

Profiles in change: Colorado physician leaders for the new **CMIE**



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Winston Churchill once said, “To improve is to change.” Most people will probably agree that change can mean improvement, especially in health care.

And, if health care needs to change, it is logical that we must change how physicians learn.

As a result of the Institute of Medicine’s reports on health care quality and patient safety during the last decade, there have been seismic changes in quality and performance standards for hospitals and medical practices. And with that we have seen widespread national focus on physician competency. For example, new specialty board requirements and maintenance of licensure recommendations both encourage lifelong learning, a continuous cycle of self-assessment, educational/improvement interventions and then reassessment – a valid learning plan that has shown to be effective for physician change in performance.

The Accreditation Council for Continuing Medical Education (ACCME), the organization that sets the standards for CME requirements, supports our nation’s efforts to improve health care

by setting high standards for CME. So institutions offering CME must now design and measure their CME meetings for change – change in the learners’ competence, performance or patient outcomes. This requires not only changes for those planning CME, but a higher level of participation from the learners. Like most changes, this is not an easy task. It will require physician champions for CME who have the necessary skills and abilities to move CME forward.

Who are Colorado’s physician CME leaders? They are the CME chairs, committee members and speakers at local hospitals, medical schools and specialty organizations, as well as the Colorado Medical Society CME committees and the committee members overseeing Colorado maintenance of licensure.

We’ve talked with a few of these leaders who are highly engaged in a CME for Change effort in Colorado and, over this next year, will share with you their challenges and successes. Our first CME leader is David Price, MD.

Price is the director of medical education of the Colorado Permanente Medical Group, medical director of the Kaiser Permanente National CME Program and a professor of family medicine at the University of Colorado School of Medicine. He was recently appointed to the Accreditation Council for Continuing Medical Education (ACCME) Board of Directors.

Q: Why are you involved in continuing medical education?

A: First, a confession: In medical school and residency, I found that I didn’t learn very much in the traditional lecture format. I knew nothing of adult learning principles, but where I felt most involved and engaged in my learning was on the wards, in the clinic, in discussions with others, or in self-paced “on my own” learning. As part of a group practice I found I learned best when I could look something up when I needed it, ask a colleague a question, or when I received feedback from a colleague on things I could have done differently. I also discovered I enjoyed “teaching” – not in the traditional lecture format, but in discussing real cases. When I found out about principles of adult learning, the abundant opportunities to incorporate them into CME became apparent.

Q: The ACCME raised the standards for CME. What changes in this new model of CME do you think are most difficult for CME institutions and their learners to adapt to?

A: Change is hard for busy people, especially when change comes from outside and not from within, even when the changes are important and necessary (as I believe they are). In discussions with other CME providers, it seems that identification of gaps on which to base CME and assessing the outcomes



of CME interventions are challenging. It also seems that many individuals who have served as faculty for CME are not yet up to speed (or do not yet totally buy into) the new CME criteria. For CME providers, this necessitates additional discussions on the rationale behind the new criteria and the changes this requires for our faculty (such as why the old days of just recycling one's standard PowerPoint deck no longer works).

The transition between passive learning (come sit at a lecture for 55 minutes and ask questions for 5 minutes) to interactive, case-based, reflective learning (including answering reflective questions on CME evaluations) has been disconcerting to some attendees, at least initially. When we went away from lectures to more interactive discussion formats, we endured three to four months of "just give us the lecture" comments on our evaluation forms. Now, while we get a sporadic comment to that effect, most often we hear about it from our learners if we talk at them too much. (Proving that change is possible!)

Q: What CME achievements at your organization stand out the most? Have you seen an impact on patient outcomes?

A: Our CME vision is to be a "strategic enabler of organizational improvement and physician/clinician professional development." It starts with a culture, emanating from senior leadership, that values and prizes CME, gives us time to attend CME, provides us with resources to do our work, and allows/encourages us to "come alongside" leaders in their work to improve the organization. We've evolved, and are continuing to evolve, toward inter-disciplinary, team-based, patient-centered CME activities. We've done a great job at making our live activities interactive and engaging, even while most of these activities are video broadcast simultaneously to more than 20 sites. We developed a new model for journal clubs and case conferences that are based on real practice gaps and explicitly focus on identifying practical next steps for implementation and follow-up on those learnings to see if they've been implemented; this

model for regularly scheduled series has been published and adopted by several other organizations. We've also recently published our work on identifying and categorizing barriers to implementation of CME activity learnings.

Q: There's a lot of talk about performance improvement CME. What is your opinion about this type of learning? Is your institution involved in it?

A: We are involved in it. I think it is a terrific concept and something that should and needs to grow over time. It makes great sense – adult learners learn at the point of care, physicians are being asked either by their specialty boards, practice organizations, or will be asked by maintenance of licensure, to be active participants in quality improvement. Why not provide a structure for CME for physicians to get credit for how we learn and how we improve our practices, and what we have to do anyway? We developed a template for PI-CME that serves to help physicians and their practice teams conceptualize a rapid cycle quality improvement project (a "how-to guide," if you will), work through it, and document it both for CME credit as well as create an archive for the next physician who wants to improve in the same area so he/she doesn't necessarily have to re-create the wheel. Our process started with Kaiser Permanente in Colorado and is now being used by many Kaiser physicians across the country – particularly family physicians, as our process counts for MOC for family physicians. Our challenge now is to come up with ways to find the right amount of documentation that facilitates reflection and learning, tells the story for others who want to engage in a similar project, but isn't overly time consuming, so that more docs will take advantage of the opportunity.

Q: Getting physicians to attend CME activities can be challenging. How do you attract and engage physician learners in CME?

A: As medicine gets increasingly complex and providing health care gets more demanding, physicians are increasingly busy. Adults learn best (if learning is defined by subsequent do-

ing) when addressing a specific real life dilemma. Thus, we try to provide CME interventions that address real life difficulties of our physicians that provide practical advice and tools, discuss ways of overcoming barriers to implementation, involve attendees in educating one another by sharing best practices, and help them meet other administrative/organizational/regulatory requirements. While our resources are finite (like everybody else's), we are trying to provide CME activities in a number of formats (large group, small group, enduring material, webinar, etc.) to cater to more learning preferences and be more convenient for our target audience.

Q: Congratulations on your recent appointment to the ACCME Board of Directors. Is there anything in particular about the country's CME system you hope to change?

A: One of the subtexts going on in the CME arena is the tension between CME as part of the right of a profession to self-regulate and CME as a "public trust" (to steal a term from ABMS CEO Kevin Weiss, MD). My view is that CME needs to be both. As we continue to evolve CME, we need to be mindful that we are not only responsible for our own academic interests, self-fulfillment and practice improvement, but we are also ultimately responsible to the public. Therefore, we need to make sure our CME is relevant to our practice, based on areas where we need to improve, structured to meet the needs of our patients, free of conflict of interest and transparent in its operations.

As I mentioned, I think the principles of the new accreditation requirements are directionally correct. Like any new initiative, I view the accreditation process as iterative, and after a lot of listening and learning, I would hope to be able to provide some suggestions on how the principles of accreditation can be met in a more streamlined fashion, both for providers as well as the ACCME, so that the continued evolution of the CME system can be more easily diffused and translated into practice. ■