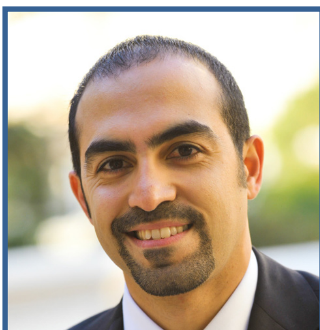
Assessing Industry's Perceptions of Continuing Medical Education Programs in Quality Improvement Initiatives



Mazi Abdolrasulnia, PhD, MBA, MPH
mazi@m-consultingllc.com

Mazi Abdolrasulnia, PhD, MBA, MPH is Founder of M Consulting LLC and Adjunct Assistant Professor of Health Care Organization and Policy, School of Public Health, University of Alabama at Birmingham. M Consulting LLC provides training and consulting services related to quality improvement.

Continuing Medical Education (CME) continues to be a major method by which heath care providers (HCP) learn the latest guidelines, treatments, and implement evidence-based practices. The ultimate goal of CME is to accelerate the translation of evidence into practice.

CME has been established as a useful and credible tool for information dissemination and diffusion of best practices and evidence. The challenge, however, is demonstrating its utility in impacting outcomes (practice and patient) in quality improvement (QI) initiatives.

This challenge will require CME to shift paradigms and focus on outcomes as a measure of CME activity. To this end, in October 2013, M-Consulting conducted an assessment of 35 pharmaceutical companies (49% response rate) to better understand the perceptions, needs and future of direction of CME as part of the Quality Agenda set forth by the Affordable Care Act (ACA) **(Table 1)**. The results, highlighted below, provide a glimpse into how industry views CME as a component of QI initiatives.

Industry Perception of CME in QI Programs

Overall, the industry believes CME is an important tool for improving quality. Eighty two percent believe quality improvement is a trend in CME that will be sustained over time. Similarly, 76% believe CME has a significant role within quality improvement in healthcare systems. In trend with other assessments of QI education for HCP's, 71% believe CME to be a mechanism for QI among healthcare providers, and even more (83%) believe CME should not only focus on HCP's but also the systems they work within.

However, there is a disconnect amongst industry perception of CME value to actual implementation. The industry perception is that only 35% of the current CME provider community has the capability of implementing effective quality improvement initiatives using CME as a tool in QI.

There was more consensus on where to include CME in quality initiatives. Fifty-nine percent believe CME as part of QI is best conducted in closed systems. Similarly, 76% believe quality improvement containing CME needs new models to effectively measure quality improvement and tools to identify appropriate criteria for evaluating grants focused on quality improvement.

TABLE 1: Characteristics of Respondent Organizations

	Mean (Range)
Number of staff within CME department	5 (1-14)
Approximate total value of grants awarded annually (millions)	14.7m (1.5-50m)
Approximate total number of grants awarded annually	322 (10-1400)

Industry's perceived barriers to CME implementation in QI framework

Cost was identified as the major perceived barrier to implementation of QI. This assessment only described cost in general terms. The concepts needs to be further explored in future assessments by breaking cost into multiple components from data access costs, to partnerships and implementation.

When asked to identify other barriers to implementation, patterns in the data increasingly feel into two large categories: organization barriers and CME design and delivery **(Table 2)**.

Elements of a successful QIE implementation identified by Industry

The industry's perceptions on what constitutes a successful implementation closely aligned with the value chain model for measuring quality. Two themes emerged for the data.

First, developing a sustainable systems-based model by:

- Sharing of best- and promising practices within and among the quality and CME worlds,
- Ensuring stakeholder involvement in design, implementation and evaluation of CME as a QI component,
- Find internal champions for commitment to CME as QI tool,
- Trained staff and commitment regarding quality from institutions,

Second, ensure data-driven initiatives and evaluation by:

- Designing and delivering programs in closed system in order to measure impact on patient experience and outcomes,
- Aligning quality measures with national standards, and
- Demonstrate gaps and impact using BIG DATA sources.

TABLE 2: Barriers to Implementation of QIE

ORGANIZATIONAL BARRIER	CME DESIGN AND DELIVERY
Negative experience with past outcomes of programs	Mostly once size fits all CME solutions to QI
Disconnect between CME to organizational goals	CME focus on open systems, especially inability to show impact on system-based measures in an open system environment
Silo medical education and QI departments	CME as QI tools are more resource intensive
CME not a partner in QI care delivery	Need for common QI terminology/taxonomy between stakeholders including, industry and CME providers

Conclusion

It is apparent that CME as a QI activity is a priority in the industry. The main message is that the CME community needs to reexamine its approach to QI education (QIE). Just as new models of care are forming, this assessment suggests that new models of how CME can significantly contribute to improving quality in a sustainable manner is desired.

If you would like more information about this study please contact me at mazi@m-consultingllc.com.

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