

# NEW CHALLENGES FOR CME

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In the context of increasing medical costs, reports of poor healthcare outcomes, and concerns about patient safety, the medical profession is under intense scrutiny by a number of powerful stakeholders. In turn, the nation's CME providers have been asked to actively participate in improving medical care. An enterprise that once valued "learning for learning's sake" has undergone a shift and now increasingly emphasizes "learning to solve problems and improve care". This begs the question of whether CME is effective and whether continuing medical education providers have a role in quality assurance and performance improvement.

Historically, the continuing medical education (CME) approach to improving clinical practice has relied heavily on information dissemination. However, the literature has shown that traditional CME,<sup>1</sup> dissemination of printed materials,<sup>2</sup> and release of authoritative practice guidelines<sup>3</sup> has often been insufficient to produce practice changes. Research also shows that no single educational approach, alone or in combination with other approaches, is universally effective. There are, to repeat an oft-quoted phrase "no magic bullets."<sup>4</sup> Interventions must be tailored to the situation, based on the aspect of care to be changed, the nature of the proposed change, the target group, the setting, and the problems encountered in implementing the change. Unfortunately, we lack a strong evidence base to support decision making about which intervention strategies will be effective under different conditions.<sup>5</sup>

Against this background, planners should incorporate evidence-based educational practice. The latter term refers to research results, accepted principles, and best practices of effective continuing education. These include the following:

- Conducting a thorough assessment of the needs of the target audience and potential barriers to change<sup>6</sup>
- Tailoring educational activities to meet the needs of the learner
- Anticipating barriers<sup>7</sup> and providing opportunities for learners to plan to overcome them<sup>8</sup>
- Using active rather than passive learning strategies<sup>9</sup>
- Recognizing that physicians make changes in stages and that longitudinal efforts to change practice may be required<sup>10,11</sup>
- Offering a variety of educational formats/strategies to accommodate clinicians at different stages of change<sup>12</sup> and preferred learning modalities<sup>13</sup>
- Designing multifaceted educational activities incorporating multiple strategies (e.g., didactic presentations and case-based discussion)<sup>14</sup>
- Providing clinicians with examples of successful implementation of the changes being presented<sup>11</sup>
- Using self-assessment tools to help learners reflect on their practice and identify their individual needs<sup>15</sup>
- Incorporating program elements designed to assist clinicians with translating new knowledge into clinical practice (such as opportunities to practice using new counseling skills, and practical

clinical tools such as tear sheets and medication charts) and using data to assess the impact of the change<sup>5</sup>

- Inclusion of performance improvement activities to facilitate change in practice and address systems issues that might otherwise inhibit implementation<sup>5</sup>

By incorporating evidence based educational practices, CME providers have been increasingly able to show that they can be effective partners in improving care. Indeed, the Agency for Healthcare Quality and Research recently published an evidence based report that showed that CME can be effective at improving knowledge, changing attitudes, enhancing skills, altering physician behavior, and impacting clinical practice outcomes.<sup>16</sup> Unfortunately, many CME providers have not embraced these best practice principles and strategies.

At the same time, the Accreditation Council for Continuing Medical Education (ACCME) will start to utilize new criteria to determine the accreditation status of CME providers in November 2008. The new criteria have significant implications for the design, delivery, and evaluation of individual CME activities (as well as entire CME programs) because they strongly embrace the notion that the purpose of CME is to improve physician competence, physician performance, or patient outcomes. As a result, CME providers will now be expected to measure the impact of educational interventions in terms of competence, performance, or patient outcomes.

CME units associated with academic medical centers and specialty societies will need to change their operations as a result of these new criteria. For example, staff will need to learn about performance measures and the competencies put forth by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties. Connections will need to be forged between CME offices and the quality improvement committees associated with faculty practice plans, teaching hospitals, and healthcare systems. CME personnel will need to move away from the traditional role of meeting planner and towards the responsibility of educational consultant. Instructors will need to undergo faculty development related to educational methods that are more likely to change the behavior of physician learners. Evaluation methods will move away from "happiness" scores and towards data registries that are linked to dashboards which will be used for Maintenance of Certification, Maintenance of Licensure, Pay for Performance, and Joint Commission surveys. As a result, many CME units have changed their names to groups of persons involved in Continuing Professional Development (CPD) because the latter term better reflects their new charge.

This session will explore these and other issues in an effort to help medical educators and practitioners prepare for the challenges facing CME and CPD just around the bend.

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