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MyCPD and Evolve

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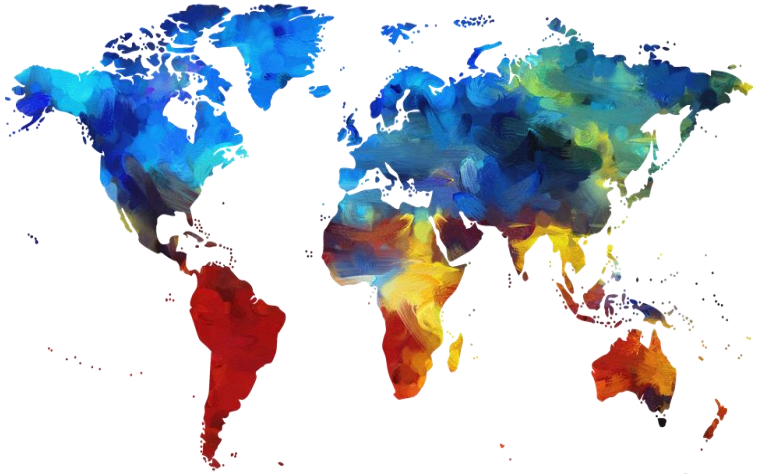
Looking at CPD globally

- Medical regulators around the world have been looking at ways to ensure doctors maintain and enhance their professional skills and knowledge and provide safe, high-quality medical care
- These processes are often called revalidation or recertification
- Regulators have chosen a variety of ways to implement this from self-directed programs through to high stakes exams



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Looking at CPD globally

Closest to home

- For several years, physicians in **New Zealand** have been required to do a minimum of 20 hours of continuing medical education, 10 hours of peer review and to participate in an audit of medical practice

Other examples

- **USA** - many states require a high stakes pass/fail exam
- **UK** - requires a five year cycle of yearly reviews/a portfolio of evidence/MSF as well as a review of complaints

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Medical Board of Australia Expert Advisory Group (EAG)

The MBA explored revalidation in Australia by appointing a EAG to review the evidence, consult with Doctors and propose a new model.

August 2017

The EAG released a final report recommending an integrated approach to revalidation.

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Medical Board of Australia Expert Advisory Group (EAG)

- X The MBA ruled out a UK style revalidation and made it clear that practitioners will not be required to re-sit their fellowship exams every five years

The MBA's integrated approach recommends:

- Strengthened CPD
- Increased proactive identification & assessment of 'at-risk' and poorly performing practitioners

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Medical Board of Australia - Professional Performance Framework

Strengthened continuing professional development

- All doctors to have a CPD home
- CPD to be relevant to scope of practice
- CPD to be based on personal professional development plans
- 50 hours CPD per year, a mix of:
  - performance review
  - outcome measurement, and
  - educational activities.
- CPD home to report to the Board where medical practitioners have not completed their CPD program requirements.

Active assurance of safe practice

- Board to identify risks to patient safety and define the principles for screening those at risk
- Increasing age is a known risk factor:
  - peer review and health checks for doctors who provide clinical care aged 70 and three yearly after that
  - Board will not receive the results of peer review and health screening unless there is a serious risk to patients.
- Professional isolation is a known risk factor:
  - education on how to identify and manage this risk
  - increasing peer-based CPD for professionally isolated practitioners.

Strengthened assessment and management of practitioners with multiple substantiated complaints

- Board to strengthen its assessment and management of practitioners with multiple substantiated complaints
- Board to require practitioners with multiple substantiated complaints to participate in formal peer review.

Guidance to support practitioners

- Board to continue to develop and publish clear, relevant and contemporary professional standards including:
  - revise *Good medical practice: A code of conduct for doctors in Australia*
  - refine existing and develop new registration standards
  - issue other guidance as required.

Collaborations to foster a positive culture

- Promote a culture of medicine that is focused on patient safety
- Work in partnership with the profession to reshape the culture of medicine and build a culture of respect
- Encourage doctors to:
  - commit to reflective practice and lifelong learning
  - take care of their own health and wellbeing
  - support their colleagues.
- Work with relevant agencies to promote individual practitioners accessing their data to support practice review and measuring outcomes.

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The PPF and its impact on CPD

The changes in MyCPD are the result of:

1. requirements already in place in New Zealand; *and*
2. changes flagged by the Medical board of Australia

Transition

The College has created an interim step that is designed to assist Australian Fellows towards meeting these changed requirements.

Given the size of the changes, the College has realigned the CPD framework to match the three MBA categories and created an interim step to ensure Fellows begin to do some activities (approx. 14 hours) that review performance and/or measure outcomes.

RACP MyCPD 2019 - categories and credits

- Educational Activities
  ✪ 1 credit per hour
- Reviewing Performance
  ✪ ✪ ✪ 3 credits per hour
- Measuring Outcomes
  ✪ ✪ ✪ 3 credits per hour

Maximum 60 credits per category
At least 40 credits (14 hours) to be from:
- Reviewing performance and/or
- Measuring outcomes

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What is relevant for each MyCPD category?

- RACP MyCPD is a self-directed program
- New 2019 MyCPD categories align with future PPF changes
- Common examples are listed in each category
- Important to use professional judgement on:
  - The CPD activities that are relevant to your scope of practice
  - The CPD category that is relevant for each activity

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2019 MyCPD Framework

- An interactive MyCPD Framework can be found on the RACP website. This includes links to resources that Fellows may find of help:
- https://www.racp.edu.au/fellows/continuing-professional-development/cpd-help-desk/mycpd-framework/2019-mycpd-framework

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Range of RACP support and resources

- Range of eLearning resources
- CPD Team
- CPD Help Desk

RACP CURATED Collections

RACP Curated Collection: Clinical Audit

CPD Evidence

Frequently Asked Questions

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Evolve Top-5 Recommendations

Developing Evolve Recommendations

Evolve is a partnership between the RACP and specialties. The movement provides a trusted process for each Specialty to remain up-to-date with the latest evidence. The development of Evolve ‘Top-Five’ recommendations is:

- Fellow-led, collaborative, evidence and consensus-based
- flexible – guided by agreed criteria, the process allows for adaptability in approach and pathways tailored to Specialties, and
- transparent.

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Reflecting on clinical practice

The RACP is encouraging physicians to implement these recommendations in their work and health service.

Reflecting on clinical practice

Evolve encourages physicians to consider:

- Are these low-value practices that I do?
- Are these low-value practices that I see happening?
- Are there systems, processes or expectations that encourage or drive these low-value practices in my health service?

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Clinical Audit and Peer Review Ideas

8 min read

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Each idea is tagged with relevant Professional Practice Framework domains.

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Evolve and Choosing Wisely audit

Judgement & Decision Making

Read your specialty's Evolve 'Top-Five' recommendations on low-value care through **Evolve for RACP specialties** and Choosing Wisely for other medical college specialties. Next, select a low-value practice that is relevant to your practice, and conduct an audit using consecutive clinical notes, letters, or discharge summaries to see if that recommendation was followed. Review the findings yourself, or with a colleague or your team. Finally, make a plan for improvement and set a date for re-audit in your Professional Development Plan. Don't forget, you can also share your findings with other physicians by emailing **evolve@racp.edu.au.**

Review the findings yourself, with a colleague or with your team. Make a plan for improvement and set a date for re-audit in your PDP.

Peer review activity: Discuss your findings at your departmental meeting and together develop recommendations for improvement.

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anzcns THE AUSTRALIA AND NEW ZEALAND CHILD NEUROLOGY SOCIETY

How ANZCNS developed their Evolve Recommendations

- The ANZCNS Board initially identified nine priority recommendations regarding low-value clinical practices in paediatric neurology.
- An evidence review was developed for these recommendations and served as the basis for an online survey sent to all ANZCNS members asking respondents if they agreed, disagreed or were unsure if these recommendations were
  - evidence based
  - undertaken in significant numbers, and
  - important in terms of reducing patient harm and unnecessary healthcare expenditure.
- Based on survey responses, each of the nine was assigned a score and ranked accordingly and the top-5 recommendations were shortlisted on this basis.

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Australia and New Zealand Child Neurology Society Evolve Recommendations

1. Do not routinely perform electroencephalographs (EEGs) for children presenting with febrile seizures

2. Do not routinely perform computed tomography (CT) scanning of children presenting with new onset seizures

3. Do not routinely undertake repeat blood level monitoring of antiepileptic drug (AED) treatments

4. Do not routinely undertake neuroimaging for new onset primary headache without first examining for neurological abnormality

5. Do not routinely perform electroencephalographs (EEGs) for children presenting with syncope (fainting)

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Australia and New Zealand Child Neurology Society Evolve Recommendations

3

Do not routinely undertake repeat blood level monitoring of antiepileptic drug (AED) treatments

The serum concentration of an antiepileptic drug (AED) varies markedly between patients taking the same dosage because of differences in people's ability to absorb, distribute, metabolise and excrete drugs. The utility of drug blood level monitoring assumes that plasma drug level correlates better with clinical response or side effects than with dosage, or provides better information than clinical review of the patient. However, evidence from a major randomised controlled trial suggests that repeat blood level monitoring of AED treatments has no discernible impact on patient outcomes in terms of remissions from seizures or incidence of adverse effects. Other studies have also shown that there is no definitive correlation between a patient's AED blood level and clinical efficacy.

Specific exceptions where targeted AED blood level assessment can be useful include their use in assessing compliance, titrating AEDs in complex polypharmacy regimens, or adjusting for altered AED metabolism in disease states, puberty, or pregnancy.

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Australia and New Zealand Child Neurology Society Evolve Recommendations

4

Do not routinely undertake neuroimaging for new onset primary headache without first examining for neurological abnormality

Most headaches are attributable to benign conditions. Studies suggest that the yield of neuroimaging findings in children with headache that actually change patient management is no higher than 2.5 per cent. This supports the practice of selective imaging of paediatric headache patients with clinical presentation suspicious for intracranial abnormality.

Moreover, the routine use of neuroimaging may lead to the discovery of incidental benign abnormalities, which may cause undue alarm, and headaches may be wrongfully attributed to these incidental findings. For instance, a retrospective study revealed benign neuroimaging abnormalities in approximately 20 per cent of paediatric headache patients who underwent neuroimaging.

Neuroimaging on a routine basis is therefore not indicated in children with new onset primary headaches and a normal neurological examination. It should be reserved for a selected group of children whose history and/or physical examination suggest serious intracranial pathologies.

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Australia and New Zealand Child Neurology Society Evolve Recommendations

5

Do not routinely perform electroencephalographs (EEGs) for children presenting with syncope (fainting)

Studies have found that the incidence of epileptiform discharges (i.e. distinctive EEG patterns associated with epileptic disorders) in patients with syncope is roughly similar to its incidence among healthy subjects, and that therefore EEG has very low diagnostic yield among these patients. Moreover, clinical criteria have been formulated that can differentiate syncope from seizures with very high sensitivity and specificity.

Thus, guidelines recommend that an EEG should not be performed if syncope is the most likely cause of the transient loss of consciousness. Moreover, clinical criteria have been formulated, which can differentiate syncope from seizures with very high sensitivity and specificity.

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Australia and New Zealand Association of Neurologists Evolve Recommendations

The **Australian and New Zealand Association of Neurologists** (ANZAN) has reviewed the evidence and consulted with its expert members to develop the following recommendations to support best patient care and reduce the use of unnecessary or ineffective practices within a given clinical context.

1. Don't perform imaging of the carotid arteries to investigate simple faints
2. Don't perform imaging of the brain to investigate non-acute primary headache disorders
3. Don't perform epidural steroid injections to treat patients with low back pain who do not have radicular symptoms in the legs originating from the nerve roots
4. Don't use opioids for the treatment of migraine, except in rare circumstances
5. Don't routinely recommend surgery for a narrowing carotid artery (>50% stenosis) that has not caused symptoms

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Australia and New Zealand Association of Neurologists Evolve Recommendations

4 Don't use opioids for the treatment of migraine, except in rare circumstances

Migraine is the most frequent cause of headache seen in the medical office, urgent care, or emergency department. Almost all patients should receive migraine-specific medications or non-opioid analgesics because these medications are the most effective migraine treatments. However, many patients continue to receive opioids for migraine treatment. Use of opioids increases the risk of headache and chronic migraine arising from medication overuse. The per capita cost of headache and chronic migraine arising from medication overuse can be 3 times that of episodic migraine according to a European study (Diener et al. 2005). When medical conditions such as cardiovascular disease or pregnancy preclude use of migraine-specific treatments, or when migraine-specific treatments fail, opioids are sometimes considered for rescue therapy. In these circumstances, use should be limited to 9 days per month or less to avoid medication overuse headache, and doctors should continue to focus on preventive and behavioural aspects of migraine care. In addition, long-term follow-up is needed to prevent treatment complications.

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Internal Medicine Society of Australia and New Zealand Evolve Recommendations

1. Avoid medication-related harm in older patients (>65 years) receiving five or more regularly used medicines by performing a complete medication review and deprescribing whenever appropriate

2. Don't request daily full blood counts, erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) as measures of response to antibiotic treatment if patients are clinically improving

3. Once patients have become afebrile (non-feverish) and are clinically improving, don't continue prescribing intravenous antibiotics to those with uncomplicated infections and no high-risk features if they are tolerant of oral antibiotics

4. Don't request Holter monitoring, carotid duplex scans, echocardiography, electroencephalograms (EEGs) or telemetry in patients with first presentation of uncomplicated syncope and no high risk features

5. Don't request computerised tomography pulmonary angiography (CTPA) as first-choice investigation in non-pregnant adult patients with low risk of pulmonary thromboembolism (PTE) by Wells' score (score =< 4); imaging can be avoided in low risk patients if D-dimer test is negative after adjusting for age

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Internal Medicine Society of Australia and New Zealand Evolve Recommendations

1 Avoid medication-related harm in older patients (>65 years) receiving five or more regularly used medicines by performing a complete medication review and deprescribing whenever appropriate

Studies show that the risk of medication-related harm rises once the number of regularly prescribed medicines exceeds five; this risk increases exponentially as the number reaches eight or more. Medicines that deserve particular attention are benzodiazepines and other sedative-hypnotics, anti-psychotics, hypoglycaemic agents, antithrombotic agents, anti-hypertensives, and anti-anginal agents.

Trying to achieve aggressive treatment targets, such as BP <130/80 or HbA1c <7 per cent, in frail older patients with multiple co-morbidities confers little benefit and a higher risk of harm.

Discontinuation should be considered where past indications for specific medicines are no longer valid, the risk of harm outweighs the benefits within a patient's remaining life span, or medicines are associated with past toxicity or non-adherence.

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Internal Medicine Society of Australia and New Zealand Evolve Recommendations

4 Don't request Holter monitoring, carotid duplex scans, echocardiography, electroencephalograms (EEGs) or telemetry in patients with first presentation of uncomplicated syncope and no high risk features

Holter monitoring, carotid duplex scans, echocardiography, electroencephalograms (EEGs) and telemetry have very low diagnostic yield in patients with uncomplicated syncope and no clinical features of, or risk factors for, the following:

- arrhythmia (e.g. palpitations preceding syncope, exertional syncope, unheralded syncope, history suggestive of heart failure or ischaemic heart disease)
- carotid stenosis (syncope would need to be associated with focal neurological symptoms or signs suggestive of transient ischaemic attack),
- cardiac valvular disorders (e.g. definite heart murmurs) or
- seizures (very rarely present as syncope with no other epileptic features eg. tongue biting, urinary incontinence, post-ictal confusion, muscle pain).

Most syncopal episodes are vasovagal or secondary to postural hypotension for which careful history and lying and standing blood pressure measurements are the most important diagnostic criteria combined with standard 12-lead ECG.

How else physicians can be involved

- Visit the Evolve website and get to know their Specialties Top 5 Recommendations
- Be a part of developing your Specialties Top-5 Recommendations
- Join the Evolve Policy Reference Group and help shape and drive the Evolve initiative
- Make Evolve recommendations a routine part of clinical handovers
- Build your skills to enable them to participate in joint decision making with their patients, or have difficult discussions with their colleagues or supervisor
- Include Evolve in education sessions like grand rounds, workshops, clinical case reviews, team meetings and more
- Conduct clinical audits and feedback on an Evolve recommendation
- Engage hospital management in implementing the recommendations across the health service
- Discuss the recommendations with referring doctors and your multidisciplinary care team
- Undertake research on Evolve and implementation of Evolve recommendations

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Don’t forget you may be able to claim some of your Evolve activities as CPD. Check against MyCPD Framework.

Questions?

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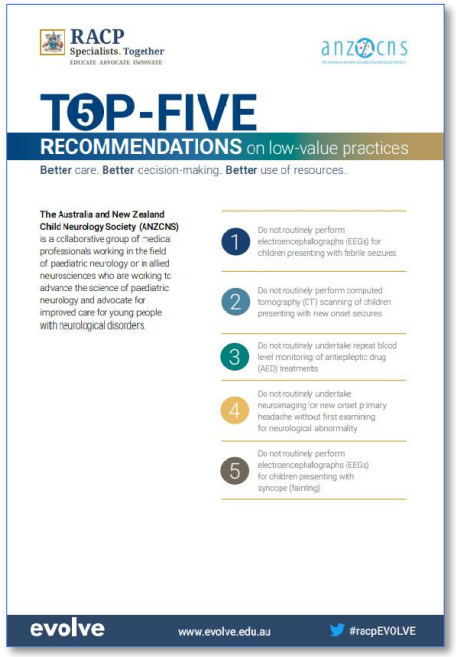

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