IOM Calls for Continuing Education Institute

BY JOYCE FRIEDEN

A public-private institution launched 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.

Serious flaws exist 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.

"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, the Continuing Professional Development Institute, that would involve the full spectrum of stakeholders in health care delivery and continuing education. It 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 Dr. Gail Warden, committee chair.

"We believe that 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."

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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, "are didactic in nature [and] don't meet the needs of participants as learners, and there is conflict and bias associated with them."

A big problem with the report is that the committee reviewed continuing medical education as it used to be, Dr. Kennison said. "They wanted to evaluate a model of a car, but instead of using a 2010 model, they used a 2006 model," he 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.

"We've been doing this for more than 2 years now," he noted. "Because the group didn't evaluate performance-improvement CME, they missed a major stepping stone associated with the current status of CME."

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 doesn't 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.

"As orthopedic surgeons, we deal with physical therapists all the time," he said. "We felt strongly about developing a community that is really across disciplines."

Leery of a Government Committee

Several report recommendations 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. So the idea of having one government committee saying, 'This is continuing education for all fields of health care'—that is going to be a problem. I think you're going to scare away innovation."

Instead, "I think 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."

For example, he added, the organization could say, "'Here are some metrics for how you evaluate continuing education.'" He continued, "If they could come up with metrics, either through surveys or some other tested metric, that would be great. Then you can always be improving your continuing education." ■

The Institute of Medicine report, "Redesigning Continuing Education in the Health Professions," is available online at www.iom.edu/continuinged.

Provider Participation in Quality Reporting Jumped in 2008

BY JOYCE FRIEDEN

Physicians and other health professionals participating in Medicare's Physician Quality Reporting Initiative received a total of $92 million in incentive payments under the program in 2008, the Centers for Medicare and Medicaid Services announced.

That figure is about three times the $36 million paid out in 2007, the agency noted. The number of medical professionals receiving payments also increased during the same period, from 57,000 to 85,000.

The average payment in 2008 was more than $1,000, with the largest single payment at $98,000. During 2007, the reporting period lasted only 6 months for all participants, while in 2008 participants could report for a 6- or 12-month period.

"We are very pleased with the results for 2008," acting CMS administrator Charlene Frizerra said in a statement. "More health professionals have successfully reported data, and the substantial growth in the national total for PQRI incentive payments demonstrates that Medicare can align payment with quality incentives."

Under PQRI, providers receive incentive payments for reporting data on quality measures. The payments amount to 1.5% of each provider's total estimated allowed charges under Medicare Part B. Although more than 153,000 health professionals participated in the program during 2008, only 85,000 met the requirements for satisfactory reporting and therefore received incentive payments.

The CMS expanded the number of measures providers could report on, from 74 in 2007 to 119 in 2008. The measures were developed in cooperation with physician and health care quality organizations.

Providers also had the option in 2008 of reporting to the CMS through use of one of the 31 qualified medical registries. Many providers already were using registries to report data to researchers dealing with disease management and preventive medicine. Nearly 8% of the PQRI participants in 2008 attempted to use a registry to submit data; of these, 96% were successful and received an incentive payment. ■

2008 Health Spending to $2.3 Trillion, but Growth Rate Slow

Health care spending grew less than 5% in 2008, the slowest growth rate since the federal government officially began measuring it in 1960, according to a report from the Centers for Medicare and Medicaid Services.

Although the rate of increase is slower, health care spending still outpaces the gross domestic product. In 2008, health care spending rose 4.4% to $2.3 trillion, compared with a 2.8% increase in the GDP. And health spending continues to consume a larger portion of the overall GDP, taking up 16.2% in 2008, compared with 15.9% in 2007 (Health Affairs 2010;29:147-55).

The overall slowdown in health spending growth is reflected in slower rates of increase in hospital spending, physician services, retail prescription drug spending, and nursing home and home health services.

For example, spending on physician and clinical services increased 5% in 2008, down from 5.8% in 2007. The deceleration in physician services was driven by a decrease in patient volume, even as the intensity of services picked up in 2008.

In a teleconference, Rick Foster, CMS chief actuary, said this trend was due mainly to the recession. As people lost jobs and health insurance in 2008, they may have opted to seek health care only when their conditions became more serious, and more costly to treat, he said.

The federal government's share of health spending soared to nearly 36% in 2008, up from 28% in 2007, according to the CMS. The increase is due in part to the American Recovery and Reinvestment Act of 2009, which retroactively shifted $7 billion in federal funds to Medicaid at the end of 2008.

—Mary Ellen Schneider