Transitioning to Performance-Based Continuing Professional Development

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ABSTRACT
Improvement in healthcare quality is dependent on measurement for baseline assessment and evidence of improved patient care. Continuing professional development has become more than the educational components of continuing medical education. It must include measurement of performance linked to education and other systems-based process interventions that lead to improved performance and delivery of care. There are many demands for increased assessment of clinicians to ensure accountability, competence, and improvement. Linking of measurement and education is essential to ensure healthcare quality.

INTRODUCTION
There are many drivers of improvement in healthcare quality. At the turn of this century, there were many calls for improvement of healthcare delivery and patient safety. In 2001, the Institute of Medicine’s Crossing the Quality Chasm reported that as many as 98,000 deaths per year were caused by medical errors [1]. The Midwest Business Group on Health cited the healthcare dollars wasted and an annual cost of poor quality of $2000 per covered employee [2]. McGlynn and colleagues at RAND discovered that only 55% of evidence-based recommended care was actually delivered [3].

During the same period, continuing medical education (CME) researchers were looking closely at the effectiveness of CME in actually changing physicians’ practices. Davis et al discovered that traditional CME alone was not effective in improving practice, but they did find that it could lead to desired changes when connected with other modalities [4]. Yet, CME was not changing, CME providers continued to produce the type of programming they were comfortable with and that their physician learners demanded. Online CME continued to grow as technology improved and physicians found it more difficult to leave their practice to attend CME activities at remote venues. Between 1998 and 2003, the number of Internet-based CME activities increased more than 700%, compared with the 38% growth in total CME activities [5], and the number continued to climb through 2008 [6]. Internet technology provided a new delivery format, but the content and design remained largely the same as live CME, with little linkage to a specific practice.

In 2005, the American Medical Association Physicians Recognition Award (AMA PRA) introduced criteria for performance-improvement CME [7]. Based on basic quality-improvement concepts, this new CME format provides a CME credit reward for physicians who are participating in practice-based quality improvement. Credit is awarded by a CME provider according to the physician’s documentation of the completion of 3 stages. Stage A is the assessment of practice against evidence-based performance measures. Stage B is the implementation of intervention(s) for improvement. Stage C is remeasurement of practice following intervention. Five CME credits are awarded for completion of each stage, with 5 additional credits awarded if the whole cycle is completed, for a total of 20 credits. This process is consistent across all 3 CME credit systems in the United States (AMA PRA, American Academy of Family Physicians, American Osteopathic Association) [8,9].

This new type of CME requires a new skill set on the part of CME providers and their learners. Most of these individuals have no formal training in quality-improvement concepts, processes, and tools. Although measuring outcomes has become more important in CME in recent years, the level of practice-change measurement required for performance-improvement CME is uncommon. Evidence-based performance measures are typically not part of CME needs assessment, content, or outcomes measurement.

Along with a new focus on practice improvement, the Accreditation Council for Continuing Medical Education (ACCMCE) Updated Criteria for Accreditation offers CME providers the opportunity to attain a higher level of accreditation if they work in collaboration outside the CME unit. Providers mastering criteria 16 to 22 are rewarded with level 3 accreditation [10]. These criteria include the integration of CME into processes for improving practice, including the use of noneducational strategies, overcoming barriers to change, collaboration with other stakeholders, and positioning CME within the organization to influence the scope and content of improvement interventions. Whether the provider aspires to level 3 accreditation or not, there are challenges in meeting new expectations with regard to practice-specific goals and gap analyses. Clearly, there is a need for new processes for continuing professional development to advance beyond CME, but many CME providers are not in a position to meet these demands.

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PERFORMANCE MEASURES IN CONTINUOUS PROFESSIONAL DEVELOPMENT

Performance measurement in medicine is intended to bring new evidence to a practice. Just enough data are gathered to inform and improve, on the assumption that small tests of change will accelerate improvement. There are 2 types of performance measures—process and outcomes [11]. Process measures evaluate whether appropriate actions were taken for an intended outcome and how well they were performed. Generally, these processes are within the control of the clinician and other parts of a system (eg, ordering the hemoglobin A1C test for the diabetic patient). Outcomes measures assess changes in the health status of patients (eg, whether the patient’s hemoglobin A1C value is at the desired level). Practice data are necessary for both types of measures. Process measures can be analyzed from administrative data, such as billing reports, insurance claims, and so forth, whereas outcomes measures rely on actual patient clinical data from medical records.

Like evidence-based medicine in general, evidence-based performance measures are not available in all areas of medicine. In fact, there are few, if any, validated measures in many clinical areas. Performance measures are developed by expert panels, which review the science and make recommendations on the basis of the current best evidence. The most prevalent group is the AMA-convened Physicians Consortium for Performance Improvement (PCPI), a multispecialty group of physicians and scientists who continuously develop new measures [12]. All current performance measures can be found at the National Quality Measures Clearinghouse [13]. Measures are submitted to the National Quality Forum (NQF) where they are vetted and endorsed. NQF-endorsed measures are used to evaluate practice in hospitals, health plans, and other healthcare-delivery settings. Recent measures implemented by the Center for Medicare and Medicaid Services (CMS) in their Physicians Quality Reporting Initiative (PQRI) allow for increased compensation for physicians and systems demonstrating the use of approved measures [14]. Other payers are following suit, leading to significant incentives for implementation of performance measures and quality improvement in practice.

In addition to improving healthcare delivery and providing incentives for desired performance, measures have an important role in improving the development of CME. Starting with the end in mind (desired patient outcomes), educational content can be designed around performance measures. Evaluation of current practice as defined by evidence-base performance measures can give a baseline assessment of educational need. For example, envision a practice in which hemoglobin A1C is measured appropriately according to standards only 65% of the time. This information will signal the clinician(s) to evaluate why the percentage is so low. Is there a lack of knowledge and understanding of the care appropriate for diabetic patients? Is there a lack of systems-based processes in the practice that allows these patients to go undetected? This process is the initial needs assessment. Measures can also be used to develop learning objectives. Rather than vague, global objectives for CME, very specific measurable objectives can come from evidence-based measures. For example, all patients with diagnosed diabetes should receive 1 or more hemoglobin A1C tests per year [15]. Education designed to meet this objective will include medical information as well as processes and tools to ensure the outcome. Finally, outcomes assessment of practice against the measure can be performed to evaluate the effectiveness of the interventions. Rather than being an isolated activity, CME becomes one of several interventions to ensure practice change and improvement. This approach will result in transition from CME to a continuous improvement in performance.

CONTINUOUS PERFORMANCE IMPROVEMENT TO ENSURE ONGOING COMPETENCE

The American Board of Medical Specialties (ABMS) introduced ongoing Maintenance of Certification (MOC) in 2001 to ensure the continuing competence of board-certified physicians [16]. Charged with protecting the public, certifying boards have had varying requirements for board certification, with most allowing lifetime certification without a recertification process. The ABMS now requires all their member boards to implement ongoing MOC with a standardized 4-part process. Part I requires a valid license to practice medicine. Part II requires lifelong learning (CME) and self-assessment. Part III requires demonstrated cognitive knowledge (the traditional board exam). Part IV requires demonstrated performance improvement in practice [17]. This new approach to the maintenance of board certification correlates perfectly with the movement of CME toward continuous improvement in performance. MOC parts II and IV are particularly congruent with CME’s commitment to self-assessment (individualized needs assessment), lifelong learning, practice measurement, and improvement of healthcare delivery.

Similarly, state medical licensing authorities are considering the need to increase the rigor of licensure and relicensure to ensure the safety of the public. State laws vary dramatically in their requirements. None require evidence of ongoing competence, although 44 states require CME credit for relicensure as an indicator that a physician is at least maintaining his/her knowledge base [18]. In 2003, the Federation of State Medical Boards (FSMB) commissioned the Special Committee on Maintenance of Licensure to study the continued competence of licensed physicians. Their House of Delegates adopted the following policy statement in 2004:
“State medical boards have a responsibility to the public to ensure the ongoing competence of physicians seeking relicensure” [19]. In May 2008, the FSMB House of Delegates adopted 5 principles of maintenance of licensure, including one to support physicians’ commitment to lifelong learning and to facilitate improvement in physicians’ practice [20].

Another example of the movement to ongoing performance improvement comes from the Joint Commission, whose new Ongoing Professional Practice Evaluation (OPPE) requires accredited healthcare organizations to look at performance data for all practitioners, with privileges granted on an ongoing basis rather than at the traditional 2-year reappointment [21]. Practice data may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussions with peers and other colleagues. These reviews are expected to occur more frequently than annually. From these evaluations, organizations are expected to take action, whether it is to continue, limit, or deny privileges.

Board certification, medical licensure, and hospital privileging are all mechanisms for ensuring the safety of patients. Long-standing conventions that allow physicians to qualify once and never have to demonstrate competence again are quickly disappearing. Regulation is leading the way to rigorous, ongoing demonstration of maintenance of competence.

MAKING THE TRANSITION TO PERFORMANCE-BASED CONTINUING PROFESSIONAL DEVELOPMENT

Measurement is fundamental to performance-based processes for ensuring the continued competence of healthcare professionals. Traditionally, postgraduate medical education has focused little on assessment, curriculum, or individual learner outcomes. Metrics for success have included participation numbers, learner satisfaction, and financial viability. New attention on patient safety, quality improvement, and professional accountability has led to more emphasis on valid measurement of baseline performance, trending, benchmarking, and improvement. Concepts and tools of continuous quality improvement are being translated from other industries in order to demonstrate value and effectiveness in healthcare delivery.

Providers of continuing professional development will need to be adept at not only development of educational content but also ongoing measurement of individuals’ deficiencies in practice. Systems and processes must be analyzed so that a broad spectrum of interventions for improvement can be implemented. Collaboration must be fostered between those responsible for quality measurement, healthcare informatics, professional development, and research to provide continuous improvement of the entire healthcare-delivery system.

REFERENCES


15. American Medical Association Web site. Physician

**Resources**
The following resources may be useful for making the transition to performance-based continuing professional development.

**Performance Measures**
AMA Physicians Consortium for Performance Improvement (PCPI)
www.ama-assn.org/go/quality

**Joint Commission**
www.jointcommission.org

**National Committee for Quality Assurance (NCQA)**
www.ncqa.org

**National Quality Forum (NQF)**
www.qualityforum.org

**Ambulatory Quality Alliance (AQA)**
www.aqaalliance.org

**Hospital Quality Alliance (HQA)**
www.cms.hhs.gov/HospitalQualityInits/33_HospitalQualityAlliance.asp

**Pharmacy Quality Alliance (PQA)**
www.pqaalliance.org

**Physicians Quality Reporting Initiative (PQRI)**
www.cms.hhs.gov/pqri

**National Quality Measures Clearinghouse (NQMC)**
www.qualitymeasures.ahrq.gov

**Professional Development**
Alliance for CME Professional Competencies Self Assessment

American College of Medical Quality
www.acmq.org

Institute for Healthcare Improvement (IHI) Open School

National Association for Healthcare Quality
www.nahq.org

National Institute for Quality Improvement and Education
www.niqie.org