Evaluation Crosswalk

This Evaluation Question Crosswalk serves as evidence of a methodologically sound evaluation strategy that mapped evaluation questions to intended outcomes, identified gaps, and guided revisions to improve alignment between stated expectations and evaluation measures across an annual Regularly Scheduled Series (RSS) cycle, while remaining consistent with Joint Accreditation standards and the known limitations of self-reported outcomes data.

Evaluation Question Rik Levels – Definition and Interpretation

To mitigate the risk of over-attribution in self-reported evaluation data, evaluation questions were classified using a four-level question risk framework. Risk level reflects the likelihood that an item's wording could be interpreted as asserting patient, system, or population outcomes beyond what can be supported through behavior-level (Kirkpatrick Level 3) self-report data. Items classified as High risk were excluded from learner evaluation instruments; Moderate risk items were revised to strengthen alignment with observable practice behavior consistent with a Low risk level.

Risk Level	Meaning / Basis for Risk Assessment
Low	The question clearly assesses self-reported behavior or contribution aligned with Kirkpatrick Level 3. Language is action-oriented, retrospective, and avoids attribution of patient, system, or population outcomes. Unlikely to raise reviewer questions.
Low–Moderate	The question is substantively appropriate for behavior-level evaluation but contains limited outcome-adjacent or evaluative language that could prompt clarification if interpreted narrowly by a reviewer.
Moderate	The question includes outcome-oriented or impact-suggestive language that could be interpreted as asserting patient or system outcomes beyond what can be supported through self-reported RSS evaluation data. Mitigation through wording refinement is recommended.
High	Language reflects outcome achievement, effectiveness, or impact beyond the learner's observable actions or contributions, creating a high likelihood of misinterpretation as Kirkpatrick Level 4 (Results). Items at this risk level are not appropriate for self-reported evaluation.

Evaluation Question Crosswalk

Evaluation questions were systematically revised to align with Joint Accreditation expectations and the Kirkpatrick model, and the Interprofessional Education Collaborative (IPEC) Core Competencies, with a deliberate focus on Kirkpatrick Level 3 (Behavior). Original items that emphasized understanding, perceived ability, or self-assessed improvement were refined to measure what learners actually did in practice, rather than what they learned or what they believe they can do. Revised questions use clearly retrospective, action-oriented language (e.g., applied, used, implemented, made changes) to prompt learners to recall real practice or role adjustments made as a result of participation, thereby strengthening attribution of reported change to the educational activity. Outcome-oriented language was intentionally avoided to ensure the data reflect observable behavior change appropriate for self-report. This approach strengthens attribution of reported change to the educational activity while appropriately aligning with relevant IPEC competency domains, including Roles/Responsibilities, Teams and Teamwork, Interprofessional Communication, and Values/Ethics.

The tables below present a crosswalk of current and revised evaluation questions, with corresponding justifications and risk considerations, demonstrating how the evaluation design operationalizes these methods. The revised annual RSS evaluation is intentionally structured into two sections to reflect different levels of change and appropriate attribution within self-reported data. Section One uses “extent” language to measure individual-level behavior change while Section Two uses “impact” language to capture the influence on team-based and system-level practices.

Section One: Practice & Behavior Change

All revised questions are low-risk and aligned with **Kirkpatrick Level 3 (Behavior)** and use retrospective, action-oriented language to measure the extent to which learners applied knowledge or implemented changes in their own clinical or professional roles. Revised questions intentionally avoid patient or system outcome attribution and focus on observable practice changes within the learner's control, supporting defensible self-reported evaluation data for an annual RSS.

Original Question	Risk Level	Risk Level Justification	Revised Question	Justification for revisions	IPEC
As a result of participation in this series:	Moderate	Did not cue learners to reflect on what they actually did or distinguish behavior change from learning, ability, or intent Not appropriate for extent of change Likert-scale	Please rate the extent to which participation in this series resulted in the following (consider specific examples from your practice or role):	Clearly frames the evaluation as retrospective, behavior based, and appropriate for an extent-based Likert-cale. Encourages recall of concrete changes improving the specificity and validity of self-reported behavior change	**N/A**
I improved my practice and/or patient outcomes	Moderate	Evaluates two levels- Practice and Patient Outcomes Patient outcomes cannot be verified through self-report	I made specific, identifiable changes to my practice or role.	Shifts from a broad, self-assessed improvement claim to change in practice grounded in real interactions.	**RR- RR1**
I improved the quality of patient care	Moderate	Asserts patient outcome improvement not verifiable through self-report Broad improvement claim without specific behavior	I made specific, identifiable changes to my practice or role that enhanced the delivery of quality care.	Shifts from a broad, self-assessed improvement claim to change in practice grounded in real interactions.	**RR-RR1** **TT-TT3**
I improved my ability to comply with clinical guidelines	Low–Moderate	Self-assessed improvement claim not verifiable through self-report Broad improvement claim without specific behavior	I used current clinical guidelines more consistently in my practice or role.	Shifts from a broad, self-assessed improvement claim to change in practice grounded in real interactions.	**RR-RR4**

I implemented new diagnostic and/or therapeutic strategies	Low–Moderate	May imply patient outcomes impact	I implemented specific, identifiable diagnostic and/or therapeutic strategies that changed how I approach care delivery.	Removes implied outcome attribution and emphasizes implementation that changed the learner's approach to care delivery	**RR-RR2** **TT-TT3**
I engaged in performance improvement processes	Low–Moderate	Vague engagement without observable action	I participated in or supported performance improvement processes.	Shifts from vague, self-assessed claim to change in practice grounded in real interactions.	**TT-TT5** **RR-RR4**
I identified system issues that affect the quality of patient care	Low–Moderate	Embedded patient outcome language	I identified specific system-level issues affecting my practice setting and adjusted my practice or role accordingly.	Shifts from vague practice or role claim to change in practice or role grounded in real interactions.	**RR-RR4** **TT-TT5**
I contributed to implementing solutions to system issues	Low–Moderate	"Contributed to implementing" is vague and weakly observable, It does not align with what the learner actually did From a Kirkpatrick Level 3 perspective, there should be evidence of behavioral change, not passive or indirect involvement	I made specific, identifiable changes in my role that supported the implementation of solutions to system-level issues affecting my practice or role.	Shifts from vague claim to change in practice or role to change in practice or role grounded in real interactions.	**TT-TT5** **RR-RR1**

I improved my understanding of changes in the healthcare delivery system	Low–Moderate	Knowledge-level wording Focuses on understanding, not behavior (Kirkpatrick Level 2) Self-assessed improvement claim not verifiable through self-report	I applied knowledge of changes in the healthcare delivery system to make specific changes in my practice or role.	Shifts from a broad, self-assessed improvement claim to change in practice grounded in real interactions.	**RR-RR4** **TT-TT5**
I used quality-improvement data to enhance patient care	Moderate	Implies patient outcome improvement Unverified outcome claim	I used quality data to inform changes in my practice or role.	Removes an unverified outcome claim and emphasizes use of data to inform practice changes	**TT-TT5** **RR-RR4**
I improved my understanding of causes of complications, adverse events, and errors	Low–Moderate	Self-assessed improvement claim not verifiable through self-report	I applied knowledge about the causes of complications, adverse events, or errors to adjust my practice or role.	Shifts from understanding to applied knowledge and change in practice	**RR-RR2** **VE-VE4**
I improved my ability to manage complications, adverse events, and errors	Low–Moderate	Self-assessed improvement claim not verifiable through self-report	I implemented specific strategies to manage complications, adverse events, or medical errors.	Shifts from broad improvement language to implementation of strategies - change in practice	**RR-RR2** **VE-VE4**
I considered the cost-effectiveness of care in my practice	Low–Moderate	Awareness-level wording	I applied cost-conscious considerations more consistently when making care or practice decisions.	Replaces a general consideration claim with applied decision-making behavior	**RR-RR2** **VE-VE4**

Section Two: System, Team & Care Environment

Section Two items are designed to assess self-reported contributions to interprofessional (IP) team-based and system-level practice. For interprofessional continuing education, these items appropriately focus on observable behaviors, collaboration, and practice or environment changes that support care delivery. Language is intentionally framed to avoid outcome attribution while capturing the extent to which participation influenced team functioning and system-related practice changes.

Original Question	Risk Level	Risk Level Justification	Revised Question	Justification for revisions	IPEC
N/A	N/A	N/A	Please rate the impact of the series on the following (consider specific examples from your practice or role):	Captures the learner's influence on team-based and system-level practices.	N/A
I improved my ability to deliver culturally appropriate care	Low–Moderate	Self-assessed improvement claim not verifiable through self-report Broad improvement claim without specific behavior	Changes in approach to providing culturally appropriate care.	Shifts from a broad, self-assessed improvement claim to change in practice (behavior)	**VE-VE3** **CC-CC3**
I incorporated ethical principles into my professional practice	Low–Moderate	General incorporation claim Vague	Application of ethical principles in clinical or professional decision-making.	Shifts from a general incorporation claim to applied decision-making	**VE-VE1** **RR-RR1**
I functioned effectively as a member of my IP team	Low–Moderate	Subjective effectiveness rating	Functioning as a member of my IP team.	Removes "effectively" to ensure focus on objective behavior	**TT-TT1** **RR-RR1**
I promoted effective communication among IP team members	Low–Moderate	Subjective effectiveness rating	Communicating among IP team members to support care delivery.	Removes "effective" to ensure focus on objective behavior	**CC-CC1** **TT-TT1**
I worked effectively with an IP team to enhance care	Low–Moderate	Subjective effectiveness rating	Working with an IP team to support care delivery.	Removes "effectively" to ensure focus on objective behavior	**TT-TT3** **CC-CC1**

I improved my understanding of abilities of IP team members	Low	Knowledge-based-competence not performance.	Considering the abilities and roles of IP team members in care delivery.	“Considering” reflects an action taken during care delivery, not just understanding or awareness The context of care delivery anchors the item in real practice, not learning or intent	**RR-RR3** **TT-TT1**
I included patients and families in shared decision-making	Low	Refers to behavior (including patients/families), not learning or intention Avoids explicit patient outcome claims	Including patients and families in shared decision-making.	Refers to behavior (including patients/families), not learning or intention Avoids explicit patient outcome claims	**CC-CC3** **VE-VE1**
I considered the ideas and perspectives of IP team members	Low	Refers to behavior (including patients/families), not learning or intention Avoids explicit patient outcome claims	Considering the ideas and perspectives of IP team members in care delivery.	“Considering” reflects an action taken during care delivery, not just understanding or awareness The context of care delivery anchors the item in real practice, not learning or intent	**CC-CC2** **TT-TT**