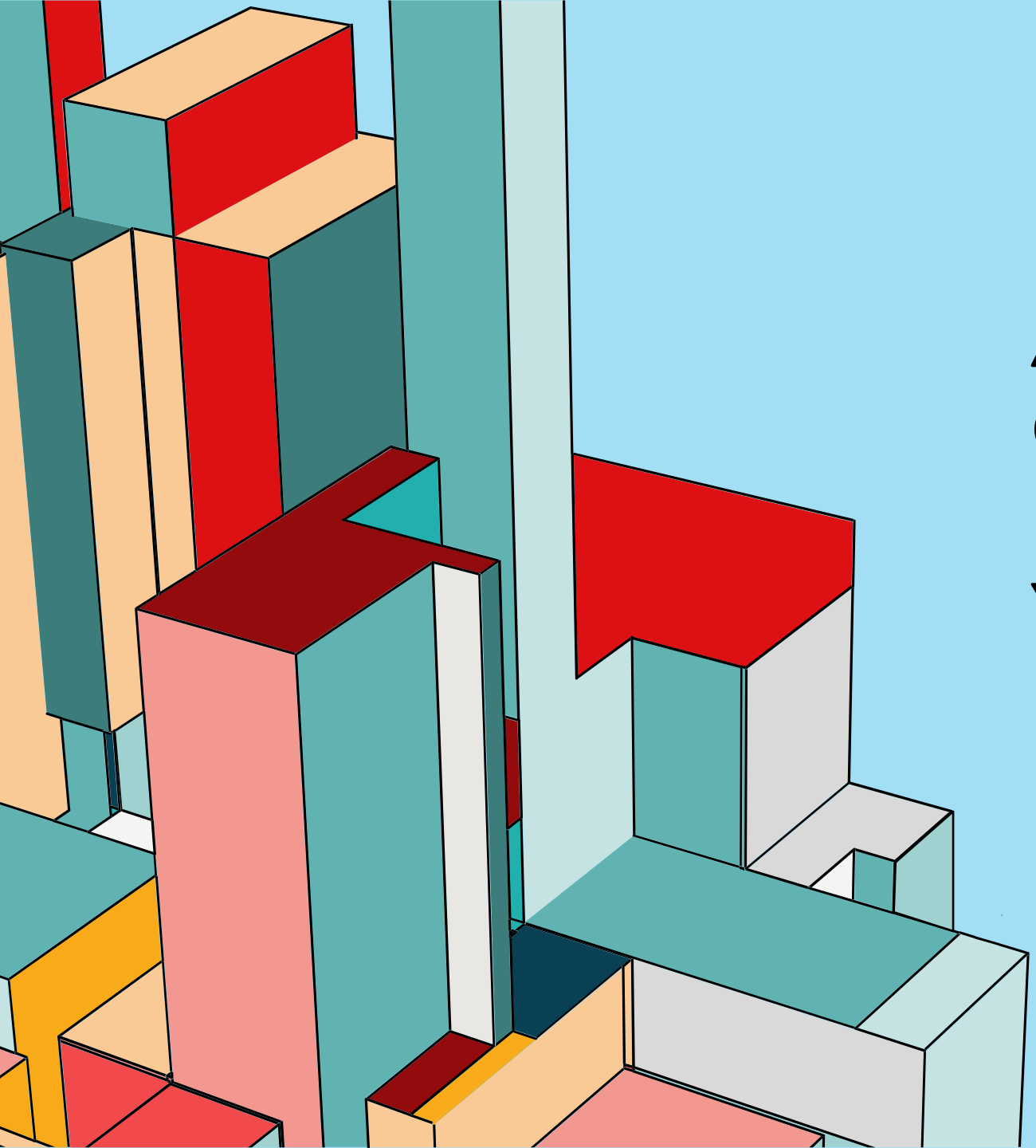


ACTIVITY CREATION AND DESIGN: ENGAGING YOUR LEARNERS

P2P Worksheet

Purpose: ____ exists to…

Practices:
1. …
2. …
3. …

1. Purpose
Why is the work important to you and the larger community?

Principles:
Must dos & must not dos include:
1. …
2. …

5. Practices
What are we going to do? What will we offer to our users/ clients? How?

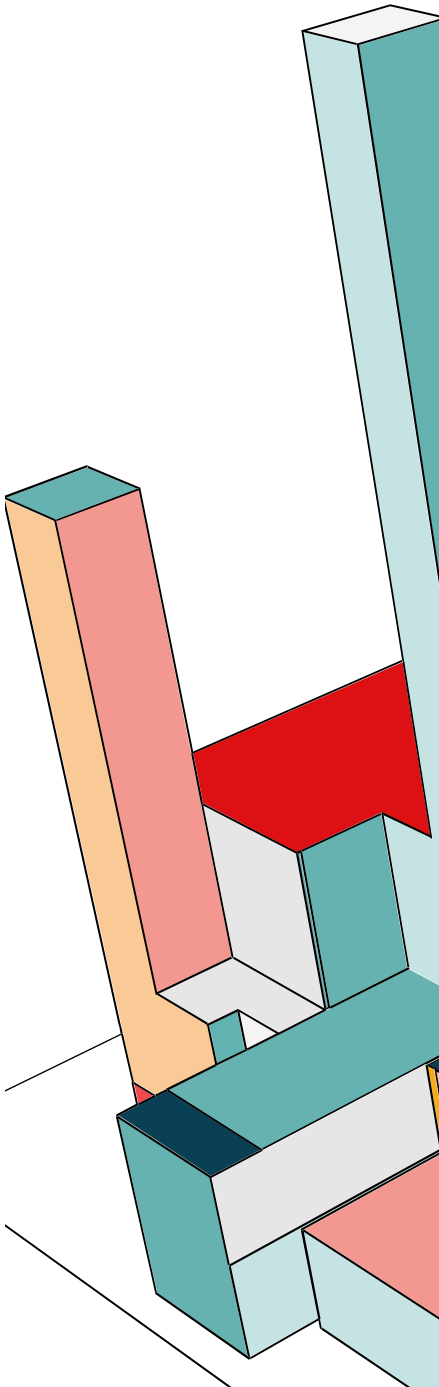
2. Principles
What rules must we obey in pursuit of our purpose?

Structure:
1. …
2. …
3. …

4. Structure
How will we organize to distribute control?

3. Participants
Who must be included to achieve our purpose?

Participants:
1. …
2. …
3. …



At the Start of a CME Activity (as an Icebreaker + Alignment Tool)
Use P2P with participants and faculty to **clarify goals** and **shape the session direction** in real time.

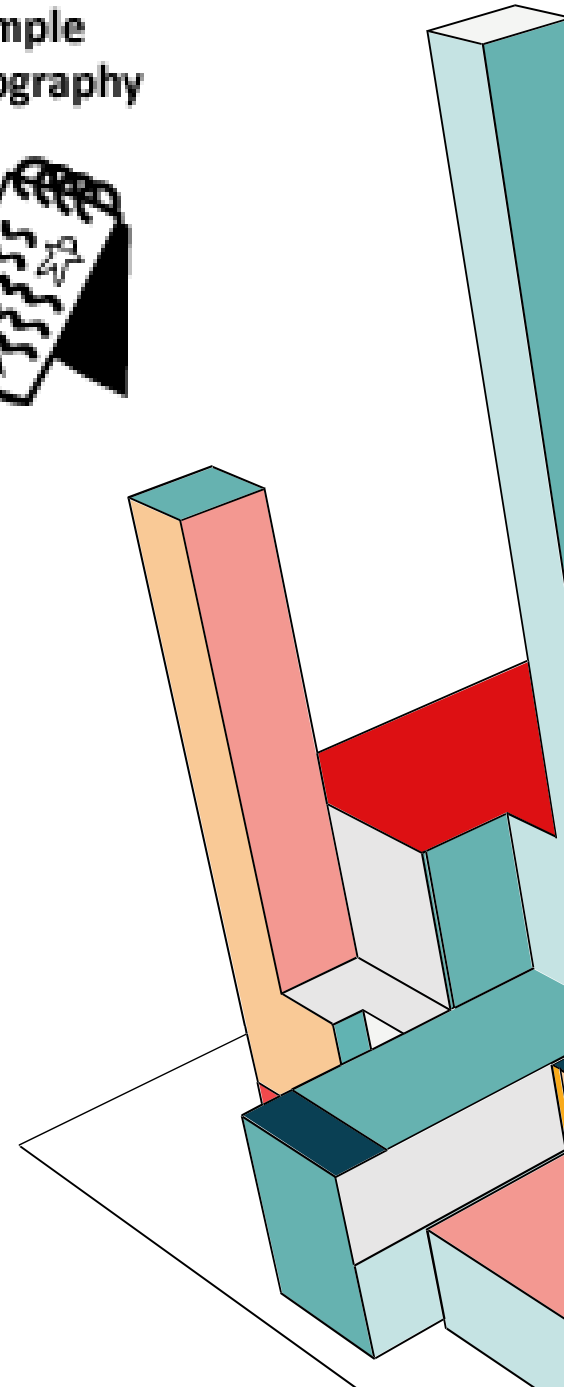
Example:

You're hosting a CME workshop on "Addressing Physician Burnout."
Participants are asked (in small breakout groups):
What's our shared *purpose* today?
What principles should guide our dialogue (e.g., confidentiality, empathy, curiosity)?
Who are the participants, and what perspectives are essential (clinicians, administrators, educators)?
How will we organize our session time to meet these goals?
What daily *practices* could sustain well-being?

During CME Program Planning
Use it to co-design the vision and strategy for a new educational series or annual symposium.

Example:
A urology department is launching a “Clinical Excellence in Men’s Health” CME series.
Purpose:
“To improve men’s health outcomes through better screening, early intervention, and coordinated specialty-primary care.”
Principles:
“Evidence-based; interdisciplinary; learner-driven; aligned with value-based care principles.”
Participants:
Urologists, primary care providers, CME planners, nurse navigators, patients, industry (non-commercial roles).
Structure:
Quarterly case-based webinars, one annual in-person summit, and an online discussion forum.
Practices:
CME planners use audience polling; faculty review patient outcome data quarterly; each session closes with a “commitment to change” reflection.
Outcome:
A shared, actionable blueprint for a CME series that everyone helped design — increasing engagement and accountability.

Simple ethnography



A Simple Ethnography session has **three phases:**

1.Observe – Spend time watching how work actually happens in the real setting.

1. Look for what surprises you or challenges your assumptions.
2. Note what's *easy, hard, or variable* about the task.

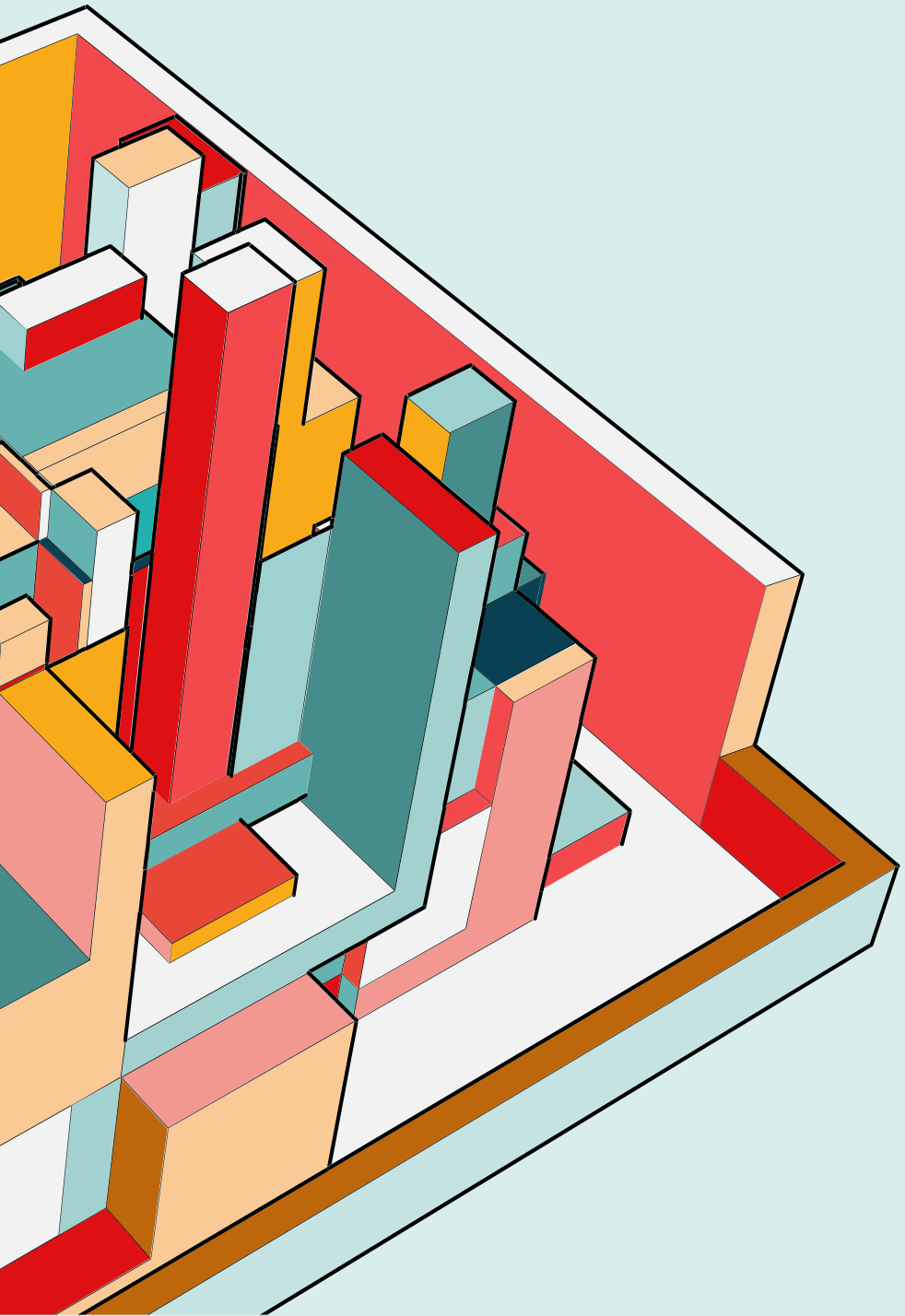
2.Reflect – Debrief with peers or team members: What patterns or insights emerged?

3.Apply – Identify implications for improving education, workflow, or teamwork.

Typical duration: a few hours to one day, followed by a short debrief.

Example:
At a CME symposium on *Improving Patient Safety Culture*, participants are asked to:
Pair up.
Observe each other's response to a safety simulation (how they communicate, document, or escalate).
Debrief: What behaviors or assumptions did you notice that support or hinder safety?
Result:
Participants experience *learning through observation*, building self-awareness and team insight.

Observation Focus	What We Saw	What Surprised Us	What It Means for Education
Hand hygiene workflow	Staff skipped sanitizing after gloves	Time pressure, poor dispenser location	Environmental and behavioral barriers
EHR charting	Inconsistent data entry	Template confusion	Training gap, usability issue
Patient handoff	Missed allergy info	Lack of checklist	Communication gap



What³ debrief

What?

SO What?

NOW What?

Post-Case Reflection

After a case discussion, ask participants to reflect using the W³ questions.

Example:

In a CME session on **managing opioid use disorder in primary care**, present a real patient case, then debrief:

What?

“What did the patient present with? What treatment steps were taken?”

So What?

“What does this case reveal about stigma, workflow, or system barriers?”

Now What?

“What will you change in your approach to screening or prescribing next week?”

After a Simulation or Skills Lab

Use W³ immediately after a **simulation exercise** or **hands-on workshop.**

Example:

In a *sepsis recognition simulation*:

What? "What signs did you notice first? What interventions were initiated?"

So What? "What does this tell you about team communication under stress?"

Now What? "What change will you make to your rapid response or communication habits?"

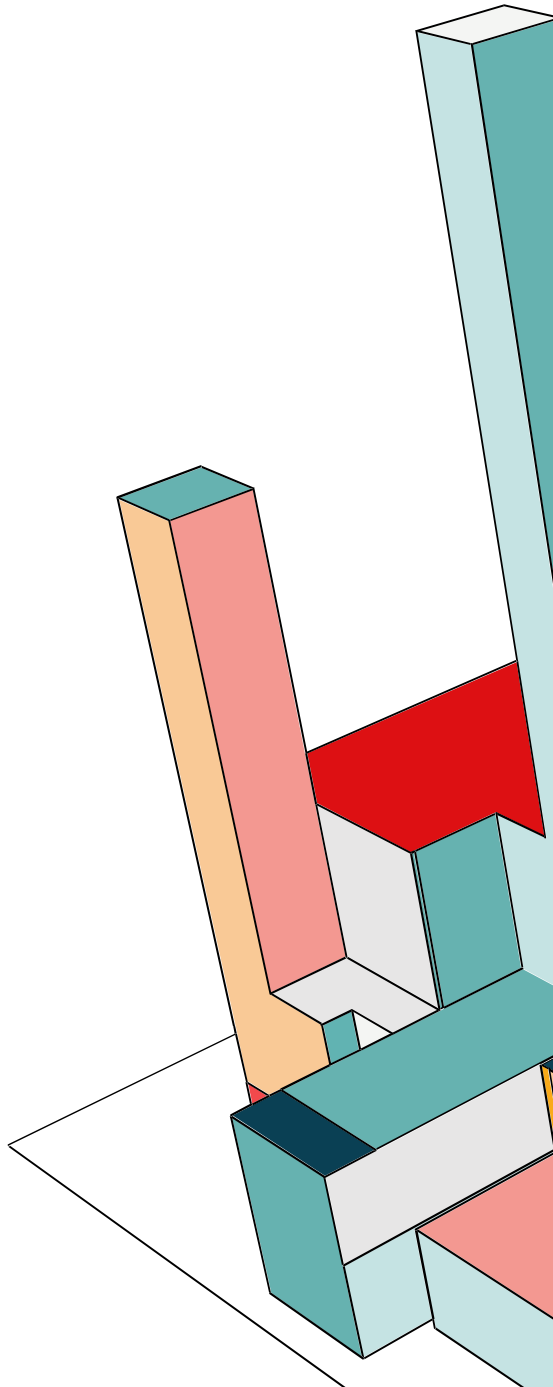
SHARK TANK

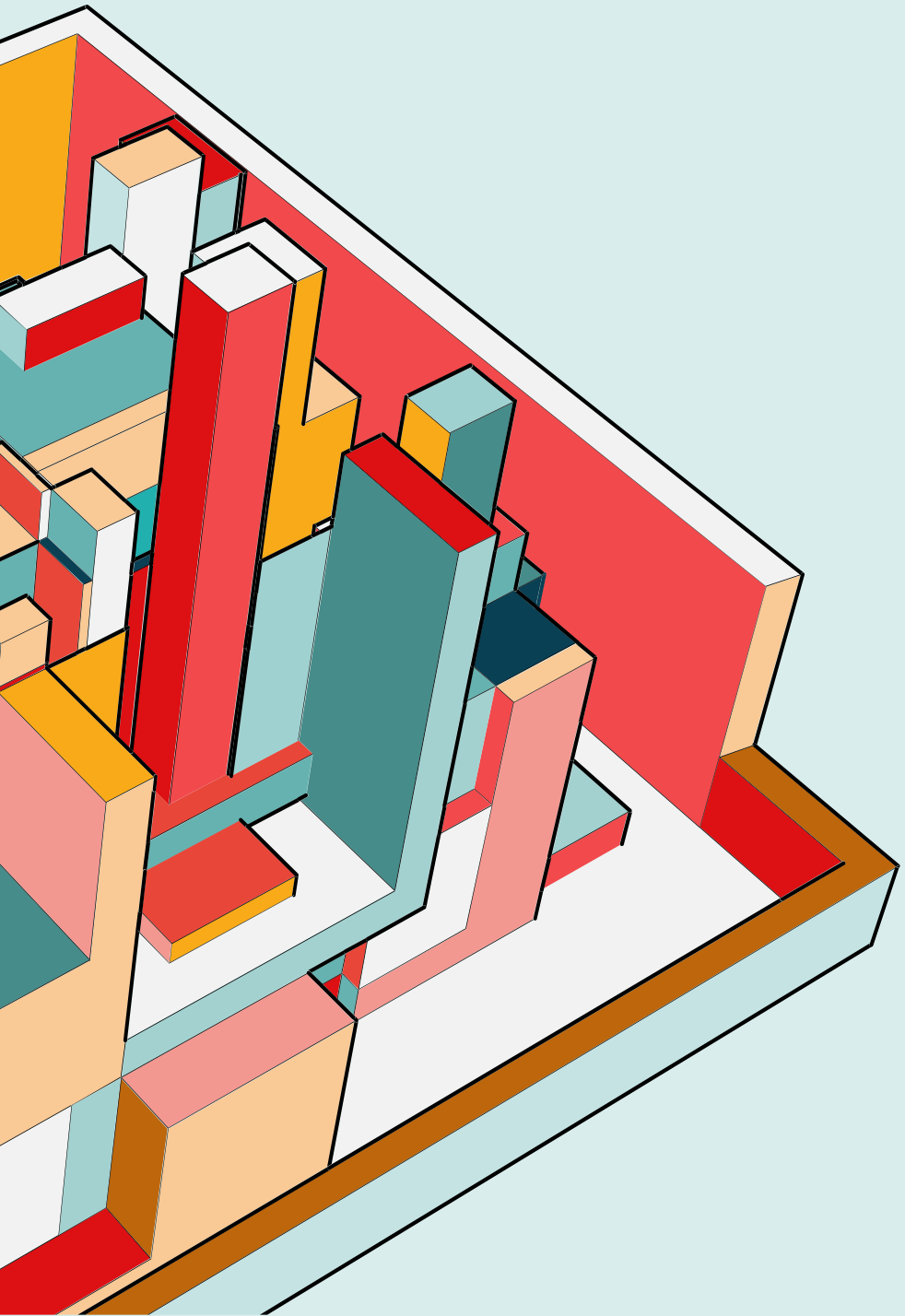
- Present a complex problem and have participants collaborate in groups to design best practice responses, then pitch them “Shark Tank” style.

BE THE TEACHER

- “Reverse symposium”: Ask participants to share a short success story, tip, or tool from their own practice.

  Also a good opportunity to share challenges.





POST SYMPOSIUM DEBRIEF OPTIONS

- SHOUT OUT: As learners exit the activity, ask them to stop at the “shout out” desk and record a 15 second video on what they will change.

- FISHBOWL: Determine tangible changes learners can implement post activity. Color code these changes and place cards on tables with a “fishbowl” and have learners select their intended change and drop into bowls.

SEPSIS PROTOCOLS

What Would You Choose?

Choose wisely & share your thoughts!

OBJECTIVES

01 Develop proficiency related to the sepsis bundle

02 Explore consequences of clinical decisions

03 Apply evidence-based protocols in case scenarios

How To Play

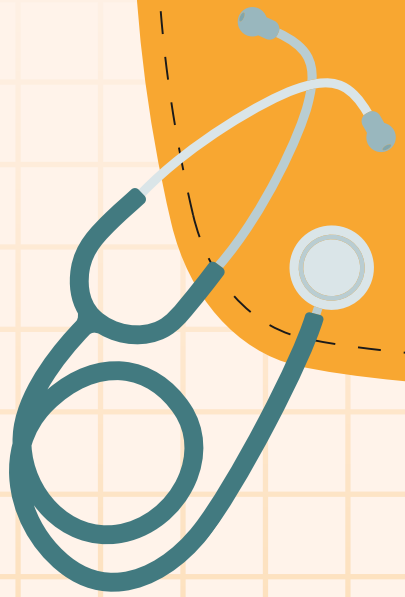
01 **Review the case to determine best practice approaches.**

02 **Select response and review branch outcomes assessment.**

Scenario #1

- 62 -year-old male arrives with fever, confusion, and rapid breathing.
- Vital signs: Temp 39°C, HR 118, RR 26, O2 sat 92%

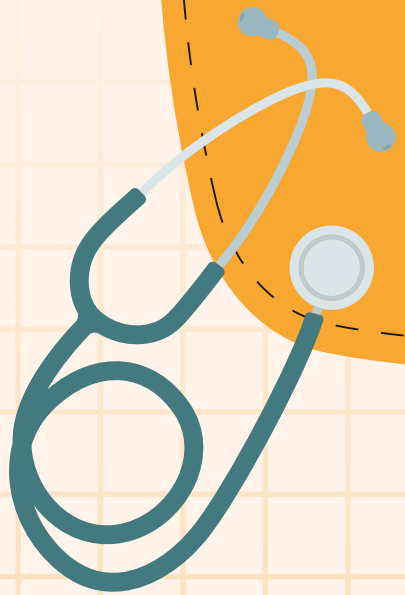
What is your **first action?**



OPTIONS

- Order lactate and blood cultures immediately
- Wait until after fluids and antibiotics for labs
- Start antibiotics first, then think about cultures

What is your **first action?**



OUTCOMES

Initiate sepsis bundle correctly. Cultures and lactate guide therapy.

If you had waited to order labs until fluids were given:
Delay in diagnostics → labs are missed, sepsis severity underestimated. Lactate later 5.2.

If you had started antibiotics first:
Antibiotics given without cultures → harder to tailor therapy later.

THE BLOODY BOARD GAME

Pisano TJ, Santibanez V, Hernandez M, Patel D, Osorio G. The Bloody Board Game: A Game-Based Approach for Learning High-Value Care Principles in the Setting of Anemia Diagnosis. *MedEdPORTAL*. 2020;16:11057. https://doi.org/10.15766/mep_2374-8265.11057

Patient 1

ANEMIA 6 - $200 QUESTION

Anemia 6 - $200 Question
Ctrl+Click to follow link

Name two absolute indications for red blood cell exchange transfusion in patients with Sickle Cell Disease

HPI: 62-year-old asymptomatic business owner male presenting for a follow up visit after a physical.

PMHx:

PE:

Labs:

ANEMIA 6 - $200 ANSWER

Anemia 6 - $200 Answer
Ctrl+Click to follow link

a. Acute chest syndrome
b. Stroke or Stroke in evolution

Clues		
$100	$200	$400
PMHx Physical Exam CBC	MCV MCHC RDW Retic Count Metabolic Panel B12/Folic acid HbA1c/TSH FOBT/UA CRP/ESR Bilirubin/LDH/ Haptoglobin	Iron studies BM biopsy EPO level Peripheral smear ANA/DsDNA/C3/C4 Colonoscopy Electrophoresis Coombs test H. pylori test

Card number	History of Present Illnes	Past Medical History	Physical Exam	Complete Blood Count		MCV	MCHC	RDW	Reticulocyte Count	Comprehensive Metabolic Panel		Other labs	Iron studies
1	62-year-old asymptomatic business owner male presenting for a follow up visit after a physical	Born in Hawaii. Type II diabetes for 14 years, known retinopathy.	unremarkable	Hb	10	90	27.78	15	1.5	LFTs	Normal	HbA1c 7.8%	ferritin 58 (normal 20-300)
				Hct	36%					BUN/Cr	42/1.9	FS 146	serum iron 100 (60-170)
				WBC	10							GFR 35	TIBC 210 (240- 450)
				Platelets	250							B12 510	iron saturation 48% (20-50)