COMMENTARY

It’s Time to Dismantle CE and Build a CPI System

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While well intentioned, most continuing education (CE) programs do not have much impact on patient care.\textsuperscript{1,2} The one-and-done variety – isolated CE lectures where experts talk at people for an hour or two that are not part of a curriculum and have no systematic follow-up – are particularly ineffective. We need to rethink the whole CE enterprise. I am not the only one who thinks so as several commentaries have suggested reforms that, if adopted, could make CE a developmental process rather than a transactional activity.\textsuperscript{3-5}

The report, \textit{Continuing Education in the Health Professions: Improving Healthcare Through Lifelong Learning}, sponsored by the Josiah Macy Jr. Foundation and published more than a decade ago, offered a series of transformative recommendations but change has been far too slow.\textsuperscript{6}

State laws and licensure requirements, unfortunately, reduce CE to quantitative units of activity rather than a qualitative process that is integrated with practice. The purpose of CE in the minds of most health professionals is to accumulate hours rather than change what they do. Ultimately, CE should enhance our individual and collective capacity to do good things – such as improve the quality of care we provide, increase access to care, and reduce the cost of care.\textsuperscript{7} Yet, CE has done little to impact those aims and occasionally has had the opposite effect (eg, promoted the adoption of less than cost-effective tests, procedures, and treatments). What can we do to change CE so that it engenders positive change? There are six interdependent recommendations that could and should be implemented.

First, let’s stop calling it continuing education (CE). The terminology conjures up notions of credit hours and bean counting. Let us call it continuing professional development (CPD) or, better yet, continuous practice improvement (CPI). It is not about transactions or credit hours – it is a process. We need to be more purposeful.

Admittedly, changing the words does not solve the problem – but changing the language will prompt re-examination and help redefine expectations.

Second, let us stop awarding credit for engaging in CE based on hours. This is going to be a hard nut to crack because our entire educational system and its associated business model is centered on credit hours.\textsuperscript{4,8} Time does not necessarily predict outcomes. It can be spent productively or unproductively. Credit hours were initially developed as “standard units” to make faculty workload more equitable and determine who was eligible for a pension.\textsuperscript{9} It was not intended to be a proxy for student learning or competency. So how can we reward productive behavior? Recently the Macy Foundation published a report about competency-based health professional education and abandoning our current time-based system.\textsuperscript{10} A novel approach to outcome-based CPI has been proposed and the American Nursing Credentialing Center recently began a pilot program to award nurses CE credit based on outcomes.\textsuperscript{4,11} The conceptual framework for an outcome-based model awards credit for moving up through five levels of performance. At the lowest level, Level 1, the practitioner is able to articulate the new knowledge and skills needed to address a practice-related problem and formulate a goal. At Level 2, the practitioner is able to document the acquisition of new knowledge (eg, passing a multiple choice test). At Level 3, the application of the new knowledge and skill is demonstrated in an educational setting (eg, a simulation, OSCE, or case-based assessment). At Level 4, the practitioner provides evidence that the new knowledge and skill have been integrated into his/her practice (ie, behavior change). For Level 5, the practitioner documents how the new knowledge and skills resulted in improvements in outcomes (eg, patient health, access to care, or efficiency in care delivery). Under this system, a practitioner is awarded credit for identifying practice-related problems, articulating learning needs, and then taking progressive action toward a meaningful outcome. Learning in an outcome-based model

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could include both individual and team-based practice goals. Documenting progress toward practice-based goals will be foreign to most practitioners, so we would need to provide instruction and create tools to guide them. Ideally, all health professionals would adopt a similar model for documenting CPI and the tools could be commonly shared. A common structure and process for engaging in CPI would provide an economy of scale and (hopefully) reduce the administrative burdens that currently exist.

Third, we need to teach people how to plan their learning. Sure, learning is something all of us are inherently capable of doing without instruction. But most people are not aware of how humans learn. Most think “learning” primarily occurs in lecture halls and is the responsibility of teachers. After all, that’s the predominant model of instruction that people have experienced throughout their lives. Taking responsibility for one’s own learning isn’t something that most people intuitively know how to do.12 We’re talking to our students about self-directed learning in undergraduate and professional degree programs today, but the skills needed to meaningfully engage in CPI are not innate. Indeed, most people are aware they do not do it well.13 With time and practice, people can master the tactics and strategies needed to be lifelong learners.14

Fourth, we should encourage people to engage in CPI activities that include both social interaction and quiet reflection. Learning is both a social phenomenon and a personal experience.15 CPI requires introspection to develop self-awareness, to set goals, to think through things on our own. But it also requires dialog, modeling, and coaching. We need to discuss our understanding of the world with others. Additionally, we learn when others share their understanding with us. There is no substitute for seeing a good performance and receiving feedback regarding our own. These best practice principles are well-known to educators but too often neglected when CE activities are created.

Fifth, we need to provide incentives for people to earnestly engage in the CPI process and for achieving meaningful goals.16 Requiring CE has not achieved the desired end, so making the process mandatory is a tricky problem. We know that intrinsic motivation is more powerful than extrinsic stimuli, but well-designed incentives can encourage change. Incentives – rewards more than punishments – work but only if they are meaningfully aligned with the goal.17 Thus, we should reward people for engaging in a process that aligns with the goals of the triple aim and reward them again when a goal is achieved. The Centers for Medicare & Medicaid Services (CMS) has received comments from numerous professional organizations regarding the provision of financial incentives to physicians for participating in CPI under MACRA (Medicare Access and CHIP Reauthorization Act).18 This would be a positive step if appropriately structured. However, financial incentives are not the best method for promoting complex behavior change – and can actually subvert the desirable outcomes they are intended to produce.16 So employers and professional organizations will need to think creatively about ways to recognize and reward people for engaging in CPI that leads to meaningful change. Moreover, we need incentives that promote individual and collective action.

Lastly, CPI should be embedded into the work people do every day. The idea that we must set aside an hour to attend a lecture, a day for a workshop, or three days to attend a conference to do the work of learning is misguided. Learning is a dose-related phenomenon but like most therapeutic interventions, works best in small increments delivered at regular intervals, rather than big doses administered all at once. A bolus might be needed to get the treatment started, but excessively large doses are either toxic (ie, painful and demotivating) or eliminated (ie, discarded or forgotten). New knowledge, skills, and attitudes need to be reinforced, repeatedly practiced, and reconsidered.19 We need to move toward a distributed learning model.20 Technology and practice-based learning groups can help us integrate CPI into our daily work.21-23

Adopting these recommendations and dismantling the CE enterprise is a tall order. There are too many institutions, regulations, and structures that have been formulated around our current notion of CE. And there are lots of people invested in maintaining the status quo. But if the current system is not delivering health care that is patient-centered, safer, more effective, more equitable, and more efficient, it seems we need to dismantle it and reconstruct it based on what we know works.

REFERENCES


