Advisory Committee on Interdisciplinary, Community-Based Linkages

Continuing Education, Professional Development, and Lifelong Learning for the 21st Century Health Care Workforce
January 27-28, 2011
Rockville, Maryland

Meeting Minutes

Attendance

ACICBL Members:
Jane Hamel-Lambert, PhD, MBA (Committee Chairperson)
Robert J. Alpino, MIA
Helen M. Fernandez, MD, MPH
David R. Garr, MD
Patricia A. Hageman, PT, PhD
Beth D. Jarrett, DPM
Linda J. Kanzleiter, MPsSc, DEd
Susan Kwan, MPH
Barbara N. Logan, PhD, MA, MSN
Carmen L. Moreno, PhD
David H. Perrin, PhD, ATC
Elyse A. Perweiler, RN, MA, MPP
Sandra Y. Pope, MSW
Linda J. Redford, RN, PhD
Cecilia Rokusek EdD, RD
Ronald H. Rozensky, PhD, ABPP
Carl M. Toney, PA

HRSA Staff:
Joan Weiss, PhD, RN, CRNP, Designated Federal Official, ACICBL and Director, Division of Public Health and Interdisciplinary Education (DPHIE)
Louis Coccodrilli, MPH, RPh, Branch Chief/Area Health Education Centers Program, DPHIE
Norma J. Hatot, CAPT, United States Public Health Service, Senior Program Officer/DPHIE
Madeleine Hess, PhD, RN, Deputy Director/DPHIE
Patrick Stephens, Technical Writer/DPHIE
Roger Straw, PhD, Division of Workforce and Performance Management/Bureau of Health Professions
Shelly Williams, Secretary/DPHIE

Invited Guests:

Ronald Cervero, PhD
Candice Chen, MD, MPH
Karen Drenkard, PhD, RN, NEA-BC, FAAN
Kristin Kari Janke, PhD
Paul E. Mazmanian, PhD
Greg Neimeyer, PhD
Marilyn D. Phillips, PT, MS, CAE

Format of Minutes

These minutes consist of four sections:

I. Introductions
   A. New Member Orientation
   B. Writing and Planning Subcommittee Meetings
II. Expert Presentations
III. Proposed Recommendations
IV. Committee Business

I. Introduction

In the absence of Dr. Joan Weiss, Designated Federal Official (DFO), Mr. Lou Coccodrilli, Branch Chief and immediate past DFO welcomed everyone with a special emphasis on the new Committee members. He also discussed the purpose of the meeting and introduced Dr. Jane Hamel-Lambert, Committee Chairperson. Dr. Hamel-Lambert welcomed Committee members and reviewed the agenda. The Planning and Writing Subcommittee members worked on the 11th Annual Report as scheduled while Mr. Coccodrilli provided the new members with a detailed orientation of the Agency and Bureau followed by the Committee legislation, charter, and responsibilities. Ms. Shelly Williams provided the details related to travel reimbursement. A period of inquiry ensued, affording the new members with an opportunity to ask all of their questions.

II. Expert Presentations

Lifespan Professional Development through Practice-Based Education
Ronald Cervero, PhD
Professor and Associate Dean, College of Education, Co-Director, Institute for Evidence-Based Health Professions Education, University of Georgia

In recent years, there has been much discussion about the effectiveness of the current system of continuing education for health care professionals. With the current health education continuum, the major emphasis occurs prior to the start of a career (i.e., pre-service). For most professionals, once they enter service, there are limited educational and training activities. These continuing education activities are often linked to re-certification of licenses. Some disciplines have specific content requirements; others

simply require that a specific number of training hours be completed. For the most part, practitioners select the topics of their continuing education activities. Many stakeholders have been asking if this is the best system for ensuring that providers are adequately prepared given the vast amount of new information that must be assimilated in an ongoing manner in order to provide optimal patient care.

The current system of providing continuing education is very fractured and utilizes methods that may not be optimal for the promotion of learning. Mostly, didactic methods are used. There are numerous providers that do not coordinate their efforts. Activities are often supported by vendors that stand to benefit financially from the learning. For example, 70 percent of CME is financed by pharmaceutical companies and medical device manufacturers.

The Institute of Medicine (IOM) explores this issue in the report, *Redesigning Continuing Education in the Health Professions.* In the report, the IOM concludes that the system is deeply flawed and cannot properly support the ongoing development of health professionals. In particular, it is structured around participation and not performance improvement. According to the report, an effective continuing professional development system should ensure that health professionals can:

- Provide patient-centered care;
- Work in interprofessional teams;
- Employ evidence-based practice;
- Apply quality improvement; and
- Use health informatics.

The concept of lifelong learning for health professionals is not new. In 1962, an article in the *Journal of Medical Education* identified the need for clinicians to be able to select, organize, and evaluate information so that they can keep up with the constant flow of new information. In 2010, the American Nurses Credentialing Center (ANCC) and the Association of American Medical Colleges (AAMC) released a report built on the concept of lifelong learning by emphasizing the need to incorporate interprofessional and team-based education and practice and linking health care education and delivery with the workplace.

There is a large body of research on continuing education, focusing on both the impact of activities (i.e., does it improve knowledge, competence, performance, and patient health outcomes) and why certain activities have an impact. In reviewing the many studies on the impact of these activities, researchers have identified influencers related to the impact of continuing education. These include needs assessment for practice change; program intensity; focus on learners from similar practice settings; and administrative support and policy incentives that support practice change. Other important factors are ongoing (i.e., more than one exposure) and interactive training. Live media has been found to be more effective than print and multimedia approaches are more effective than single media interventions. Researchers have also looked at the incorporation of technology. For example, simulation methods are effective for building skills.

Point-of-care learning is one approach that is thought to show great promise and some professional organizations have recognized the value of this method. For example, the American Medical Association (AMA) provides Category 1 credit for point-of-care learning using the Internet. Clinicians are required to 1) state the clinical question; 2) identify the Internet source; and 3) describe how the information was applied to clinical practice.

A move toward a system of lifelong learning could be facilitated by the following steps:

- Move from a series of uncoordinated activities to a *lifelong learning curriculum*;
- Focus on practice-based learning and not content updates; and
- Align the credentialing system to focus on acquisition of knowledge and practice change.

Dr. Cervero suggested that the Committee consider the following recommendation.

The Secretary of the Department of Health and Human Services(DHHS) should, as soon as practical, commission a planning committee to develop a public-private institute for continuing health professional development. The resulting institute should coordinate and guide efforts to align approaches in the areas of:

a) *Content and knowledge of continuing professional development (CPD) among health professions;*
b) *Regulation across states and national CPD providers;*
c) *Financing of CPD for the purpose of improving professional performance and patient outcomes; and*
d) *Development and strengthening of a scientific basis for the practice of CPD.*

Discussion Points

- With needs assessment, there is often a disconnect between what practitioners say they need and what is needed to improve patient outcomes. The needs assessment must be done within the context of practice.
- Employers have a financial incentive to support effective learning in the workplace. The learning has to be tied to the intended practice changes. For employers, it is expensive to have employees that are unproductive and not practicing to the full extent of their licenses.
- The practice of medicine is a social act—it cannot happen in isolation. Along with needs assessment, learning must involve all team members. Practitioners need to be educated around the system of care and how to work as a team.
- Providing continuing education activities to multiple disciplines can be challenging. There should be a streamlined application process for the various accrediting bodies.
- Not all practitioners have access to an interdisciplinary team (e.g., solo providers, providers in long-term care facilities). Methods must be developed to allow them to interact with other providers. The Internet could facilitate the development of virtual teams.

Continuing Education and Professional Development: Shifting the System Toward Lifelong Learning

Paul E. Mazmanian, PhD
Professor and Associate Dean, Continuing Professional Development and Evaluation Studies
School of Medicine, Virginia Commonwealth University

Educational Outcomes
Level 1: Participation
Level 2: Satisfaction
Level 3: Knowledge (Declarative and Procedural)
Level 4: Competence
Level 5: Performance
Level 6: Patient health
Level 7: Community health

Continuing education produces outcomes and has a role in patient safety. Educators have a responsibility to provide effective educational interventions. With continuing education, there are various levels of outcomes. Not all interventions result in the higher level outcomes—those that change provider practice, improve patient outcomes and the overall health of the community. Research indicates that the most effective educational interventions are audit/feedback, reminders, double interventions, and multiple interventions.

The needs assessment allows practitioners to target interventions. To conduct effective assessments, practitioners need data to assess their performance. The data will help to determine if the practitioners are perceiving actual needs and, in particular, the needs that will result in the changes necessary to improve outcomes. Some practitioners may lack the ability to self-assess and could benefit from external assessments. There are tools/other instruments that can support the assessment process.

Continuing professional development (i.e., lifelong learning) differs in many ways from the current system of continuing education. Continuing professional development has the following characteristics:

- Settings: practice and other settings;
- Tools: uses methods for overcoming barriers to change such as prompts, reminders, and patient-mediated methods;
- Targets: clinicians, teams, health systems, patients, populations, and policymakers;
- Content: clinical plus possible focus on evidence-based information and team performance; and
- Guiding model(s): incorporates clinician-learner and educational delivery system, evidence-based, learning portfolio, directed self-assessment, CE credits, accreditation, ongoing certification, and licensure.

Team training is an effective method of providing continuing professional development. Team training allows members to practice skills and receive feedback that can influence team processes and outcomes. An important aspect of this training is the emphasis on role clarification, which has been shown to increase performance. It is important to note that the impact of team building decreases with the size of the team.

The move toward certification of practitioners in some disciplines will have an impact on the continuing education system. The educational requirements and exams required for certification will drive practitioners' decisions about professional development.

Dr. Mazmanian supported the recommendation proposed by Dr. Cervero.

Discussion Points

- When students are in the pipeline, they do not recognize the importance of continuing education and do not see a need to acquire the skills necessary to be lifelong learners.
- Cultural competence is an example of an area where practitioners do not perceive a need to build their skills.
- Needs assessment data should be linked to reimbursement (e.g., better outcomes result in higher reimbursement).
- The current system of providing care is reactive, not reflective. While current medical training emphasizes reflection, there are many generations of practitioners who have not been introduced to the practice of reflection.
- Denial is a factor in needs assessment. Team members must help one another recognize what they do not know.
- Title VII, Part D programs are being asked to link their continuing education interventions to patient outcomes. This is extremely difficult because it is difficult to track students over time. Additionally, there are many factors that play a role in patient outcomes.
- Continuing education activities should not be developed in a vacuum. There needs to be continuity between pre-service and practice. Some accrediting bodies are moving toward a curriculum for continuing education.
- In some settings, training decisions are made at the corporate level and focus on the bottom line, not necessarily improved patient outcome. These decision makers must also be educated about the role of professional development.

Educating Health Professionals for a Transforming Health Care System
Candice Chen, MD, MPH
Assistant Professor of Pediatrics, Department of Health Policy, George Washington University

While there have been significant advances in health, health disparities and escalating costs remain challenges around the world. The education of health professionals is very technical, often at the expense of building skills in the areas of community care and team care. To address these challenges, a group of 20 global leaders developed a series of recommendations to reform the education of health professionals. A central focus is social accountability defined as, "The obligation to direct their education, research, and service activities towards addressing the priority health concerns of the community, region, and/or nation that they have a mandate to serve." The recommendations include:

- Adopt competency-driven approaches to instructional design;

- Adapt these competencies to rapidly changing local conditions drawing on global resources;
- Promote interprofessional and transprofessional education; and
- Promote a new professionalism that develops a common set of values around social accountability.

Issues related to social accountability include the geographic distribution of providers (e.g., rural and/or underserved areas) and other barriers to access, such as the shortage of primary care providers. The Affordable Care Act (ACA) is designed to address some of these challenges. In particular, accountable care organizations (ACOs) are designed to bring providers together to provide more cost-effective care. The ACOs must include primary care providers and meet quality performance measures. The Center for Medicare and Medicaid Innovation will test models that address a defined population where there are deficits in care leading to poor clinical outcomes or potentially avoidable outcomes.

Another model is the patient-centered medical home (PCMH), which facilitates partnerships between a patient and his or her personal physician resulting in a "whole person" orientation to care. The PCMH can be complicated and difficult to implement due to the many components.

To explore the issue of social accountability, Dr. Chen and her colleagues conducted a study to develop a metric called the social mission score to evaluate medical school output in three areas:

- Percent of graduates who are underrepresented minorities;
- Percent of graduates who work in health professional shortage areas; and
- Percent of graduates who practice primary care.

Social Accountability of Medical Schools

- Anticipate society's health needs
- Partnering with the health system and stakeholders
- Adapting to the evolving roles of doctors and other health professionals
- Fostering outcome-based education
- Creating responsive and responsible governance of medical school
- Refining the scope of standards for education, research, and service delivery
- Supporting continuous quality improvement in education, research, and service delivery
- Establishing mandated mechanisms for accreditation
- Balancing global principle with context specificity
- Defining the role of society

The highest scoring schools of medicine were Morehouse, Meharry, and Howard, all Historically Black Colleges and Universities. The other high scoring schools were predominantly public schools. These are schools that have a history of focusing on social issues, community-based training, and diversity. The researchers also identified a link between NIH support and the social mission score with schools that received more NIH funding rating lower in terms of social mission.

Dr. Chen made the following recommendations related to continuing education:

1) Continuing education must include education on the changing health system, in a flexible and timely manner.
2) Policy and leadership training will be critical to producing health professionals who can advocate for a better health care system.
3) Continuing education must be linked to pre-service education, as well as to payment and practice reforms.
4) Continuing education must include outcomes evaluation focused on the nation's priority health needs.

Discussion Points

- It is necessary to expand the scope of research supported by NIH—not just basic science but there needs to be a move toward policy research. AHRQ may be a more appropriate agency to support research into effective continuing education methods.
- Providers of continuing education need to publish the results of their training initiatives to build the body of research.
- It is necessary to make clear to health care practitioners that they are frontline public health providers. There is a need to break down the silos between public health and clinicians.
- Health care practitioners need to be better educated about population-based health. They also need to focus on the areas of health promotion and prevention.
- Many medical school students select their specialty when they enter school. Changes are necessary to move more students toward primary care. Medical schools can play a role. They need to consider who they are recruiting and why—MCAT scores may not be the best predictor of what makes a good doctor.
- Loan forgiveness programs can relieve the financial pressures that motivate students to select specialties over primary care.
- Title VII, Part D programs have a long history of training practitioners but are not experienced in providing the type of training discussed by the presenters. The grantees will need to design programs that will produce the desired outcomes and will require technical assistance to achieve this goal.
- The National Training and Coordination Collaborative (NTACC) for Geriatric Education Centers (GECs) is working with GECs to identify appropriate outcome measures.
- For on-site, interprofessional/team-based education, more tools are necessary. Also, there is no mechanism for providers to receive continuing education credit for these activities. The Robert Wood Johnson Foundation is funding projects in this area.
- Resources are necessary to develop effective interventions to respond to the new demands for continuing professional development.
- Faculty plays a role in continuing education. Faculty members can also help to instill a commitment to lifelong learning.

Interprofessional Panel Discussion

Greg Neimeyer, PhD
American Psychological Association
Marilyn D Phillips, PT, MS, CAE
American Physical Therapy Association
Karen Drenkard, PhD, RN, NEA-BC, FAAN
American Nurses Credentialing Center
Kristin Kari Janke, PhD
University of Minnesota College of Pharmacy

The Committee asked representatives from several health professional organizations to present their perspectives on continuing education. While each of the presenters had their unique point of view, several common themes emerged.

- The definition of continuing education is variable, across and within disciplines.
- When continuing education is mandated, there is greater participation.
- Education has to be outcome based.
- Problem-based learning, reciprocal teaching, academic detailing, and point-of-care learning are effective approaches.
- The use of technology (e.g., reminders, simulation, online training) can expand opportunities for continuing education.
- Reflection and feedback are important components of continuing education.
- More interprofessional continuing education opportunities are necessary.
- Self-assessment tools should be developed and linked to existing educational resources.
- Portfolios provide an opportunity for self-assessment but practitioners need training on how to develop and maintain a portfolio. Qualitative and quantitative assessment measures for portfolios are necessary.

Ongoing gaps and or challenges were identified by the panelists.

- A definition of continuing competence is necessary (it will differ across stakeholders) and it is necessary to identify ways for practitioners to demonstrate their competence. Testing may not be the most appropriate way to demonstrate competency.
- Providers of continuing education need technical assistance on how to measure outcomes.
- The process for accrediting continuing education needs to be streamlined (e.g., joint accreditation).

Performance Measures and Longitudinal Evaluations
Roger Straw, PhD
Director**,** Division of Workforce and Performance Management/BHPr/HRSA

Performance measurement is embedded in the larger workforce agenda in ACA. To support this, ACA established the National Center for Health Workforce Analysis and state and regional centers for health workforce analysis. It also increases grants for

longitudinal evaluations—which must be capable of studying practice outcomes (not health profession programmatic outcomes).

The ACA increases the awards to Title VII, Part D grantees to conduct longitudinal evaluations. These evaluations must study practice patterns and collect and report performance measures, which will be developed by the ACICBL. Under ACA, Advisory Committees are responsible for developing guidelines for the longitudinal evaluations. It is anticipated that the ACICBL will do this for AHEC, geriatrics (GEC, GTPD, GACA), allied health projects, mental and behavioral health, and others in the following areas:

- Develop, publish, and implement performance measures for programs under this Part;
- Develop and publish guidelines for longitudinal evaluations for programs under this Part; and
- Recommend appropriation levels for programs under this Part.

The next steps include identifying measures that will be presented to the Advisory Committees. The evaluation will focus on periodic and longitudinal studies. Grantees will have to collect data and be able to address whether trainees complete training, enter practice in the area of their training, and continue practice in that area (e.g., primary care, underserved areas).

Discussion Points

- Issues of privacy and confidentiality will play a major role in how grantees can provide data on trainees over time. Programs will need guidance on how to do this. Unique identifiers are used by most programs. However, alumni organizations are very protective of their data.
- Any research conducted by the government will be subject to IRB.

III. Proposed Recommendations

The Committee members discussed the development of a recommendation calling for a national institute that would address the issue of continuing education for health professionals. The discussion focused on two approaches: 1) to develop a recommendation similar to the one proposed by Drs. Cervero and Mazmanian or 2) endorse the recommendations included in the IOM report, *Redesigning Continuing Education in the Health Professions.* While there was discussion of modifying the IOM recommendations, it was ultimately decided that it would weaken the recommendation if the Committee attempted to qualify its endorsement or changed the wording of some of the recommendations. Ultimately, the Committee decided to craft a recommendation similar to the one proposed by Drs. Cervero and Mazmanian. The agreed that the recommendation should be expanded to reflect the importance of incorporating interprofessional and community-based continuing education activities.

IOM Report: *Redesigning Continuing Education in the Health Professions*

Recommendation 1: The Secretary of the Department of Health and Human Services should commission a planning committee to develop a public-private institute for continuing health professional development. The Institute should coordinate and guide efforts in: 1) content and knowledge of CPD; 2) regulation across states and professions; 3) financing of CPD (both private and public funds will be needed); and 4) strengthening of a scientific basis.

Recommendation 2: The planning committee should design an Institute that: 1) creates a new scientific foundation for CPD; 2) develops, collects, analyzes, and disseminates metrics; 3) encourages development of health information technology; 4) encourages development and sharing of improvement tools and theories of knowledge across professions; 5) fosters interprofessional collaboration; and 6) improves the value and cost-effectiveness of CPD delivery.

Recommendation 3: The Continuing Professional Development Institute (CPDI) should be designed to work with other entities whose purpose is to improve quality and patient safety and involve patients and consumers in CPD.

Recommendation 4: The CPDI should lead efforts to improve the scientific foundation of CPD by: 1) integrating research methods and findings from all disciplines and professions; 2) generating research directions to advance understanding of linkage between CPD and patient and population health status; 3) transforming new knowledge into tools and methods to improve patient care; and 4) promoting the development of measurement instruments to evaluate CPD effectiveness and efficiency.

Recommendation 5: The CPDI should enhance data collection at the individual, team, organizational, system, and national levels, including: 1) relating quality improvement data to CPD; and 2) developing national standardized learning portfolios.

Recommendation 6: The CPDI should work with all stakeholders to develop national standards for regulation of CPD.

Recommendation 7: The CPDI should analyze the sources and adequacy of funding for CPD to develop a sustainable business model free from conflicts of interest.

Recommendation 8: The CPDI should identify, recognize, and foster models of CPD that build knowledge about interprofessional team learning and collaboration.

Recommendation 9: Supporting mobilization of research findings to advance health professional performance, federal agencies that support demonstration programs should collaborate with the CPDI.

Recommendation 10: The CPDI should report annually to its public and private stakeholders through a national symposium on the performance and progress of professional development and its role in enhancing quality of care and patient safety.

IV. Committee Business

Election of Vice Chair

In order to ensure the succession of leadership, Dr. Weiss asked the Committee to elect a Chairperson and Vice Chairperson since Dr. Hamel-Lambert's term expires March 30, 2011. The members did not make a decision; further discussion indicated during the next meeting. The newer members needed more time to develop a better understanding of the responsibilities of these two roles.

All Advisory Committee Meeting

This meeting is tentatively planned for November 2011.

Expression of Gratitude
Dr. Weiss thanked the 10 members who will complete their terms by March 30, 2011 for their service. At that time, the Committee membership will shift from 21 to 11, which will still be a quorum. A Federal Registry Notice remains open for nominations.

Next Meeting
The next meeting will be February 24 – 25, 2011.