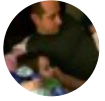


# Case Study: Evaluating the success of your supported education



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Oct 21 · 3 min read



**Problem:** We get a mixture of evaluation reports from educational providers who have received grant support from our company. However, none of them are measuring the same things — they have different target audiences, different survey questions, and had different objectives and goals to begin with.

How do I figure out the overall impact of educational activities we supported on physician practice and patient health? Is that even possible?

**Approach:** In 2018, a leading pharmaceutical company partnered with CE Outcomes to take advantage of a breakthrough technique that provides a cost-efficient and valid assessment of physician practice patterns following participation in education compared to nonparticipants. In this case, the focus was on diagnosis and management of a rare disease, neurogenic orthostatic hypotension (nOH).

**How do we determine clinician practice?** Research has indicated that the quality of health care can be assessed by clinical vignettes that imitate the patient encounter in actual clinical practice. Compared to chart audits, clinical vignettes have been shown to be a valid method of assessing clinical decision-making. Far more cost effective and efficient than chart audits, vignettes provide a robust breakthrough technique in evaluating the quality of clinical practice, in this case, in order to determine the impact of educational activities

#### *Comparing participants to non-participants*

- A patient vignette survey developed with a clinical expert designed to assess key practice decisions in diagnosis and management of nOH patients.
- The survey was distributed to US neurologists and cardiologists in Feb/March 2018.
- Screener questions at the beginning of the survey were designed to separate respondents into two groups by participation in supported CME programming.

#### *Analyzing impact data*

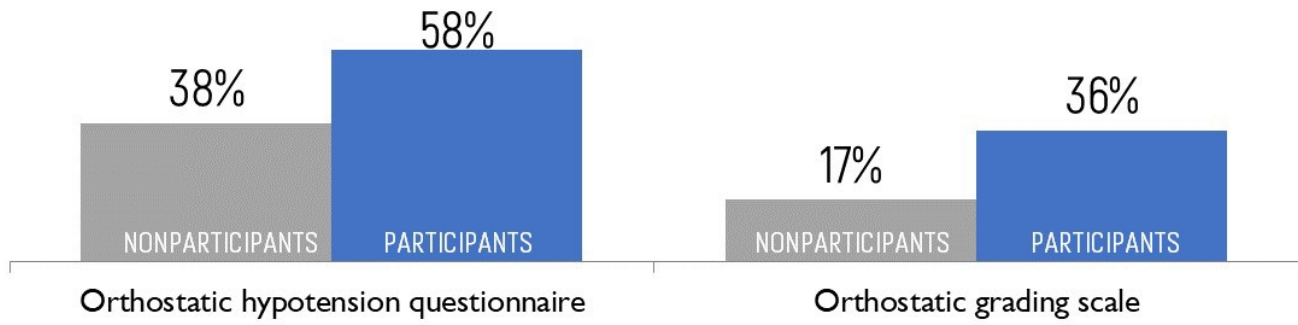
Within 60 days, a national sample of 293 physicians was analyzed. Participants included physicians who participated in 13 different activities receiving grant support. Descriptive and regression analysis showed main drivers of change, including specialty, nOH patient load, and educational participation.

#### **Solution:**

Within 90 days, at a fraction of the cost of chart audits, we were able to say with confidence there were significant differences ( $P < .05$ ) between those who participated in our educational programs and nonparticipants, specifically:

**Participants are more likely to use standardized tools to monitor patients with nOH**

Q. How would you monitor this patient's response to management?

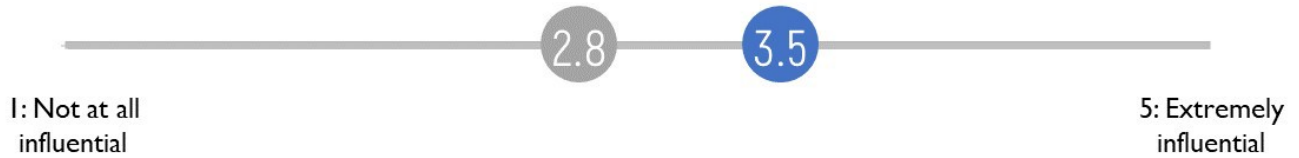


**Participants are more likely to be influenced by monitoring data**

Q. How influential are results of standardized OHQ in managing patients with nOH?

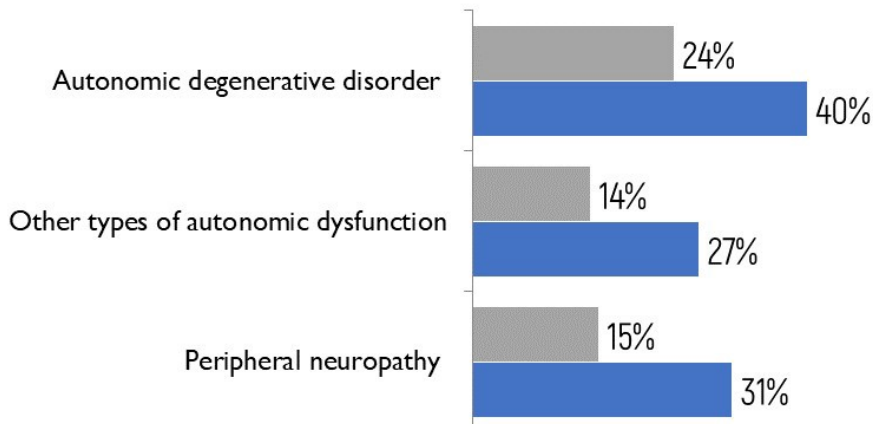


Q. How influential are results of standardized QoL questionnaires in managing patients with nOH?

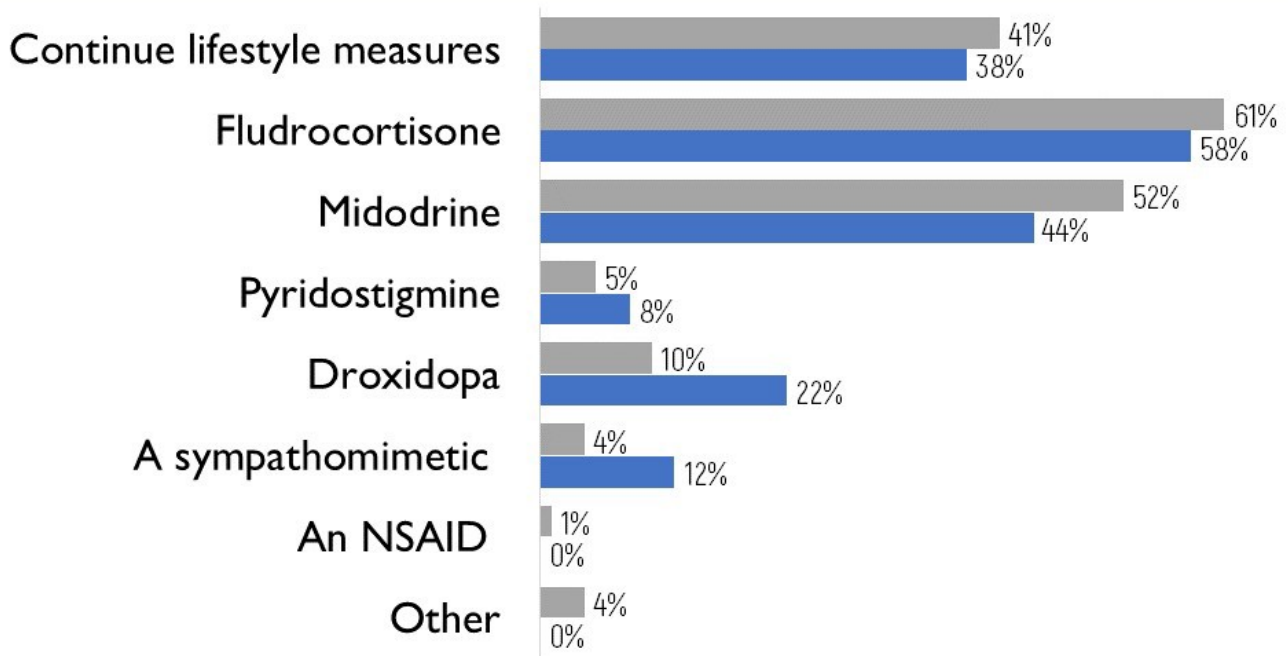


**Participants are more likely to routinely screen certain patient populations for nOH**

Q. Indicate whether you would screen this patient type routinely for nOH



**Participants are more likely to use new evidence-based treatments to manage patients with nOH**



**Participants are significantly more confident in managing nOH**

Q. How confident are you in diagnosing nOH?



Q. How confident are you in optimally controlling nOH symptoms?



1: Not at all confident

5: Extremely confident

**Keys to the solution:**

- Cross-program evaluation of participant vs nonparticipant specific practice patterns
- Non-invasive to physician practice, cost-effective and valid results within 90 days

Click here to view the full poster presented as part of the “Best in Class Outcomes” at the 2018 Alliance for Continuing Education in the Health Professions Industry Summit.