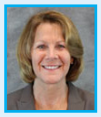
New Patient-Centered Models of Continuing Education in the Quest for Quality



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The Patient Protection and Affordable Care Act (ACA) of 2010 followed a long quest for quality improvement (QI) in health care that began with the work of early quality stewards such as the Institute of Medicine (IOM), the National Quality Forum (NQF), the Agency for Healthcare Research and Quality (AHRQ), the National Committee on Quality Assurance (NCQA), and the Utilization Review Accreditation Commission (URAC). Under the tenets of QI, continuing education (CE) providers are beginning to recognize the important role they can play in improving population health and the considerable responsibility that comes with supporting health care professionals (HCPs) and patients in this new health care quality paradigm.

Improving quality and reducing costs are cornerstones of health care reform, and public reporting about processes and outcomes in our health care system is well underway. The National Quality Strategy (NQS) serves as a compass for the nationwide focus on quality, guided by the 3 aims to improve patients' experiences of care, to enhance population health, and to reduce health care costs.[1,2] The 6 NQS priorities are patient-centric and can serve as a compass to guide revisions in how we design, deliver, and evaluate effective CE.[1]

In 2001, the IOM released its influential report, *Crossing the Quality Chasm: A New Health System for the 21st Century*.[3] The organization called for fundamental changes to the US health care system to achieve the aims of improved patient experiences and population health as well as reduced costs. Moreover, the IOM authors recognized the importance of engaging and educating patients as essential prerequisites to QI. A key aspect of patient engagement is shared decision-making (SDM). As defined by AHRQ, a leading supporter of patient education and engagement tools for more than 10 years, SDM is a process in which the patient and HCP exchange information to make collaborative treatment decisions.[4,5] The HCP provides evidence-based information about the benefits and risks of treatments, along with decision aids, to help the patient understand his/her options. The patient conveys his/

National Quality Strategy Priorities

1. Making care safer by reducing harm caused in the delivery of care
2. Ensuring that each person and family is engaged as partners in their care
3. Promoting effective communication and coordination of care
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
5. Working with communities to promote wide use of best practices to enable healthy living
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models

Patient-Provider Learning Model Developed Through Evidence-Based Definitions, Taxonomies, and Frameworks

In the CME enterprise, Joint Accreditation in Medicine, Pharmacy, and Nursing has been established by the ACCME, ACPE, and ANCC to distinguish the standards for education providers to design interprofessional collaborative practice (IPCP)-based education "planned by the healthcare team for the health care team."[1] The ACCME identifies patients as a central part of the IPCP team.[2] PRIME's 20-year history in applying IPCP to our learning framework provided a strong foothold in 2006 for our groundbreaking work in quality improvement education, followed by our elite Joint Accreditation in 2013. Now we have evolved our Integrated Quality of Care Education (iQCE™) Model to uniquely encapsulate and measure tethered patient and provider learning at its nucleus to guide our pioneering work.

As illustrated in Figure 1 (page 6), PRIME's Patient-Provider Learning Model establishes 4 stages as central and shared aims of patient and provider engagement. Our approach involves identifying what patients and providers need to know, believe, and do in order to optimize engagement in health care treatment strategies through shared decision-making. For example, in order for true medication adherence to occur, patients must have at least basic knowledge about their medications; they must believe that their medications are effective and safe; and they must share in decision-making regarding which medications are best suited to their socioeconomic status and lifestyle needs. At the same time, health care professionals need to develop communication and coordination skills to adequately address their patients' conceptions (and misconceptions), attitudes, and barriers pertaining to treatment initiation and adherence. A continuing education (CE) model that engages both clinicians and their patients aligns with the ACCME's new CE provider criteria for patient engagement.[1,2]

The voice of the patient is an essential component to achieve the 3 national aims of improved patient experiences, better population health, and lower costs. While this can take a number of different forms, patient engagement has become critical because of 3 convergent themes: First, the complexity of the health care system makes it difficult for patients to obtain, communicate and understand information about their health and treatment.

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her personal beliefs and values about health care, as well as treatment preferences and concerns.

As a proven method of patient engagement, SDM promotes patients' rights to be fully informed and engaged in decisions that affect their present and future health. From the HCP's perspective, effective SDM involves acquiring specialized knowledge and skills, including the following fundamental educational needs:

- Knowledge regarding risks and benefits of all available therapies, or reliable and accurate resources that can be accessed in a timely manner at the point of care
- Competence in communicating scientific information in an understandable manner to patients and caregivers, accounting for their level of health literacy and cultural factors that influence effective communication
- Skill in recognizing when SDM should occur and incorporating it within time-limited patient assessments

When the HCP is effective in engaging the patient in SDM, the patient is provided with the support needed to make the best individualized care preference decisions, while allowing the HCP to feel self-confident in the care prescribed. A lack of patient engagement in decision-making is often attributable to the HCP's knowledge and practice gaps. These gaps may include insufficient knowledge or resources to help patients understand the comparative effectiveness of available therapies; a lack of outcomes expectancy; and inadequate sources of motivation, such as reimbursement to expend the time necessary to conduct SDM.[6,7] However, patient-related factors may also undermine the goals of SDM. For example, effective SDM may not occur for patients who are visually or audibly impaired, those for whom English is a second language, or those with low literacy. For some patients, values, beliefs, religious preferences, and cultural traditions may pose barriers to participating in SDM. Other patients may avoid SDM because they are experiencing information overload or denial about their health.[6,7]

Assessing Quality Measures for Patient Engagement and Experiences

As current health policy and even reimbursement models dictate a rapid move toward patient engagement, many educational gaps among HCPs and patients become evident. Health care reform is defining an unchartered

landscape for a value-reward system, and quality is the prize. Transparency, accountability, and performance must be quantifiable, and the Centers for Medicare & Medicaid Services (CMS) have been a dominant force for incentivizing HCPs and systems in this movement. Medicare Advantage (MA) plans have been impacted by the CMS Five-Star Quality Rating System since the ACA promulgated change in 2010.[8] Under the "Star" system, MA plans receive bonuses for favorable quality ratings or penalties for falling short of benchmarks. A number of criteria, including patient engagement, are utilized to measure the quality of care delivered by HCPs in the MA networks. As a result, MA plans have been working hard to engage patients and measure their satisfaction with their HCPs and their health care coverage. Additionally, more than 90% of health plans in the United States use NCQA-endorsed HEDIS measures to assess their performance in managing health care delivery, providing benchmarks for comparing important dimensions of health care, and thereby promoting best practices for quality outcomes and patient safety.[9]

Quality measures are also being assessed at the HCP level; these measures include patient engagement and care coordination, as well as clinical, functional, and safety outcomes. Under the CMS Physician Quality Reporting System (PQRS), primary care and specialty HCPs are documenting and reporting multiple patient benchmarks tied to reimbursement.[10] The PQRS program uses a combination of incentive payments and payment adjustments, or penalties, to encourage eligible professionals to report quality measures.

Patient communication, engagement, and experiences are also being measured through quality benchmarking in accountable care organizations (ACOs) and patient-centered medical homes (PCMHs) under pilot programs by CMS as well as accreditation standards set by NCQA and URAC. The 2014-2015 Medicare Shared Savings Program requires ACOs to report 33 quality measures, 6 of which assess the patient/caregiver experience.[11] As a result of these requirements, health insurers and HCPs contracted with health plans are under additional scrutiny to measure and improve the quality of care rendered to patients, including patient engagement and the overall patient experience. As CMS moves forward in addressing gaps tied to quality measures, it is likely that more specific measures will be developed to enhance patient engagement and QI at the point of care delivery.

2014-2015 Medicare Shared Savings Program: ACO Quality Measures for Patient/Caregiver Experience

1. Getting Timely Care, Appointments, and Information
2. How Well Your Doctors Communicate
3. Patients' Rating of Doctor
4. Access to Specialists
5. Health Promotion and Education
6. Shared Decision-Making

The Role of Continuing Education to Advance Quality for Providers and Patients

The role of CE in the quest for QI in health care delivery is currently being explored, and new models have emerged in the CE community. As CE organizations, supporters, and professional organizations identify new methodologies, the need also exists to design education that can be unilaterally provided for HCPs and their patients, customized to the unique needs of each group. Through tandem educational designs, effective education can integrate patients and caregivers in treatment decision-making with their HCPs to offer a better pathway for improved patient health, more efficient care, and better population health.[12] What does this mean for a CE organization or supporter? It means re-thinking patient education so that the focus is not a one-way clinician-to-patient transfer of knowledge, but a new two-way learning paradigm between the clinician and the patient. It means recognizing that patient engagement and learning should be part of a QI educational program design whenever possible. A CE organization's mission statement should reflect patient

engagement and learning, integrating these goals with the involvement of the interprofessional team as strategies are developed to measure success.

The Alliance for Continuing Education in the Health Professions (ACEhp) is creating a quality improvement education (QIE) roadmap to assist CE professionals and stakeholders in developing strategies for transforming the US health care system through quality-focused education.[13]

"The Alliance continues to respond to the changing external environment in regards to the professional development of health professionals," commented Lou Diamond, MD, Chair of the Alliance QIE Advisory Panel and Roadmap Report. "The current effort focuses on integrating educational tools and techniques, as well as education professionals and resources, into a QI intervention known as the *change package*. Education professionals are integral members of the QI team."

According to Dr. Diamond, a draft of the QIE Roadmap Report will be released at the Alliance Quality Symposium (Baltimore, MD, September 23-25, 2014). The core of the report will focus on 10 QIE domains with recommendations for action and next steps. The report will also feature case studies, utilizing SQUIRE, a tool for describing the rationale, methods, and outcomes of QI projects in which education has been an integral component of the change package.

Within and external to the CE enterprise, educational tools, resources, and processes are being developed to assist HCPs in meeting their required reporting measures. These include, but are not limited to, decision support tools to align with specific quality measures, as well as communication tools to assist with patient engagement and learning.

Patients will need training in how to communicate effectively with their providers and how to advocate for their right to be informed decision-makers in their care. They will need new knowledge to interpret treatment information and to consider treatment options in order to make effective decisions about their ongoing care. HCPs will need support in developing the necessary skills to communicate complex information in an understandable and time-efficient manner with diverse patient populations. HCPs will need education to assist them in addressing various aspects of patients' functional status and safety issues, as well as socioeconomic considerations that may pose barriers to treatment adherence. HCPs will also need guidance in when and how to identify and discuss resource management needs for patients and patient referrals as part of care coordination and effective transitions of care.

Becoming Avid Learners of Quality Improvement

Health care educators need to recognize that in order to address quality in education, we should practice QI in our organizations. In order to practice QI, we need to have competence in QI. In order to have competence in QI, we need to become avid learners of QI. Each CE organization's journey toward competence will require a unique approach that is consistent with its mission, vision, and the consumers it serves. If an organization provides education for both HCPs and patients, it will need to identify and align national QI measures with its educational strategies, with a goal to improve HCP performance and patient care outcomes. If an organization provides education within a closed system, it will need to identify and align systems-level quality outcomes that can fill system gaps. Essentially, health care educators will need to become learners of quality.

Before an organization can transform its culture to successfully embrace QI, staff must be trained. Every member of the CE team needs to understand what QI is, what role it plays in the current health care environment, and how it can be applied within the CE framework. There are many resources and methods available to assist organizations in training their

staff regarding QI. Methods include failure modes and effects analysis, Plan-Do-Study-Act protocols, Lean Six Sigma, and root cause analysis, all of which have been used to improve the quality and safety of health care.[14] Fundamentally, training should begin with an understanding of the current health care environment and the integral changes impacting HCPs, systems, communities, and patients. Thereafter, staff members need to understand the tenets of QI impacting different groups of HCPs and sectors of health care.

Once a culture of quality has been established through top-down and bottom-up buy-in, it must be cultivated to protect its foothold. As with any worthwhile cause, QI takes sustained commitment and effort, which can easily be dismissed by a management team that is time-strapped or burdened by old habits. Some of the most common current strategies utilized by health care organizations include those mandated by URAC for quality accreditation:[15]

- Seeking accreditation in quality, which requires a system-wide approach to continuous QI
- Allocating resources for internal organizational stewards, such as a quality management committee and a director of quality
- Implementing standard operating procedures that promote a commitment to ongoing QI projects and processes within each department or division
- Establishing mechanisms to harvest, track, and measure customer service, accuracy of marketing, transparency, and accountability in the delivery of products and services
- Creating quality indicators to guide the organization's leadership, management, and decision-making

By developing strategies and competencies in quality, CE professionals are in the best position to effectively educate others.

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Second, patients' needs and preferences are often ignored in the care process given the limited time providers have to address complex problems facing many patients. Third, many providers lack the skill and ability to enable patients to become better stewards of their own care while supporting them with patient-centered care.

The need to engage patients has been well documented in the literature. As early as 2001, the Institute of Medicine (IOM) outlined in its report *Crossing the Quality Chasm: A New Health System for the 21st Century* reforms to achieve a more patient-centered approach to care delivery.[3] The 2010 passage of the Affordable Care Act (ACA) identifies patient engagement (e.g., shared decision-making) as a critical component to improving care and lowering cost (section 3506).

> *Affordable Care Act Section 3506: The Program to Facilitate Shared Decision-making will establish standards and create educational tools in an effort to make treatment decisions the result of an open communication between patients, patient representatives, and providers regarding available treatment options and the patient's preferences and values.*

Despite the evidence suggesting that engaged and activated patients experience better care at lower costs (value), the medical education community has yet to fully embrace and incorporate these strategies into the learning and education process. Numerous studies have found that engaging patients in their care improves knowledge of health care choices, lowers decisional conflict, reduces the number of patients undecided after counseling, and improves agreement between patient values and health care options chosen.[4] Additional research has demonstrated that engaged patients have lower inappropriate health care utilization and overall lower cost.[5] Engagement also predicts a number of positive health behaviors, such as diet and exercise, compliance with drug regimens, and using quality information.[6]

PRIME has reviewed over 40 standardized tools, scales, and survey inventories for assessing patient engagement as part of our new Patient-Provider Learning Model. Broadly, many of these assessment tools focus on patients' satisfaction with care and their perceptions of care delivery. As a contractor for the Agency for Healthcare Research and Quality (AHRQ) and other quality-centric federal agencies focused on patient-centered care, PRIME has adopted the framework set forth by the National eHealth Collaborative, a project sponsored by the Healthcare Information and Management Systems Society (HIMSS).[7] Designed with the goal to improve patients' understanding of their health and related conditions so they take a more active role in their health care, the framework comprises various stages of engagement which align with CMS Meaningful Use Stages. Our adaptation of the HIMSS framework focuses on the 4 stages of engagement outlined in Figure 1.

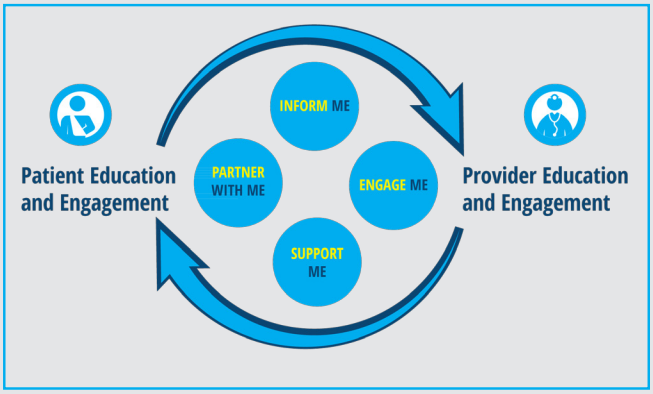

Figure 1. PRIME's Patient-Provider Learning Model

Within the PRIME Patient-Provider Learning Model, our approach to meaningful measurement is facilitated by independent yet tethered patient and provider surveys. For example, through a HIPAA-compliant patient portal at www.AfterMD.com, we are able to obtain, harvest, and analyze patient surveys grouped by health care provider in order to give personalized feedback to providers about their patients' clinical experiences, including how patients rate their provider's skills in the C's: counseling, communication, and coordination. We also survey providers to compare their perceptions and beliefs with those of their patients.

This feedback enables providers to benchmark their patient engagement skills and set personalized goals through our targeted educational interventions.

Through our iQCE™ model, PRIME has once again taken a lead role in the CE enterprise by adopting and adapting established, evidence-based definitions, taxonomies, and incorporation of patient-provider learning methodology and frameworks to incorporate patient and provider tethered education into quality improvement and IPCP educational programs.

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Kathleen Moreo has led the organization through 20 years of educational excellence. Ten years ago, she pioneered systems-based CE quality improvement educational programs tied to national performance measures.
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Lynn Goldenberg has a 15-year tenure integrating clinical competencies, accreditation, and certification domains within PRIME's education model and has been instrumental in aligning patient learning strategies.
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Other Key PRIME® Personnel Driving Our Change Package in Quality and Patient-Provider Learning

Tamar Sapir, PhD—Director of Scientific Affairs
Dr. Sapir is responsible for leading a team of master's- and doctoral-level writers, editors, and outcomes analysts. In addition, she serves as liaison to external expert faculty in designing, implementing, and analyzing integrated quality of care educational (iQCE™) programs for individual providers, health care teams, systems, and communities.
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