IOM Calls for Continuing Education Institute

BY JOYCE FRIEDEN

A public-private institution that has been proposed by the Department of Health and Human Services would be the best way to raise standards and quality for continuing health education, according to a report issued by the Institute of Medicine.

There are serious flaws in the way that continuing education for physicians and other health professionals is "conducted, financed, regulated, and evaluated," concluded the authors of the 200-page report "Redesigning Continuing Education in the Health Professions." They added, "The science underpinning continuing education for health professionals is fragmented and underdeveloped."

Because of that, "establishing a national interprofessional continuing education institute is a promising way to foster improvements in how health professionals carry out their responsibilities," the authors said. The report was sponsored by the Josiah Macy, Jr. Foundation.

The 14-member Institute of Medicine committee that produced the report proposed the creation of a public-private entity that would involve the full spectrum of stakeholders in health care delivery and continuing education.

That new entity, which would be called the Continuing Professional Development Institute (CPDI), would look at new financing mechanisms to help avoid potential conflicts of interest. The institute also would develop priorities for research in continuing health education and recognize effective education models.

The medical community must move from a culture of continuing education to one of "continuing professional development … stretching from the classroom to the point of care, shifting control of learning to individual practitioners, and [adapting] to the individual's learning needs," said committee chair Dr. Gail Warden.

"Academic institutions need to be much more engaged than they have been in continuing education," Dr. Warden, president emeritus of the Henry Ford Health System, Detroit, said during a teleconference. "The system should engender coordination and collaboration among professions that should provide higher quality for a given amount of resources and lead to improvements in patient health and safety."

New Report for Old CME Model?

Continuing medical education (CME) vendors had mixed reactions to the committee's report.

Rick Kennison, D.P.M., president and general manager of PeerPoint Medical Education Institute, said that he agreed with the committee's recommendations in the area of traditional CME. Those types of programs, such as live meetings and society annual meetings, "don't meet the needs of participants as learners, and there is conflict and bias associated with them."

But a large problem with the report is that the committee reviewed continuing medical education as it used to be, Dr. Kennison said. "There have been a lot of changes in CME in the course of the last few years that were completely overlooked by the committee."

For example, Dr. Kennison said that his organization has already moved to performance-improvement CME, which is a goal outlined in the report. Performance-improvement CME, he explained, involves "direct learning by the participant—self-directed learning—in which the participant uses metrics and supplies data to help determine change and improvement in patient care.

Dr. Kennison said his company's CME programs are sponsored by the pharmaceutical industry. But the funding is in the form of general grants related to diseases and conditions, he noted, and does not involve sponsoring education initiatives that highlight specific drugs or classes of drugs.

Dr. Edmond Cleeman, a New York orthopedic surgeon and founder of TRIARQ, a medical education organization for orthopedists, physical therapists, and other health professionals in the orthopedic field, agreed with the committee's recommendation that continuing health education needs to be team based and multidisciplinary. In the TRIARQ program, which is still being developed, students taking the courses will pay the costs themselves.

"We felt strongly about developing a community that is really across disciplines. Doctors have things that we can learn from physical therapists too," he said. For example, physicians and physical therapists can work together to develop the best exercises for patients in pain.

Leery of a Government Committee

On the other hand, there are several report recommendations that gave Dr. Cleeman pause. "To form another government committee and force a single type of a mold, and add additional regulations on all medical subspecialties and on CME—that's not the right approach," he said. "Each discipline is very different, and the needs for each discipline should be determined by its own governing body.

Instead, "It's a good idea to have a private organization, maybe like the American Medical Association," said Dr. Cleeman. "Their goal would be to assist in developing goals for continuing education." ■

The IOM report is available online at www.iom.edu/continuinged.

MY TAKE

Examine Effectiveness, Cost of CME

The proposed institute could have a dramatic effect on continuing "education" requirements for internists and other health care professionals. Through the establishment of a professionally inclusive public-private institute, research on the effectiveness of continuing education models could inform the health professional community about how best to develop educational programs and continuing professional competencies.

DR. SCHUSTER

Although interdisciplinary health team education might improve health outcomes for patients, it's difficult to assess the value of single interventions on patient outcomes. Also, each profession, such as medicine, nursing, and pharmacy, will continue to have specific needs for professional education.

Several institutions have embraced the newest standards of the Accreditation Council for Continuing Medical Education.

Their modified programs involve active learning and outcomes evaluation, and avoid potential conflicts of interest associated with financial support by the pharmaceutical and medical device industries.

However, in an era of economic constraints, particularly for primary care providers, new standards developed by any organization must consider not only educational efficacy but also efficiency and cost.

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Part D 'Doughnut Hole' Raises Costs, Lowers Adherence

BY DENISE NAPOLI

Diabetes patients without coverage of the Medicare Part D "doughnut hole" spent more out of pocket on their medications and had worse adherence compared with diabetes patients who had coverage.

Modified doughnut-hole coverage of generic drugs conferred only "modest differences in out-of-pocket spending and no differences in adherence" compared with diabetes patients without any coverage at all, according to a recent study.

The so-called doughnut hole refers to a coverage gap built into Medicare Part D (prescription drug coverage). Beneficiaries pay only a copayment for their drugs until the total cost reaches a certain threshold. Once costs hit that level, they pay 100% of their costs until their out-of-pocket expenses reach a second, higher amount, and catastrophic coverage kicks in.

In 2006, the Medicare Advantage Prescription Drug (MAPD) plans on which the current study was based had a coverage gap that began at $2,250, and persisted until out-of-pocket expenses hit $3,600; in 2010, the doughnut hole goes from $2,830 to $4,550.

The study, led by Vicki Fung, Ph.D., of the Kaiser Permanente Medical Care Program, in Oakland, Calif., compared diabetes patients in a staff-model, integrated health maintenance organization's MAPD plan. In the first group were 16,654 patients whose Part D plan provided no coverage in the doughnut hole; in the second were 12,126 with employer-supplemented insurance offering some coverage in the gap.

Patients were aged at least 65 years, had been covered at least from Jan. 1, 2005, through Dec. 31, 2006, and had one or more oral diabetes prescriptions dispensed in 2005. Those with dual Medicare/Medicaid coverage and those receiving a low-income Medicare subsidy were excluded.

A total of 17% of patients without gap coverage had out-of-pocket drug expenses of at least $2,250—putting them into the doughnut hole—as did 35% of those with some gap coverage. Patients without gap coverage had lower annual total drug costs, on average: $1,750, versus $1,802 for patients with employer-supplemented gap coverage, the researchers found. However, patients without gap coverage spent significantly more than did their covered counterparts: an average of $806 annually versus $279, a 189% increase (Health Serv. Res. 2010 Jan. 7 [doi:10.1111/j.1475-6773.2009.01071.x]).

Additionally, patients without gap coverage had an adherence rate of 62%, compared with 66% among patients with coverage. (Adherence was defined as having been dispensed enough drugs to cover greater than or equal to 80% of days prescribed.)

"Our findings reinforce the need to examine carefully the clinical and economic effects of all Part D drug benefit and delivery structures," they said.

The authors declared no conflicts, and said MAPD plan administrators reviewed the paper but had no control over design, conduct, or interpretation of the study. ■