.
☐	Expert opinion from university or physician leaders. Attach meeting notes or survey results with relevant suggestions highlighted.
☐	Questionnaire (Learner Perceived Needs). Attach questionnaire summary with relevant suggestions highlighted.
☒	Literature reviews. Site the source or include a copy of the article. **The art of letting go: Referral to palliative care and its discontents** Broom, Alex ; Kirby, Emma ; Good, Phillip ; Wootton, Julia ; Adams, Jon Social Science & Medicine, Feb 2013, Vol.78, p.9 Accompanying patients from active treatment towards specialist palliative care is a complex sphere of clinical practice that can be fraught with interpersonal and emotional challenges. While medical specialists are expected to break 'bad news' to their patients and ease their transitions to specialist palliative care if required, few have received formal training in such interpersonal complexities. Furthermore, there also often exists clinical ambiguity around whether to continue active treatment vis-a-vis refocusing on quality of life and palliation. In this paper we explore the experiences of twenty Australian medical specialists, focussing on issues such as: dilemmas around when and how to talk about dying and palliation; the art of referral and practices of representation; and, accounts of emotion and subjective influences on referral. The results illustrate how this transitional realm can be embedded in emotions, relationships and the allure of potentially life-prolonging intervention. We argue that the practice of referral should be understood as a relational and contextually-bound process. **A systematic review of the associations between empathy measures and patient outcomes in cancer care** Lelorain, Sophie ; Brédart, Anne ; Dolbeault, Sylvie ; Sultan, Serge Psycho-oncology, December 2012, Vol.21(12), pp.1255-64 Despite a call for empathy in medical settings, little is known about the effects of the empathy of health care professionals on patient outcomes. This review investigates the links between physicians' or nurses' empathy and patient outcomes in oncology. With the use of multiple databases, a systematic search was performed using a combination of terms and

	subject headings of empathy or perspective taking or clinician-patient communication, oncology or end-of-life setting and physicians or nurses. Among the 394 hits returned, 39 studies met the inclusion criteria of a quantitative measure of empathy or empathy-related constructs linked to patient outcomes. Empathy was mainly evaluated using patient self-reports and verbal interaction coding. Investigated outcomes were mainly proximal patient satisfaction and psychological adjustment. Clinicians' empathy was related to higher patient satisfaction and lower distress in retrospective studies and when the measure was patient-reported. Coding systems yielded divergent conclusions. Empathy was not related to patient empowerment (e.g. medical knowledge, coping). Overall, clinicians' empathy has beneficial effects according to patient perceptions. However, in order to disentangle components of the benefits of empathy and provide professionals with concrete advice, future research should apply different empathy assessment approaches simultaneously, including a perspective-taking task on patients' expectations and needs at precise moments. Indeed, clinicians' understanding of patients' perspectives is the core component of medical empathy, but it is often assessed only from the patient's point of view. Clinicians' evaluations of patients' perspectives should be studied and compared with patients' reports so that problematic gaps between the two perspectives can be addressed. **Moral Distress Amongst American Physician Trainees Regarding Futile Treatments at the End of Life: A Qualitative Study** Dzeng, Elizabeth ; Colaianni, Alessandra ; Roland, Martin ; Levine, David ; Kelly, Michael P ; Barclay, Stephen ; Smith, Thomas J Journal of general internal medicine, January 2016, Vol.31(1), pp.93-9 Ethical challenges are common in end of life care; the uncertainty of prognosis and the ethically permissible boundaries of treatment create confusion and conflict about the balance between benefits and burdens experienced by patients. We asked physician trainees in internal medicine how they reacted and responded to ethical challenges arising in the context of perceived futile treatments at the end of life and how these challenges contribute to moral distress. Semi-structured in-depth qualitative interviews. Twenty-two internal medicine residents and fellows across three American academic medical centers. This study uses systematic qualitative methods of data gathering, analysis and interpretation. Physician trainees experienced significant moral distress when they felt obligated to provide treatments at or near the end of life that they believed to be futile. Some trainees developed detached and dehumanizing attitudes towards patients as a coping mechanism, which may contribute to a loss of empathy. Successful coping strategies included formal and informal conversations with colleagues and superiors about the emotional and ethical challenges of providing care at the end of life. Moral distress amongst physician trainees may occur when they feel obligated to provide treatments at the end of life that they believe to be futile or harmful.
☐	Public health priorities. Describe:
☐	New medical technology. Describe:
☐	Tests that determine learner competence (e.g., pre- and post- test results, self-assessment activities). Attached a copy of the test with relevant sections highlighted.
☐	Quality data or quality improvement initiative from organization. Attach reports or documentation with relevant sections highlighted.

☐	Tests that determine learner competence (e.g., pre- and post- test results, self-assessment activities)
☐	Data from local, statewide, regional, or national resources. Attach relevant reports or documentation.
☒	Data from outside sources such as the National Institutes of Health or Public Health Service. Attach relevant reports or documentation. **National Cancer Institute** https://www.cancer.gov/about-cancer/advanced-cancer/care-choices/palliative-care-fact-sheet#r2 Is there any research that shows palliative care is beneficial? Research shows that palliative care and its many components are beneficial to patient and family health and well-being. In recent years, some studies have shown that integrating palliative care into a patient's usual cancer care soon after a diagnosis of advanced cancer can improve their quality of life and mood, and may prolong survival. The American Society of Clinical Oncologists recommends that all patients with advanced cancer receive palliative care.
☐	Results of evidence based medicine studies. Attach studies.
☐	Legal or regulatory requirements (OSHA, JCAHO, etc). Attach reports or documentation with relevant sections highlighted.
☒	Licensure or State mandate (ex: risk management). Attach reports or documentation with relevant sections highlighted. • Iowa Board of Medicine Chronic Pain and End-of-Life Training: https://medicalboard.iowa.gov/licensure/chronicpain_endoflife.html • Iowa Administrative Code 653 Chapter 11: https://www.legis.iowa.gov/docs/iac/chapter/653.11.pdf
☐	Change in national standard of practice. Attach reports or documentation with relevant sections highlighted.
☐	Board preparation courses based on pass rate/board scores. No additional documentation necessary.
☐	Quality resource website databases (e.g., ahrq.gov, guideline.gov)
☐	Other:

Learner Attributes

Educational activities must be developed in the context of desirable learner attributes. The Accreditation Council for Continuing Medical Education (ACCME)/American Board of Medical Specialties (AMBS) and American Osteopathic Association (AOA) endorses the sets of competencies developed by The Institute of Medicine (IOM) and the Accreditation Council for Graduate Medical Education (ACGME) as measures of quality and success in educational programming. Please check the appropriate attributes that apply to the development of and desired results for this educational activity or series. *AOA; ACCME C6*

☐	Osteopathic Philosophy/ Osteopathic	Demonstration and application of knowledge of accepted standards in osteopathic manipulative treatment appropriate to the specialty; dedication to

	Manipulative Medicine (AOA)	life-long learning and to incorporating the practice of osteopathic philosophy and OMM in patient care.
☐	Medical Knowledge (ACGME/ABMS, AOA)	Demonstration and application of established and evolving biomedical, clinical, and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
☒	Patient Care (ACGME/ABMS AOA,)	Demonstrate the ability to effectively treat patients and provide medical care that incorporates the osteopathic philosophy, patient empathy, awareness of behavioral issues, the incorporation of preventive medicine and health promotion.
☒	Patient-Centered Care (IOM, ACGME)	☒ Identify, respect, and care about patients' differences, values, preferences, and expressed needs.
		☐ Relieve pain and suffering.
		☒ Coordinate continuous care.
		☐ Listen to, clearly inform, communicate with, and educate patients.
		☒ Share decision making and management.
		☐ Continuously advocate disease prevention, wellness, and promotion of healthy lifestyles, including a focus on population health.
☒	Works in Interdisciplinary Teams (IOM)	Demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.
☒	Professionalism (ACGME/ABMS, AOA)	Manifested through a commitment to carry out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
☒	Practice-Based Learning and Improvement (ACGME/ABMS, AOA)	Involves the investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.
☐	Employ Evidence-Based Practice (IOM)	Integrate best research with clinical expertise and patient values for optimum care, and participate in learning and research activities to the extent feasible.
☐	Apply Quality Improvement (IOM)	☐ Identify errors and hazards in care.
		☐ Understand and implement basic safety design principles, such as standardization and simplification.
		☐ Continually understand and measure quality of care in terms of structure, process, and outcomes in relation to patient and community needs.
		☐ Design and test interventions to change processes and systems of care, with the objective of improving quality.
☐	Systems-Based Practice (ACGME/ABMS, AOA)	Manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system for health care and the ability to effectively call on system resources to provide care that is of optimal value.
☒	Interpersonal and Communication Skills (ACGME/ABMS, AOA)	Demonstrate interpersonal and communication skills that enable a physician to establish and maintain professional relationships with patients, families, and other members of health care teams.

☐	Utilize Informatics (IOM)	Communicate, manage knowledge, mitigate error, and support decision making using information technology.

Learning Objectives

Define specific goals/objectives for the CME activity. What changes in knowledge, attitudes, or skills are expected as a result of this activity? What changes in patient care are expected? What will attendees know, or be able to do, as a result of participating in the activity*? AOA Standards 2.1.5, 2.2.3.2, 2.2.3.3.1; ACCME C7, SCS 1.1; CPME 3.0, 4.1, 7.1, 9.2*

Upon completion of this activity, participants will be able to:

1. Understand ethical dilemmas and implications
2. Understand the process of end-of-life decision making
3. Empathize with patients and caregivers

Activity Schedule

The accredited provider shall use the objectives developed for an educational activity to select the content, speakers, learning methods for the activity. If needed, attach separate documentation. *AOA Standard 2.2.3.3.1; CPME 7.1*

Time	Presentation Title and Speaker	CME/CE
4 pm	**Registration and Check-In**	
4:30 pm	**Caring for the Caregiver** Chad Hofeldt, Outreach and Communication, Cedar Valley Hospice	**0.75**
4:45 pm	**Social Implications of Death and Dying** Rev. Abraham Funchess, Human Rights Director, City of Waterloo	
5 pm	**Legislative Update** Jeff Danielson, Iowa Senator, District 30	
5:15 pm	**Break**	
5:30 pm	**Medical Ethical Decision Making** Francis Degnin, MA, PhD, MPM, Associate Professor, University of Northern Iowa	**0.75**
5:55 pm	**Palliative Care: Chaplain** Emma Peterson, Chaplain	
6:15 pm	**Dinner**	
7 pm	**Performance by the Mercy Killers**	**0.0**
8:15 pm	**Bereavement Panel**	**0.75**
9 pm	**Adjourn**	
	Total	**2.25**

Speaker Information

List speaker with pertinent credentials. Speakers who refuse to sign the financial conflict of interest form may not participate in the CME activity. For a multi topic activity, each presentation must have an evidence-based needs assessment source. A biographic sketch and/or CV is required for all speakers. If needed, attach separate documentation. *AOA Standards 2.2.4.2, 3.3, 3.5, ACCME C7, SCS 2.1-2.3, SCS 3.7, SCS 6.1-6.5, C8, SCS 3.7-3.10, SCS 4.2-4.5, C10, 5.1, 5.2; CPME Standard 5.0, 7.1*

Name, Credentials, Title	Phone, Email	Honorarium Amount? (if applicable)	Paying Speaker Expenses? (if applicable)	COI
Rev. Abraham Funchess *Human Rights Director, City of Waterloo*	319-291-4324 abraham.funchess@waterloo-ia.org	N/A	☐ Yes ☒ No	
Chad Hofeldt Outreach and Communication, Cedar Valley Hospice	319-272-1771 chofeldt@cvhospice.org	N/A	☐ Yes ☒ No	
Jeff Danielson *Iowa Senator, District 30*	319-231-7192 jeffdanielson@gmail.com	N/A	☐ Yes ☒ No	
Francis Degnin, MA, PhD, MPM *Associate Professor, University of Northern Iowa*	319-273-3015 Francis.Degnin@uni.edu	N/A	☐ Yes ☒ No	
Emma Peterson Chaplain	TBD	N/A	☐ Yes ☒ No	

Level of Outcomes

Please indicate the level of outcomes this educational activity will address. Select one.

- ☐ Level 1 outcomes, or the “smile sheet,” rate the CME activity’s quality, usefulness, objectives, presentation, and/or speakers.
- ☐ Level 2 measures a change in participants’ knowledge, skills, or attitude – an intention to change.
- ☒ Level 3 is a self-reported change in health professionals’ behavior or practice.
- ☐ Level 4 is an objectively measured change in clinician behavior or practice.
- ☐ Level 5 is an objectively measured change in patient health status.

Evaluation

Describe how you will determine if your CME activity is effective in meeting the needs for which the activity was designed. The approved CME evaluation should be used along with other effective tools. *AOA Standards 2.1.6, 2.1.7, 2.1.9, 2.1.10, 2.1.11, 3.14; ACCME C11, C13, C22; CPME Standard 4.1*

☒ Post-activity evaluation*
☐ Use of audience polling device
☐ Pre-test
☐ Post-test
☐ 90-day follow-up assessment
☐ Verbal interview of participants summarized in writing
☐ Patient outcomes data
☐ Questionnaire
☐ Planning group review
☐ Other:

* DMU CME will provide a list of required CME evaluation questions.

Describe anticipated ways to evaluate short and long-term learning value of your activity.

Short-term: To assess the short term learning value of this activity, an evaluation will be distributed to the learners on-site. The feedback provided is used to determine the effectiveness of the content presented and help plan for future activities. It will properly assess the learning and adaptation of the activity. Attendance and attendee satisfaction, per the evaluation, will assist the level of interest and understanding.

Long-term: None at this time.

Commercial Support

AOA Standards 2.2.3.3.2, 2.2.3.3.3.1-5, 2.2.4.1, ACCME C8, SCS 3.1-3.7, 3.11-3.13, C9, SCS 4.1, 4.2; CPME Standard 6.0

Independence of Activity Planning: When planning a CME activity, the activity director and members of the planning committee confirm that the following decisions will be made free of the control of commercial interests:

1. Identification of needs
2. Determination of education objectives
3. Selection and presentation of content
4. Selection of all personnel and organization that will be in a position to control the content
5. Selection of education methodology
6. Evaluation of the activity

☒ Check this box to indicate you have read, understand and comply with the independence of activity planning standards.

☒ This activity will not be requesting commercial support.
☐ This activity will be requesting commercial support (complete table below).

Company Name	Representative Name	Phone, Email	Requested Amount	Type
				☐ Grant ☐ Exhibit ☐ In Kind
				☐ Grant ☐ Exhibit ☐ In Kind

Content Validation

Applies to all those in control of content, including activity director, planning committee members and speakers. Des Moines University expects that all CME activities will adhere to the content validation statement.

1. All the recommendations involving clinical medicine in a CME activity 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.
2. All scientific research referred to, reported or used in CME in support or justification of a patient care recommendation must conform to the generally accepted standards of experimental design, data collections and analysis.
3. The content or format of CME activities and related materials will promote improvements or quality healthcare and not a specific proprietary business or commercial interest.
4. CME must give a balanced view of therapeutic options. Use of generic names will contribute to this impartiality.
5. If your CME educational materials include trade names, names from several companies should be used where available, not just trade names from a single company.
6. Feedback from learners will be collected to determine the effectiveness of this CME activity through questionnaires or other evaluation mechanisms.
7. Educational materials that are part of this activity, such as slides, abstracts, and handouts, cannot contain any advertising, trade names, or product-group messages.

☒ Check this box to indicate that you have read, understand, and will comply with the content validation statement.

Amy Hunzelman	[signature]	February 5, 2018
Activity Director	**Signature**	**Date**
Keyha Levy	[signature]	February 5, 2018
Activity Director	**Signature**	**Date**
Vanessa Ross, MHA, CMP, CHCP	[signature]	February 5, 2018
Director, DMU CME	**Signature**	**Date**