The Role of Physician Leadership in Enhancing CME Effectiveness

“CME as a Strategic Asset”

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The BIG Question

“What if we train them and they leave?”

“What if we don’t and they stay?”
In order to make this session most effective
I need to tell you some things you may not want to hear.

First, I need to know more about who is in the room...
Questions??

• What is your role in the hospital/health system?
• What is your role in CME or other education activities?
• What is your role in quality improvement?
• What is your medical specialty and do you still practice?
Objectives

• Provide overview of current CME issues for hospital physician leadership
• Engage in discussion of most important issues
• Position CME for optimal value to the medical staff and the hospital
• Discuss how to position CME to best align with quality and safety initiatives of hospitals and health systems
• Physician leaders should be able to facilitate the use of a more effective planning using a comprehensive conceptual model for planning and improvement
I’m looking for help on this, virtual team...

Traditional silos getting in the way?

Function

It’s not in my P&L.

Country

It’s not in my objectives.

Product Group

I’d like to help, but...
The problems with CME

- Lack of physician leadership
- Lack of physician engagement and involvement…passivity
- Lack of true understanding of adult education principles (we [failed to] learn this in medical school)
- Failure to link the classroom to sites of care
- Lack of feedback with regard to effectiveness
The problems with hospitals

- Lack of physician leadership
- Misalignment of incentives and payment both from third party payers and hospitals/health systems
- Sociologic changes in hospital environments with rise of specialization, changes in primary care, and evolution of hospitalist concept
- Trust issues between hospital administration and physician groups
How about this for your ‘vision’

Achieve the healthiest population possible, leading the transformation of health care in our region and setting the standard for the nation.
How about this for your ‘vision’

Achieve the healthiest population possible, leading the transformation of health care in our region and setting the standard for the nation

Dartmouth Hitchcock Health System

A wise man I once knew said “Our vision has cataracts”
Principle 1

This all starts at the top
CME Accreditation is institutional, not just to the CME office
To get us all at the same place…  
for a few minutes

• Some background on the current CME environment
  – CME has been viewed as ineffective in changing behavior and outcomes
  – No one seems to doubt that CME can transmit new information
  – Physicians feel over regulated and balk at change, especially when it is viewed as involving extra work
  – CME has been viewed by planners and faculty as adversarial because certain new ‘demands’ have been placed on faculty and learners
“The new [ACCME] standards represent a shift in CME in that providers will move through levels of accreditation that require them to take on greater responsibility for changing and improving CME opportunities to becoming a strategic asset to quality and safety initiatives.”
Criterion 1: The CME mission statement that includes all of the basic components 1) CME purpose 2) content areas 3) target audience 4) type of activities 5) with expected results articulated in terms of changes in competence, performance or patient outcomes

- The aggregate will affect participant competence or performance
- Where possible activities will be linked to patient outcomes
- Some topics may enhance knowledge as their primary goal, the overall CME program must translate knowledge into improved performance
- Some activities will improve participant performance in care setting.
- Monitor patient outcomes in the region and in our practices and link current and future activities to their improvement.
Criterion 2: Incorporates into CME activities the educational needs (knowledge, competence, or performance) that underlie the professional practice gaps of their own learners.

- The ‘provider’ (faculty, planning committee, CME office staff) starts by identifying gaps
- Deduces the knowledge, competence or performance cause(s)
- Planning process results in assuring that needs will be addressed
- Example – Our ambulatory practices are not meeting diabetes care benchmarks. Is this due to lack of knowledge about diabetes or some deficiency in practice design?
• 16. The provider operates in a manner that incorporates CME into the process for improving professional practice.

• 17. The provider uses non-educational strategies to enhance change as an adjunct to its activities/educational interventions (e.g. reminders, patient feedback)
• 18. The provider identifies factors outside of the provider’s control that impact patient outcomes.
• 19. The provider implements educational strategies to remove, overcome, or address barriers to physician change.
• 20. The provider builds bridges with other stakeholders through collaboration and cooperation.
• 21. The provider participates within an institutional or system framework for quality improvement.

• 22. The provider is in a position to influence the scope and content of activities/educational interventions.
How do we make it more effective?

- It takes work...
Principle 2

Physicians in leadership roles must facilitate change and improvement in educational processes.

“Silo busters”??
Achieving Desired Results and Improved Outcomes: Integrating Planning and Assessment Throughout Learning Activities

Donald E. Moore, Jr., PhD; Joseph S. Green, PhD; Harry A. Gallis, MD

Most physicians believe that to provide the best possible care to their patients, they must commit to continuous learning. For the most part, it appears the learning activities currently available to physicians do not provide opportunities for meaningful continuous learning. At the same time there have been increasing concerns about the quality of health care, and a variety of groups within organized medicine have proposed approaches to address issues of physician competence and performance. The authors question whether CME will be accepted as a full partner in these new approaches if providers continue to use current approaches to planning and assessing CME. A conceptual model is proposed for planning and assessing continuous learning for physicians that the authors believe will help CME planners address issues of physician competence, physician performance, and patient health status.

Key Words: education, medical, continuing, physician learning, planning, assessing, formative assessment, physician competence, physician performance
Planning and assessing learning activities: conceptual model

Stages of Physician Learning:
- Stage 1: Physician recognizes an opportunity for learning
- Stage 2: Physician searches for resources for learning
- Stage 3: Physician engages in learning
- Stage 4: Trying out what was learned
- Stage 5: Incorporating what was learned into practice

Instructional Design and Educational Planning:
- Predisposing CME Activities
  - Enabling CME Activities:
    - Presentation
    - Feedback
    - Example/Demonstration
    - Practice
  - Reinforcing CME Activities

Expanded outcomes framework:
- Enrolls in CME activity
  - Level 1
- Satisfied with CME activity
  - Level 2
- Learning: declarative knowledge
  - Level 3a
- Learning: procedural knowledge
  - Level 3b
- Improved physician competence
  - Level 4
- Improved physician performance
  - Level 5
- Improved patient health status
  - Level 6
- Improved population health status
  - Level 7

Assessment:
- Needs Assessment
  - Formative Assessment
  - Summative Assessment
How do we transmit new information more effectively?

• It takes work…

• Ever tried to work with a faculty member to change their presentations to adapt them to your needs?
Principle 3

What about the demands on faculty and learners? Think outside the box
Optimizing CME time

• Example of time allocation for 1 hour

15 min
15 min
15 min
5 min
5 min

- waiting to start
- new evidence
- application to practice
- changes needed
- next steps
Application of the Concepts to Any CME Activity

• The pie chart could equally describe the structure of any CME activity, symposium, grand rounds in its entirety, PI activity
  – New evidence – all CME should be evidence based and the rationale should be provided as to why changes should be made
  – Application to practice should be a collaborative discussion between faculty and learners and should be based on reasons for professional practice gaps
  – Changes needed refers to the difference between what is and what should be
  – The last segment should be the development of the plan for the application of new knowledge or competencies into practice and should include concrete examples and implementation plans.
  – Evaluation that follows should address the process of implementing the strategies discussed during the last phase of the activity and should be ongoing through the process
What about the extra work?

- How about adapting it to the time allotted for educational activities?
Think outside the box
Principle 4

Collaborate

ACCME 20:

The provider builds bridges with other stakeholders through collaboration and cooperation.
Adult Learners
in Contrast to ‘children’
(Unfortunately, teachers of adults frequently slip into elementary education)

• Adult learners typically:
  – Seek feedback on performance and reinforcement of learning
  – Have ability to listen, learn, and remember
  – Learn outside of teacher-centered settings
  – Pursue self-directed learning

• However, a corollary of this is that we have bludgeoned physicians with ‘butts in seats’ education for so long that they have become lazy and expect to be passive...
Adult Education: Do we do it?

In designing CME Activities, they will be more effective if learners:

• Understand what they don’t know and have a clear vision about what needs to be achieved, i.e., some ‘test of knowledge
• are “involved” in the learning process (active vs. passive) (hence the use of ‘case-based’ learning)
• link knowledge to previous experience – new learning fills in gaps
• seek self-reflection and peer collective inquiry
• address practical problems with immediate applications
• process information through multiple sensory channels with different cognitive styles
• Learning will be most effective if material is presented in different formats on recurring occasions
CME Leadership

Is your institution so structured as to facilitate the following attributes in whomever leads the function?

• Provide vision for present role & future direction
• Develop a model learning organization
• Provide support for an environment of continuous improvement in educational practice
• Maintain a high standard for professionalism and ethics in CE staff
• Be an advocate for the CME program, its mission, and its activities
Principle 5

Engage your physicians in the process
Phases of Change

- Establish a sense of urgency
- Form a powerful guiding coalition
- Create a vision
- Communicate the vision
- Empower others to act on vision
- Plan for and create short term wins
- Consolidate improvements and produce more change
- Institutionalize the new behaviors
Principles 6-8

• Take advantage of the environment
• Just say “yes”
• In improvement work they say “steal shamelessly and share seamlessly” – take advantage of what others are doing
Joint Commission Standard
Continuing Education - 2007

• Standard MS.5.10 All licensed independent practitioners and other practitioners privileged through the medical staff process participate in continuing education (CME is an adjunct to maintaining clinical skills and current competence)
  – Hospital-sponsored activities are prioritized by the medical staff
  – Relate at least in part to the type and nature of care, treatment, and services offered by the hospital
  – Education is based on the findings of PI activities
  – Each individual’s participation is documented
  – Participation is considered in decisions re reappointment or renewal or revision of clinical privileges
OPPE
Ongoing Professional Practice Evaluation

• Incorporates the Six Core Competencies of the ACGME
  – Patient Care
  – Medical/Clinical Knowledge
  – Practice-based Learning and Improvement
  – Interpersonal and Communication Skills
  – Professionalism
  – Systems-based Practice
CME as a Strategic Asset to Improve Patient Care

• Quality and Safety: Ambulatory and Hospital
• Physician Credentialing
  – Joint Commission education requirements
• Maintenance of Certification (MOC)
• Maintenance of Licensure (MOL)
  – Coming soon to your state’s licensing authority…
• Continuous Physician Professional Development (CPPD)
• OPPE
M(aintenance) o(f) L(icensure)

Three Components to MOL – Similar to MOC

• 1 Reflective Self Assessment
  – Currently this focuses primarily on CME, in the areas of primary patient care responsibility

• 2 Assessment of Knowledge and Skills
  – Structured, credible, validated tools (exams?)
  – Currently the primary means is recertification

• 3 Performance in Practice
  – State boards should require the use of comparative data, assessment and improvement
MOL Guiding Principles

• MOL should support commitment to lifelong learning and facilitate practice improvement
• Systems should be administratively feasible and developed in collaboration with other stakeholders: Authority = state medical boards
• Should not compromise patient care or create barriers to practice
• Infrastructure must be flexible with choice of options
• Processes should balance transparency with privacy concerns
Practice Performance Assessment
Sample Physician Groups
Patients with DM and HTN >50
What is the typical response to these sorts of data?

- Blood Pressure <130/80 on all 3 visits
- On 2 of these 3 visits
- HgbA1C in 1 year
- % with A1C <7.0%
- % with A1C <7.5%
- % with CAD
- % of these on ASA

- 30%
- 35%
- 95%
- 50%
- 62%
- 20%
- 52%
Performance Gap

• The previous slide measures physician performance
• Does this performance result from a gap in knowledge or competence?
• Assuming that they know how to prescribes drugs for diabetes and hypertension, why is there still a problem?
• Is it possible this is a patient or a system problem and how would we know?
• How can we design effective educational activities unless we know the answers to these questions?
Planning and assessing learning activities: conceptual model

Stages of Physician Learning

Stage 1
Physician recognizes an opportunity for learning

Stage 2
Physician searches for resources for learning

Stage 3
Physician engages in learning

Stage 4
Trying out what was learned

Stage 5
Incorporating what was learned into practice

Instructional Design and Educational Planning

Predisposing CME Activities

Enabling CME Activities
- Presentation
- Feedback
- Example/Demonstration
- Practice

Reinforcing CME Activities

Expanded outcomes framework

Needs Assessment

Assessment

Formative Assessment

Summative Assessment

Enrolls in CME activity
- Level 1
- Level 2

Satisfied with CME activity
- Level 3a
- Level 3b

Learning: declarative knowledge
- Level 4

Learning: procedural knowledge
- Level 5

Improved physician competence
- Level 6

Improved physician performance

Improved patient health status

Improved population health status
Framework for Planning and Assessing Learning

Resources

Planning Implementation

CME Activity Attendance Satisfaction

Learning Declarative Knowledge Procedural Knowledge

Competence

Performance

Patient Health Status
Backwards Planning

• In choosing some of these measures planners would ask:
  – What would we like to improve?
  – How much would we like to improve it?
  – Is the problem due to knowledge, competence or performance issues?
  – Depending on which level will guide type and structure of activities
Planning:
Start with the end in mind

- Resources
- Planning Implementation
- CME Activity Attendance Satisfaction
- Learning Declarative Knowledge Procedural Knowledge
- Competence
- Performance
- Patient Health Status
Sources of Needs

- Physicians’ ‘wants’
- Specific professional practice gaps of the same physicians
- Specific professional practice gaps of physicians practicing in region or nation
- National data, published data, measures and outcomes as reported by local or national quality organizations
### CMS Quality Measures
(from CMS Website October 2010)

#### 30-day risk-standardized mortality measures
- Acute Myocardial Infarction
- Heart Failure
- Pneumonia

#### 30-day risk-standardized readmission measures
- Acute Myocardial Infarction
- Heart Failure
- Pneumonia

### AHRQ Patient Safety Indicators (PSIs)
- PSI 04 - Death among surgical inpatients with serious treatable complications
- PSI 06 - Iatrogenic pneumothorax
- PSI 14 - Postoperative wound dehiscence
- PSI 15 - Accidental puncture or laceration
- PSI Composite - Complication/patient safety for selected indicators

### AHRQ Inpatient Quality Indicators (IQIs)
- IQI 11 - Abdominal aortic aneurysm (AAA) repair mortality
- IQI 19 - Hip fracture mortality rate
- IQI Composite #1 - Mortality for selected surgical procedures
- IQI Composite #2 - Mortality for selected medical conditions
Diabetes and Hypertension

• These performance measures assess many facets of patient care
  – Structure – practice organization and logistics
    • Can I find all the charts I am looking for?
    • Are they well enough organized so someone in my office can pull the data I need?
  – Process – aspects directly under your control
    • Have I been consistent in what I record in the chart?
    • Do I order the tests or procedures indicated?
    • Did I prescribe the appropriate drugs for diabetes and hypertension?
  – Outcomes – generally more complex and involve the interaction of all of the medical, social, economic and structural elements in the ‘system of care’
Improving Outcomes in Diabetes and Hypertension

• The approach to this might be:
  – Achieve buy in and select clinical champions necessary to assure participation of practices and individual physicians within them
  – Knowledge – assure that all practices have access to up to date background science and guidelines with regard to appropriate care (evidence based practices)
  – Competence – assure that each practice has access to patient data and has instituted appropriate structure and processes to manage these complex patients
  – Performance – measure their performance and work to improve areas which are below expectation
  – Reassess and begin new processes
Opportunities for Discussion

What do you see as the major challenges?

• How is CME structured within your organization?
• Is CME viewed as a ‘cost center’ or a ‘value center’
• Are adequate resources available?
• What is professional level of staff?
• What is buy-in from administration?
• Are the linkages appropriate?
• What is the status of the audience? Are non traditional approaches being attempted? Do they work?