Institute of Medicine Suggests CME Oversight

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.

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 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 medical education (CME) 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.

"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.

New Report for Old CME Model?

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 large problem with the report is that the committee reviewed CME 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."

Some CME vendors have moved to performance-improvement CME, which is a goal outlined in the report. This approach 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. ■

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

MY TAKE

Examine Effectiveness, Cost of CME

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

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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March 15 Is Comment Deadline

EHR System *from page 1*

plete EHR systems will be certified, noted Dr. Warren, a pediatric rheumatologist and chief medical information officer of Texas Children's Hospital, Houston.

As of this moment, no complete EHR or EHR module has been certified, he said.

Under the terms of HITECH, physicians who treat Medicare patients can get incentives up to $44,000 over 5 years for the meaningful use of a certified health information system. Physicians whose patient populations are made up of at least 30% Medicaid patients can earn up to $64,000 in incentive payments for their use of the technology. Pediatricians and pediatric rheumatologists with 20% of their patient populations on Medicaid can also qualify for the $64,000.

"Although these incentives are substantial, I would be very surprised if they cover a majority of "standalone" practice EHR costs over a 5- to 10-year period," said Dr. Warren, who is a member of the American College of Rheumatology's Committee on Health Information Technology. Dr. Warren noted that EHR costs for a practice might be very substantially reduced by partnering with their "home" community hospital, "piggybacking" onto the hospital's larger EHR system. While this may now be allowable by amendment to the Stark law, it is possible that such an arrangement would exclude the private practitioner from the eligible provider incentive payments. Dr. Warren advised very close attention to this issue in the final version of the CMS rule, following the ongoing public comment period.

Itara Barnes, who is a practice management specialist at the American College of Rheumatology in Atlanta, noted in an interview that "unfortunately, we do not have reliable data on EHR use among rheumatologists." It seems certain that the numbers will continue to rise as incentives are increased, penalties for not adopting come into play, and the younger generation of digital natives enter practice, she said.

ACR's latest benchmark survey includes a question on EHR adoption to capture some "valid stats," she said.

HHS issued two rules: one that outlines proposed provisions governing the incentive programs, and an interim final regulation that sets initial standards, implementation specifications, and certification criteria for EHR technology. Both regulations are open for 60 days of public comment, until March 15.

The criteria for achieving meaningful use start with certain minimum requirements in 2011 and build gradually, with more requirements added each year. For stage 1, which begins in 2011, meaningful-use requirements include:

- ► Use of computerized entry for 80% of all patient orders.
- ► Use of electronic prescribing for 75% of all permissible prescriptions.
- ► Maintenance of active medication and medication-allergy lists as part of the EHR for at least 80% of patients.
- ► Inclusion of demographic data (language, sex, ethnicity, insurance type, and date of birth) in the EHR of at least 80% of patients.
- ► Inclusion in the EHR of at least 50% of the lab results that can be recorded as either positive or negative or can be recorded with numerical data.

In 2012, the rules tighten for submitting quality data. While providers are allowed to report quality data to the Centers for Medicare and Medicaid Services through attestation in stage 1, data must be reported directly through certified EHR technology in stage 2. ■

Disclosures: *Dr. Warren and Ms. Barnes reported that they do not have any relevant financial disclosures to relating to electronic medical record systems or software.*

The proposed regulations, fact sheets, and instructions on how to comment on the proposed regulations can be found at www.cms.hhs.gov/Recovery/11_HealthIT.asp.

Joyce Frieden contributed to this story.

MY TAKE

EHRs Need Constant Revision

Based on my survey of rheumatologists in Mississippi, about 30% of rheumatologists in the state use an electronic health record for at least some of their clinical tasks.

With the passage of the HITECH portion of the American Recovery and Reinvestment Act, the decision to implement an EHR has essentially been made for us.

An important lesson I have learned in my 10 years using an EHR is that it is important to routinely assess how patient care and efficiency of workflow are affected by an EHR interface. If something is working well, try to build on that, but if something is adding to work or delay, change it. There is no perfect system out there, but most if not all products are customizable to some degree. I use the GE Centricity Software, and like all available systems it is customizable.

Since making the transition to EHR use, our patient volume has increased and patient satisfaction scores are improved. Data retrieval is easier, and our staff functions as an integrated team. There are potential obstacles, not the least of which is cost, but I am convinced that the positives of implementation far outweigh the disadvantages. I can't envision practicing without an EHR.

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