

## Mutual Impact: How Quality and Education Work Together

**In Brief:** In the July/August 2008 issue of *The Physiatrist*, the Academy introduced a series of articles about the quality movement. This article, the fifth installment in the series, describes the way quality has impacted and changed the delivery of continuing medical education – which could, in turn, change the quality of health care. The article was developed by Karen L. Andrews, MD, assistant professor of PM&R at the Mayo Clinic in Rochester, Minnesota, and chair of the AAPM&R Practice Improvement Project Committee; and Stephanie Mercado, director of education at AAPM&R.

THE AMERICAN MEDICAL Association defines continuing medical education (CME) like this:

**CME:** educational activities which serve to maintain, develop, or increase knowledge, skills, professional performance and relationships that a physician uses to provide services for patients, the public, or the profession.

In the past, CME was mostly delivered in a didactic format, with listening and comprehension as the primary expectations of learners. Measurement of competence was assessed via licensure, or certification exams.

Today, professionals and credentialing organizations working with CME are realizing that continuous learning and quality improvement – not just exams at career milestones – are the best way to educate and measure physician competence. CME professionals now believe that interactive education focused on outcomes and competence found through simulations and practice-based-learning are the cornerstones of CME.

### Why change CME delivery?

The motivating forces for this fundamental change in CME delivery are cost,

quality, and the perception of corporate influence. Following are examples of some of those factors that led to the shift in CME delivery.

**Factor #1: Cost.** A report from the US Government Accountability Office (GAO) shows a rapid increase in health care costs as a percentage of gross domestic product (GDP). GAO predicts that by 2013, health care costs will account for 18.3% of GDP. Additionally, health care costs in the United States significantly outpace other industrialized nations, and the quality of care is statistically no better.

**Factor #2: Quality.** The Institute of Medicine's (IOM) 2000 report *To Err is Human* highlighted the opportunity to reduce preventable medical errors. The report found that the knowledge about error reduction was easily accessible, but the implementation of the knowledge was lacking. This report on preventable medical errors was the tipping point at which patients and payers became involved and began demanding a higher standard of care.

In 2002, IOM's seminal report *Health Professions Education: A Bridge to Quality* suggested health professionals must "cooperate, communicate, and integrate care in teams to ensure that care is continuous and reliable." Therefore, quality improvement at the system level is similar to individual quality measures but adds a further dimension: It is important to develop new approaches to both intra- and inter-professional continuing education and to determine how best to disseminate effective and efficient continuing educational materials. There is need for frequent, high quality communication and strong relationships among health care providers to maximize the quality of care, improve the efficiency of the care, and improve clinical outcomes. These changes will likely motivate a huge change in CME delivery with inter- and intra-professional

and inter-disciplinary CME (continuing education for physicians, nurses, mid-level providers, and radiologists, all in the same venue) to educate care providers for a specific disease process with unified medical accreditation.

**Factor #3: The perception of corporate influence.** An April 2007 report issued by the United States Senate Committee on Finance alleged that CME is often a front for pharmaceutical and device companies to increase market share. It also harshly criticized the Accreditation Council for Continuing Medical Education (ACCME), the group that accredits medical education providers. (In 2006, AAPM&R was awarded accreditation with commendation by ACCME.)

ACCME, whose goal is to support physician learning to benefit the quality of care, was accused of slow and lax oversight and enforcement of its standards (standards that measure accredited provider's compliance). While much of the report was accurate, it was somewhat shortsighted in that it mainly focused on for-profit CME providers, not medical specialty societies such as AAPM&R who work diligently to separate commercial influence from education.

CME providers and ACCME in particular are attempting to prove CME was/is fair and balanced and free of commercial influence, regardless of whether funding for CME was present. AAPM&R strictly implements ACCME's Standards for Commercial Support and disciplines rare, improper behavior when necessary. However, there is evidence that other providers – many in the for-profit arena and some in the non-profit arena – have overstepped these boundaries, spoiling the notion that CME with commercial support can be free of influence.

**The change:** In the past, too little emphasis has been placed on helping health care professionals enhance performance

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and outcomes in their daily practices. If the Academy and the specialty can do this, *and prove this*, many of the concerns from patients, payers, and the government should be minimized.

### Vision of portfolios

As more physicians use computers in their practices, information technology will facilitate practice-based learning, provide a database of a physician's clinical performance, and provide automated patient care systems. The culmination of physician and patient data with CME would create a personal portfolio or mechanism by which physiatrists could view a snapshot of their practice. This would help them to assess needs and quality gaps. With advances in CME delivery, learners could track and report their performance and outcomes over time. This long-term link to learners would help delineate their scope of practice and provide educational interventions relevant to each learner. Needs could be assessed in aggregate across groups and specialties and at the individual physician level. If implemented on a large and reliable scale, CME could improve professional practice and patient outcomes.

In the future, education could be the tie that binds together quality, reimbursement, licensure, and certifications.

### How can we prepare to change CME?

Continuing education needs to evolve, and continuing educational professionals and physician volunteers (not outside organizations) should work to effect this change. It is important for the Academy to define our specialty further to ensure the Academy's educational interventions are relevant to Academy members' practice and support improved practice and patient outcomes. As the specialty advances its thinking, the Academy will need to pay attention to the diversity of practice as well as the necessity for hands-on learning and teaching in teams (systems), with consideration to intra-professional and inter-professional continuing education.

### Stay tuned...

So far, this series has defined quality, reviewed how quality measures are developed, and discussed the emerging delivery

trends for CME. Next month, learn about the quality movement's effect on Maintenance of Certification™ (MOC) and performance improvement.

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