

Performance improvement CME: Core of the new CME

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From pedigree to performance

For more than half a century, traditional continuing medical education (CME) sent a message to the public that physicians were well trained and keeping up with their education throughout their career. In recent years, however, the value of traditional CME—which was delivered primarily as an extension of the didactic model, including lectures and reading (or listening) followed by testing—has been questioned. The debate has centered on whether traditional CME, which may enhance the knowledge base of professionals, relates to improved patient outcomes through changing physician practice behaviors (*CPPD Report*, Winter 2007, No. 21).

The first few years of the new millennium have brought the evolution of the “new CME.” In 2002, the American Academy of Family Physicians (AAFP) introduced evidence-based CME. In 2004, the national CME credit grantors—the American Medical Association (AMA), the AAFP and the American Osteopathic Association (AOA)—changed the measurement of CME from hours to credits. On Jan. 1, 2005, culminating the work of two AMA-convened national task forces, the new CME took another step forward with the implementation of two new formats: Internet point of care (PoC) and performance improvement (PI) CME.

PoC CME takes place when the physician, confronted with a question about a patient, consults an evidence-based source and then documents the physician’s planned behavior change, based on the learned information. PI CME, which is a three-step process, begins with an assessment of each physician’s current practice using identified evidence-based performance measures. Feedback to physicians compares their performance to national benchmarks and to the performance of peers. The second stage of PI CME involves the implementation of an intervention based on the performance measures assessed in the practice. The third stage involves reevaluation of performance in practice,

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Director's column

By *Alejandro Aparicio, MD*

In January, the Agency for Healthcare Research and Quality (AHRQ) published its Evidence Report/Technology Assessment No. 149, "Effectiveness of Continuing Medical Education." The research, conducted by the Johns Hopkins University Evidence-based Practice Center, identified 139 articles and nine systematic reviews published since 1981 that met the criteria the center developed to summarize the evidence regarding continuing medical education (CME) effectiveness. While pointing out the need for more research in this area, the researchers concluded that although the quality of the evidence thus far is low, "CME appears to be effective at the acquisition and retention of knowledge, attitudes, skills, behaviors and clinical outcomes." This is yet another indication of the important role that all of you who are involved in the development of CME activities play in contributing to the education of physicians and to the well-being of their patients.

This *CPPD Report* includes an excellent article by Norman Kahn, MD, Bruce Bagley, MD, and Susan Tyler, MEd, which illustrates both the evolution and the promise of new forms of CME to meet the challenges and demands of our time. Titled "Performance improvement CME: Core of the new CME," it describes recent developments in CME, including changes in the way CME is measured, moving from hours to credits, and the adoption of two new formats—performance improvement (PI) CME and Internet point of care (POC) CME. These formats are shared by the American Academy of Family Physicians and American Medical Association credit systems. The authors go on to describe some of the major national PI CME activities and how the development of evidence-based performance measures can help in the planning of these types of CME activities.

Also included in this issue are examples by the American College of Physicians and the University of Wisconsin on how they have incorporated nationally recognized performance measures in the development of their respective PI CME

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including reflection and summarization of outcome changes resulting from the PI CME activity. Physicians completing all three components may claim a total of 20 credits in this nationally standardized format, adopted by the credit grantors (AMA and AAFP) and by the AAFP as an accreditor in the medical community. A similar design is used in the osteopathic community with credit granted by the AOA.

Two years since inception, there are now five major national PI CME activities, including:

- Education in Quality Improvement for Pediatric Practice (eQIPP), sponsored by the American Academy of Pediatrics
- Measuring, Evaluating and Translating Research Into Care (METRIC), sponsored by the AAFP
- Performance in Practice Modules (PPM), sponsored by the American Board of Family Medicine
- Practice Improvement Modules (PIM), sponsored by the American Board of Internal Medicine
- Clinical Assessment Program (CAP), sponsored by the AOA

In addition, there are a number of regional and local performance improvement activities that have been designed to earn CME credits, including the programs of state specialty societies (e.g., California, Georgia and Texas) and activities offered by health care delivery systems and health maintenance organizations.

National performance measures

Until recently, there has been little measurement of clinical performance in physician office practices. Four national groups have emerged that now dominate the development and endorsement of national benchmarks for physician performance measures.

The Physician Consortium for Performance Improvement® and the National Committee for Quality Assurance have developed evidence-based performance measures for dozens of clinical conditions. Many of these measures then go on to be endorsed by the National Quality Forum, followed by their promotion to health plans, including the Centers for Medicare & Medicaid Services, for implementation at the physician-practice level by the Ambulatory Care Quality Alliance (AQA) and in the hospital through the Hospital Quality Alliance (HQA). Nationally standardized measures enhance transparent reporting and accountability to the public. By using standardized performance measures, physician practices can generate evidence-based measurements, as well as enhance office practice routines to achieve better results for patients.

Measurement has supplemented the traditional reliance on professionalism, education and hard work to achieve best performance. By incorporating national standardized performance measures into PI CME, the new CME now sends a clear message to the public that physicians are continually measuring and demonstrating practice process changes that are linked by evidence to improved patient outcomes.

Pay-for-performance and quality designation programs

Payers of physician services are moving to a more objective assessment of both the quality of care delivered and of patient outcomes. Such programs require not only nationally standardized common performance measures but also regular reporting of performance data. Some payers provide bonus payments to physicians who collect and report quality data. Pay-for-performance programs need to recognize the opportunity to provide incentives to physicians for participation in PI CME.

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The ongoing incorporation of practice assessment, measurement, feedback, learning, implementing change and remeasurement will move medical practice toward a culture of improvement. Additional rewards for physicians documenting improvements in practice processes, and ultimately in patient outcomes, will follow if there are incentives for physicians to incorporate PI CME learning and measurements into their practices.

The practice of medicine is now challenged to incorporate data-driven continuous quality improvement. CME, together with professional development, has a great opportunity to support this change by helping to create and instill a culture of improvement.

Incorporating PI CME activities into your CME program: Stage A

Performance improvement (PI) CME, the three-stage learning model that was approved by the AMA in 2004, has gained a great deal of interest from CME providers. The AMA's winter 2007 *CPPD Report* highlighted CME providers who planned and implemented PI CME activities in 2006, and gave an overview of their experience with this type of learning format. As a follow-up, this and future issues of the *CPPD Report* will examine a different stage of PI CME, with specific examples to assist providers in implementing their own activities. This spring 2007 issue focuses on "Stage A: Learning from current practice performance assessment."

American College of Physicians

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Closing the Gap (CtG) is a practice-based, team-oriented quality improvement program of the American College of Physicians (ACP) that trains teams of physicians, nurses and other allied health professionals, and office administrators on how to improve the quality of their care for patients with chronic disease. CtG consists of three training sessions over a six- to nine-month period and two to three cycles of practice data abstraction.

During the first training session, time is dedicated to specific clinical content relating to the condition being targeted, such as cardiovascular disease or type 2 diabetes mellitus.

The measurements are chosen based on accepted national standards such as evidence-based guidelines developed by respected national groups (e.g., the ACP, American College of Cardiology or other medical societies) and national performance measurement sets such as the Ambulatory Care Quality Alliance measures set, the American Board of Internal Medicine practice improvement modules and the National Committee for Quality Assurance provider recognition programs.

In the case of the CtG: Diabetes Care program, special emphasis is placed on tight blood pressure control in type 2 diabetes mellitus. This measure is stressed because the ACP has specific clinical practice guidelines in this area and because cardiovascular disease is the leading killer of patients with diabetes. An entire hour of training is dedicated to the evidence base for tight blood pressure control and other cardiovascular risk factors. As a result, most practices choose tight blood pressure control as their target for improvement. At baseline, the practices measure their levels of blood pressure control in 25 randomly selected patients with diabetes using a chart abstraction form. Using this data, each practice establishes its own goal, which could be 75 percent of patients with diabetes at or below BP of 130/80 within six months, or less than 20 percent of patients over the goal within

six months. The practices repeat the measurements at the end of the program and sometimes three months after completion to assess whether they met their blood pressure goals.

Based on our experience running this program for the past four years, we have found that some of the key factors for whether practices accept and adopt a measure as their target include the extent of the evidence base for the measures; the evidence for the high impact of these measures on quality of care and on morbidity and mortality; and the perceived validity of the developers of the measures. So for the case of tight blood pressure control, the practices received a lecture on the ACP guideline and were given a binder containing the guideline and other training materials. The blood pressure measure was part of a pre-made data abstraction form. The binder materials also included a wide variety of tools to help practices implement tight blood pressure control, such as chart flow sheets, checklists, patient self-management goals sheets, a *Consumer Reports* review of home blood pressure monitors and more. Most of the participants are ACP members and hold the organization in high esteem.

Another key factor is the practices' perception of their ability to effect change on the measure. For example, the practices feel more confidence in improving their rates of foot exams versus their ability to attain target HbA1c levels, because getting a foot exam is more dependent on the behavior of the practice whereas A1c levels require more complex treatment regimens

and patient adherence to testing and medications. Blood pressure control is a measure that depends on both the practice and the patient. However, most practices found that they were able to work effectively with their patients on this measure, and most did achieve lower average blood pressure levels.

University of Wisconsin Office of Continuing Professional Development in Medicine and Public Health

Elizabeth Mullikin, MS, chief, regional educational programs

The University of Wisconsin (UW) Office of Continuing Professional Development in Medicine and Public Health (OCPD) collaborated with a Wisconsin community clinic on a PI CME activity. The activity addressed the identification, assessment and treatment of hypertension to reduce morbidity and mortality.

In this PI CME activity, physicians' individual percentages of patients with a diagnosis of hypertension and no systolic readings above 140 mm Hg during the measurement period—modified from Health Plan Employer Data and Information Set (HEDIS®) measures—were measured and tracked throughout the duration of the activity.

Initial physician engagement began in the planning stages with administrative buy-in and support from the clinic's medical director and Quality and Education Committee, and with making physicians aware of the problem to be addressed by providing them an analysis of the clinic's aggregate patient data on systolic blood pressure. Together these factors encouraged and motivated

physician participation and engagement in the PI CME activity.

As a result, physicians were eager to begin Stage A. To mark the official beginning of Stage A, we brought all of the physicians together for a kickoff meeting. Here we described goals and details of the PI CME activity, communicated expectations for successful completion of the activity, distributed relevant materials and answered their questions. After the meeting, physicians were given a time frame and tools to assist them in assessing their own performance.

To assess their performance, the physicians collected (using electronic medical records) and reviewed their own baseline aggregate data and then compared it to the clinic's aggregate baseline data, aggregate performance goals, national performance data (HEDIS®) and best practice guidelines (JNC 7). This exercise allowed the physicians to create personal performance goals. A "Learning Log" that was designed by UW OCPD in collaboration with the clinic's Quality and Education Committee was provided to the physicians so they could record these personal performance goals and document reflections of their engagement in both Stage A and the PI CME activity overall. Submission of this Learning Log to UW OCPD verified the physicians' engagement in Stage A and qualified for their earning of 5 AMA PRA Category 1 Credits™.

Reference

National Committee for Quality Assurance. HEDIS 2005, Volume 2: *Technical Specifications*. Washington, DC: National Committee for Quality Assurance; 2005.

activities. These examples demonstrate the flexibility of the format and its ability to integrate—depending on the needs of the physicians involved—not only evidence-based performance measures but evaluation tools and didactic educational activities.

Although approved less than four years ago in 2004, PI CME is gaining acceptance as a tool that brings CME, evidence-based performance measures, and the increased emphasis on quality improvement and patient safety closer together to improve the care of all patients. Evidence of this trend is supported by the article "CME Changes Course" by Tamar Hosansky, in the January/February 2007 issue of *Medical Meetings*. In it the author reports on the results of a physician survey showing that of those who responded to the question, nearly 20 percent were planning to use PI activities in the subsequent 12 months. Clearly we still have work to do in this area. The AMA Division of Continuing Physician Professional Development will continue to work diligently to increase acceptance, build momentum and disseminate information that will assist you in your efforts to help physicians help their patients.

Finally, as CME has continued to evolve, the AMA has continued to expand the types of educational formats which are recognized for being effective in helping to maintain, develop or increase the knowledge, skills and professional performance of physicians and are therefore worthy of *AMA PRA Category 1 Credit*™. I invite you to visit www.ama-assn.org/go/cppd to view "Recognizing physicians' participation in educational activities: What physicians should know about the AMA PRA Credit System." This new resource highlights the many different ways educational activities can be designed to promote learning and change and receive AMA PRA CME credit, as well as other physician professional development activities that may also qualify for CME credit. For more information, e-mail cme@ama-assn.org or call the AMA at (312) 464-4668.

1 Johns Hopkins University Evidence-based Practice Center. *Effectiveness of Continuing Medical Education*. Rockville, MD: Agency for Healthcare Research and Quality; 2007. AHRQ Publication No. 07-E006.

Correction

A reference in the winter 2007 *CPPD Report* misstated the title and issue information for a journal. The correct reference is: Steinert Y, Snell LS. Interactive lecturing: strategies for increasing participation in large group presentations. *Med Teacher*: 1999; 21(1):37-42.

Share your success story for implementing PI CME

To help others get started, the AMA is looking for faculty to present actual cases of PI CME from a variety of CME provider settings. Guest faculty will be asked to describe:

- How the need for the activity was identified
- Objectives and stages of the activity
- Physician engagement
- Performance measures used
- Results of the program
- Lessons learned from implementing the activity
- Advice for other CME providers who are just starting to develop PI CME activities

For more information, contact Mary Kelly at mary.kelly@ama-assn.org or (312) 464-4668.

18th annual National Task Force conference

Be sure to attend CME Collaboration to Improve Patient Care: A Call to Action, this year's annual conference on continuing medical education (CME) provider/industry collaboration, scheduled for Oct. 17–19 in Arlington, Va. In addition to providing an exciting opportunity to network and participate

in dynamic sessions with leading experts, this conference will offer interactive plenary and breakout sessions specifically geared toward collaboration among CME providers, the regulated industry, the Food and Drug Administration, and accrediting agencies.

The 18th annual Conference of the National Task Force on CME Provider/Industry Collaboration will be held at the

Hyatt Regency Crystal City
2799 Jefferson Davis Highway
Arlington, Va.

Visit www.ama-assn.org/go/cmetaskforce or contact Kevin Heffernan at kevin.heffernan@ama-assn.org for more information.

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Past editions of the *CPPD Report* can be viewed in PDF format at:
www.ama-assn.org/go/cmecppd

Calendar of events

June 10–12

2007 Annual Meeting of the Global Alliance for Medical Education: Harmonization of CME Systems Around the World
New York
www.game-cme.org

June 15–16

Alliance for CME: The Basics Institute
Rosemont, Ill.
www.acme-assn.org

June 23

AMA Division of Continuing Physician Professional Development Town Hall Meeting
Chicago
www.ama-assn.org

Aug. 9–11

“Understanding ACCME Accreditation” Workshop
Chicago
www.accme.org

Oct. 17–19

18th Annual Conference of the National Task Force on CME Provider/Industry Collaboration: CME Collaboration to Improve Patient Care—A Call to Action
Arlington, Va.
www.ama-assn.org/go/cmetaskforce

Nov. 15

Council of Medical Specialty Societies 2007 CME Summit: CME as a Strategic Asset for Improving Quality
Rosemont, Ill.
www.cmss.org

Dec. 12–14

“Understanding ACCME Accreditation” Workshop
Chicago
www.accme.org

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