

## **2009 Alliance Award for Most Outstanding Certified Enduring Material CME Activity**

**“In recognition of an organization responsible for innovation and excellence in the design, educational format, and instructional delivery of a certified CME activity”**

**Gary C. Bird, PhD, Senior Medical Liaison  
Janine A. Scotti, MBA, Director, Educational Services  
Richard Kennison, DPM, MBA, CCMEP, President/General Manager**

**Peer-Point Medical Education Institute, LLC, 1560 Sherman Avenue, Evanston, IL 60201**

### **What’s Best for My Patient: Using Evidence to Design the Right Team, the Right Treatment, at the Right Time for the Management of Colon and Rectal Cancers**

Current trends for the management of colon and rectal cancer (CRC) involve a care team-based structure involving clinicians with surgical and medical oncology specializations as well as input from gastroenterologist and pathologist colleagues. Providing continuing medical education (CME) to all clinicians involved in CRC management in a live event is problematic because of difficulties in defining a common educational theme, and the differing time constraints imposed on each member of the team. However, knowledge, competency and performance gaps are evident in this group of clinicians which require educational intervention. With this in mind, *What’s Best for My Patient* sought to bring together care team members of varying specializations, using unique, highly interactive online case simulations that maximized reach and stimulated learning.

#### **Needs Assessment for Colon and Rectal Cancer Content in the Activity**

In the United States, CRC is the third most common cancer overall and causes approximately 10% of all cancer-related deaths per year. According to the American Cancer Society, 112,340 new cases of colon cancer and 41,420 new cases of rectal cancer occurred in the United States in 2007.<sup>1</sup> Typically, some 15–20% of newly diagnosed patients will have metastatic disease at initial presentation, whereas 80–85% have earlier stage disease.<sup>2</sup> Despite advances in its management, CRC was the estimated cause of death for 52,180 people in 2007.<sup>1</sup> However, when CRC is detected at an early, localized stage, the 5-year survival rate of 90% is promising. Nevertheless, 62% of all CRC cases present as either locally advanced or metastatic disease, and the associated 5-year survival rate with a tumor that has spread to adjacent organs and/or lymph nodes is 66%. With distant metastases, only 9% of individuals will live 5 years.

Advances in the management of patients from screening and initial detection through to treatment have continued to evolve over the last decade—with the emphasis promoted by the National Comprehensive Cancer Network (NCCN) being to shift practice habits towards a multidisciplinary, team-based approach.<sup>3,4</sup> However, although the logic behind bringing together members with different specialties in the oncology clinical team is sound, there are inherent deficits in this approach that may adversely affect patient outcomes. These deficits center on knowledge, competency and performance issues that become apparent when all care team member efforts must be coordinated. Without adequate communication between its members, the team approach is at best an inefficient process, to the detriment of performance. This is compounded because the evidence-based NCCN guidelines for best practice CRC screening and treatment, and their specific implications for the various sub-specialties involved, are regularly updated leaving the potential for a knowledge or competency gap both within each specialty and between the specialties. The activity therefore had several fundamental requirements: 1) to foster a mechanism for improving the dialogue between care team members; 2) to enhance knowledge of the latest evidence-based guidelines; 3) to provide a platform for the application of that knowledge and; 4) to provide some form of “cross-pollination” so that members of the care team could better understand each others perspective on best practice patient management.

### **Learning Objectives**

Upon completion of this educational activity, the participant should be able to:

- Identify the various specialists who treat cancer of the colon and rectum and discriminate their role on the treatment team
- Explain the importance of lymph node harvesting, including the significance of the number of lymph nodes sampled and implications for accurate staging
- Use evidence-based guidelines to identify patients with cancer of the colon and rectum who may benefit from adjuvant treatment
- Describe the risks and benefits of implementing adjuvant chemotherapy in stage II and stage III colorectal cancer

### **How this Activity Closed the Practice Gaps**

It was decided that a highly interactive, but easy-to-use case simulation approach would be needed to resolve the complex issues and practice gaps facing clinicians who deal with CRC patients. Given the time-constraints placed on this group of clinicians, the activity needed to be accessible online and be available on-demand. This approach was deemed to have the greatest reach, and from the onset was designed to be a cost-effective enduring piece.

The user experience was designed to immerse the person participating in the activity with the experience of viewing a patient’s treatment from the perspective of the medical oncologist or colon and rectal surgeon. Two parallel simulations each of 30 minutes duration were presented; one case from

each clinical perspective, with both purposely utilizing an ill-structured, atypical patient history. In order to promote transference of the issues and hence understanding of a different point of view, the user was invited to complete the second simulation after completing the first. Each simulation presented a fully interactive chart showing the stage of the patient's evaluation and treatment. The results of consultations and tests performed at various dates were showed as images or as written reports, and were added to the history thus giving the user a view comparable to seeing the chart evolve in real time. The flexibility of the interface made it easy for participants to be quizzed at key stages, using carefully constructed multiple choice questions, to assess their knowledge on important issues and to examine their personal perceptions of the practice gaps. Different questions were used for each simulation, allowing the learning objectives to be addressed from different clinical perspectives. The strategy for closing the practice gaps involved post-question remediation using a combination of expert opinion, with two expert faculty members (colon and rectal surgeon, Janice F. Rafferty, MD, and medical oncologist, Robert L. Cody, MD) examining best practice in a video discussion coupled with references to evidence-based practice in the form of live links to full journal articles and to current NCCN guidelines.

### **Evaluation Outcomes**

The *What's Best for My Patient* simulations were ACCME accredited as educational activities for 1 year beginning August 1, 2007. In this time, the simulations attracted a total of 478 users, 98 of whom requested credit. Results of the evaluation to determine the effectiveness of the activity are described below.

Pre-activity questions revealed a justification of the needs assessment, as 63% of participants agreed with the statement that they felt there is room for improvement with regard to their interactions with other members of the care team. In addition, 44% of participants felt that their knowledge of the NCCN guidelines was "average" or "poor", while only 15% described their knowledge as "excellent". In addition, just over a third of participants revealed that they use the guidelines in less than 50% of their patients.

Post-activity questions demonstrated the effectiveness of the activities as a vehicle for learning. When asked if the activities met the learning objectives, 98% of respondents ranked them as "good" or "excellent". Both case simulations had greater than a 90% approval rating in answer to the question that participation in the activities will help them make better evidence-based decisions for their patients (Figure 1). More than half of participants in both simulations believed that as a result of participating in the activities, their practice patterns would be more likely to change. Similarly, greater than half of participants in both simulations believed that their interactions with colleagues would be more likely to change (Figure 2). When asked if their knowledge of the NCCN guidelines for the surgical/pharmacologic management of CRC was improved as a result of participating in the simulations, an overwhelming majority (greater than 85%) responded in the affirmative. Finally, as justification for impressing the importance of the NCCN guidelines, most participants in both simulations recognized that improved knowledge of the NCCN guidelines would enhance the management of their patients (Figure 3).

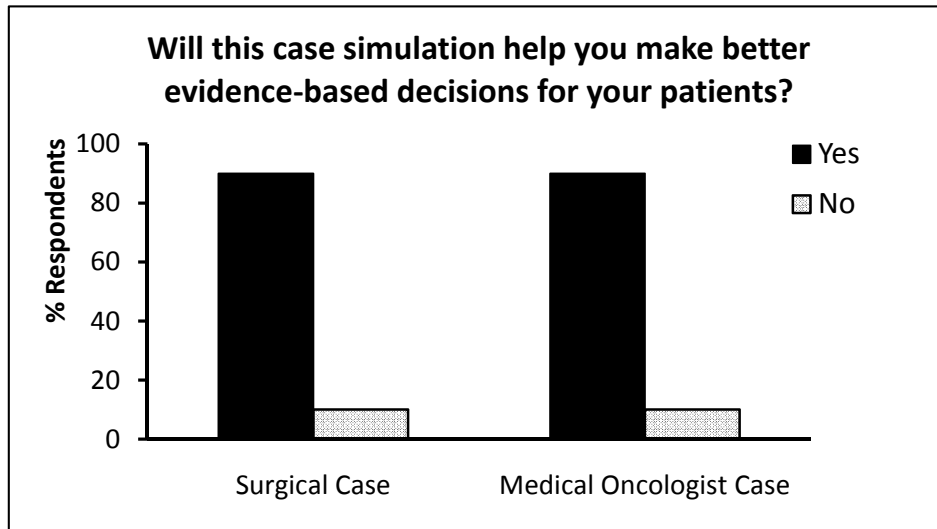
### **Conclusion**

The *What's Best for My Patient* simulations were well received, and were highly effective in meeting the learning objectives. This case-simulation format provided an interactive learning environment using a convenient, flexible platform that combined maximized reach and an educational deliverable which helped to close the practice gaps.

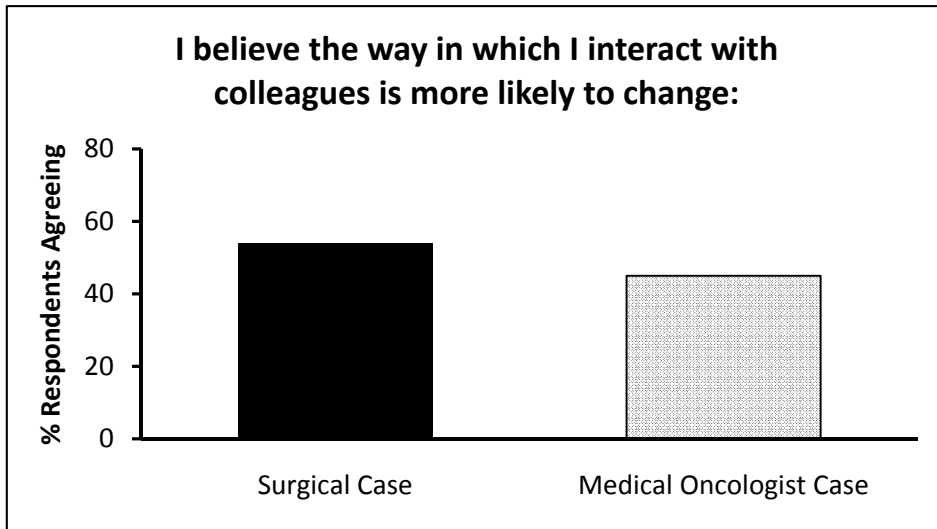
**References**

1. American Cancer Society. Cancer Facts & Figures. Atlanta, Ga, American Cancer Society. 2007.
2. Jemal A, Murray T, Ward E, et al. Cancer statistics, 2005. *CA Cancer J Clin.* 2005;55:10-30.
3. National Comprehensive Cancer Network Clinical Practice Guidelines: Colon Cancer. Available at: <http://www.nccn.org>.
4. National Comprehensive Cancer Network Clinical Practice Guidelines: Rectal Cancer. Available at: <http://www.nccn.org>.

**Figure 1: Effect of the Activity on Evidence-based Decision Making**



**Figure 2: Impact of the Activity on Improving Interaction Between Members of the CRC Care Team.**



**Figure 3: Impact of the Activity on Improving Understanding of the Importance of the Evidence-based Guidelines.**

