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Unveiling The "Concept Cars" of Innovative Medical Education Models

Alicia Sutton:
Today we're talking about the factors that can impact our listener's pursuit of lifelong learning. Take quality improvement education, which really is about system improvement and the education behind it. So how might that system approach impact the education that our listeners seek? We're here today to explore this. Welcome to another segment of Lifelong Learning on ReachMD, the channel for medical professionals. I'm your host, Alicia Sutton. With me today is Scott Webber, CEO of MedIQ, an ACCME accredited provider of medical education and also ACPE and CBRN accredited. His company has core expertise in developing quality improvement education and performance improvement education. Welcome, Scott. We're glad you could join us.

Scott Webber:
Thank you, Alicia. Nice to be here.

Alicia Sutton:
Let's take kind of a big global picture of quality improvement and give me your insights on that. What's kind of a big picture for our listeners who clearly they are medical professionals who have to operate and then perform in the field and quality is always a measurement? But what is quality improvement education?

Scott Webber:
I think the 30 thousand foot perspective on this is that from an educator's point of view we never really had the opportunity that we have coming up to truly align certifying continuing medical education along with quality improvement, performance improvement. I think with the Affordable Care Act and the National Quality Standards this is a real opportunity for us to make a difference with certified CME. I think the opportunity is now. I think what we're doing here at this conference and where this trend is going is that we, as CME providers, are really going to need to step up our game and be able to get our arms around how to develop and deliver quality and performance improvement education.

Alicia Sutton:
Quality improvement can mean different things to different people. Some people think ti's education. Some think it's research. Some think it's the system. How do you see it evolving?

Scott Webber:
One of our biggest challenges we have to overcome is the taxonomy, the dictionary, if you will, on all of these terms. So here's really what it is - from a performance improvement standpoint, we look at performance improvement at the individual level. Whether it's a physician or pharmacist or nurse it's an individual performance level. Quality improvement is more of a system or team-based approach so we're trying to deliver training and education that ultimately is going to impact the patient care team and ultimately the practice within the system and certainly the system itself. Where I think we get caught up is there was a lot of discussion early on around what role does CME have at the table here because for whatever reason, I think a lot of folks thought that CME was strictly around knowledge and competency-based type of education. We really didn't have a seat at the table. I think what people are realizing is that innovative design and understanding principles of quality-based education and that this isn't just a webcast or a live symposia or the things that we always do in the knowledge and competency-based environment. Those don't necessarily work in a performance or quality environment.

So, when we're trying to make quality or systems-based change, we've got to go and look at what are the specific barriers that are facing those systems and develop the education from the inside out, not the traditional from the outside, in. I think that's what a lot of providers have to get their arms around and it's going to be necessary, I think, in order for this to be successful.

Alicia Sutton:
On the individual level, which you mentioned, which is more of the inside out, do you think that PICME or performance improvement CME is on the inside, coming out? Is it on the individual level or is that more of a system level?

Scott Webber:
So, the performance improvement models, if you look at the AMA construct in PICME, we all went down that path for the past few years, depending on who you talk to. If you take people's temperatures you'll see people have a lot of different visceral reactions to whether we were successful in that space or not. I think what's important, and I've always said this, is that the AMA PI construct was almost like sort of the cars of the future. You know when you go to a car show in Detroit and they put out the futuristic cars that roll out and you really can't drive that car but there are aspects of it that are really important that you'll be seeing in future designs of new automobiles that are coming off the assembly line. I think the AMA PI construct is just that. It is that concept car and maybe in its full execution of that model there are some challenges with it just because of, I think, its design. But there are specifics that need to be considered, like the self-reflection, self-analysis piece of that experience where a provider is looking at their own data, they're processing, they're writing their own implementation plans of how they're going to improve. Those are the assets that I think of the AMA PI construct that really work at an individual level.

But we have to think about performance improvement at an individual level very differently and get outside of the construct and bring some new ideas of how we affect change at an individual level. We're seeing it all the time, not just in the work that MedIQ does but our colleagues in the space, both the medical education companies, the academic medical centers and the societies where they're figuring out new models to improve performance when they stop and listen to what the physicians, the individuals need and want. If we build this from the outside, because we are "smarter" than the physicians we're going to fail. We have to get at the frontline perspective and hear what the gaps and needs and barriers are. What is preventing change and growth and improvement at the individual level and build it from that vantage point, not from the outside being prescriptive and telling them what they need to do.

Alicia Sutton:
That's excellent. Actually, your analogy of the car show make total sense because you're right. The AMA construct did provide the platform the individual physician or clinician to take a look at what he or she was doing in practice and you could get data from it. Now we're going to be looking at it from the system. So, what do you think some of those data sources are at this point on the system side?

Scott Webber:
We hear a lot, obviously, about EMRs and we hear a lot about claims and data and registries and so I think all of that is very, very important. I think when you look at the individual performance what we have found at both an individual performance level and even at a system level is that any change that can be made is not sustainable over a period of time if it's not done in within a culture of quality. What I mean by that is individual physicians can change performance and make significant clinical gains in whatever specific measures are being tested out. But if the practice is not a practice that has a culture of quality or if the system itself from the C suites is not advocating and pushing quality throughout the organization, all of those gains fall off because there's nothing there to sustain it. So, as educators in this space, we've got to make certain that we're not only looking at clinical performance measures, the national quality standards as measures but we have to look at the culture of communication and how the teams are interacting in order for any changes that we make to actually stick and be sustainable over time.

Alicia Sutton:
If you're just joining us, you're listening to ReachMD, the channel for medical professionals. I'm Alicia Sutton and I'm speaking with Scott Webber from MedIQ. We're talking about quality improvement education. Scott, where do you see some changes that our listeners could put in place? Let me say, obviously the listeners are clinicians so therefore they are always on the lifelong pursuit of education, but they're also educators themselves in their practices, whether it's a small practice or a large, an ACO, a system. How could those who don't have QI initiatives in place now start to influence the education that they are working on to bring QI in, particularly if they don't have a QI department?

Scott Webber:
I think the challenge at the provider level and at the system level is getting quality and performance as a priority. It's not to say that physicians are not treating patients without thinking about quality. It's the incentives, the carrots and the sticks around performance and quality are just now coming online. That's what I was saying earlier. There's this alignment that the education that we've been delivering over the past five years, the reason that it's been challenging in the performance and quality environment and getting the participation is there have been no incentives or carrots and sticks in place for it to matter. So, at an individual clinician level and even at a system level they have so many priorities getting them to want to focus on this as a single priority can be very difficult.

Now with the Affordable Care Act and lots of other external forces taking place, it's now becoming a priority. What we have to do, our

responsibility is to be able to respond and have the tools and resources and the education available for them to make that change.

Alicia Sutton:
Do you think lifelong learning in the construct of QI is going to be a much more collaborative process with all the stakeholders? Or do you think there's a stakeholder group that might stand out and kind of lead the pack?

Scott Webber:
That's a great question and it's something I'm really passionate about because for years we talked about how the CME enterprise, all the stakeholders need to find better ways to collaborate. You remember these conversations. We would hear great success stories and then we would hear the horror stories. Now I think we've learned how to work through the chemistry with the right collaboration and bringing partners together that have certain assets and expertise that others don't have. It's never been more critical because as an education provider, we only have so many tools and resources at our disposal. We have to partner with those who have the system. We have to partner with those who have the technology. We have to partner with those who truly understand how to develop and deliver performance and quality-based training and education. I don't think that there's any one group or segment of a CME enterprise that's going to stand out ahead of anyone else. This is the time for collaboration. So, a lot of the work that we're doing, as we're bringing our expertise into relationships with the academic medical center community and specialty societies because they have the access, they have the data through registries and their own internal EMR platforms and we're bringing the resources to help make the changes that are necessary from a QI or PI point of view.

So, it's never been more important than it is right now. I think it's critical to the success, moving forward, that we were able to collaborate.

Alicia Sutton:
I think that's a very valid point. Collaboration has changed over the years. There has been at least one stakeholder that's been missing, I think, for a while. You probably would agree that the patient as the stakeholder in influencing how education is put together has been kind of a silent but much more growing voice. Do you see that more these days?

Scott Webber:
I'm about to jump out of the radio right now because here's the thing. At CBI I did a presentation on why we matter in the CME community. I said can you imagine if we started every meeting where we got together and instead of opening remarks we had physicians and pharmacists and nurses and patients up front telling us why we matter. Not me telling you why we matter but let's have patients who are being treated by physicians, who are participating in the activities that we develop and deliver and talk about their experience with their healthcare provider and their experience as a caregiver taking care of their family.

We say that patients are our priority, yet we've not been able to bring them to the forefront. I give the industry, I give the enterprise a lot of credit. We're starting to see now where patients are part of faculty, which is something that we're really proud of at MedIQ. Integrating the patient voice into education, making them part of faculty so that when an activity is delivered to a room full of healthcare providers immediately activated from an emotional point of view they're plugged in and everything that comes after they're going to absorb and be able to apply when you bring the patient into the room versus a panel of faculty of like-minded physicians that are all talking about the same thing. Patients make the difference. We're not there yet but I think we're moving down that path. When it comes to quality and performance improvement, I think it's critical now more than ever that they are the focus point. I say to everybody when you're developing education, put a picture of your family on your desk because they're patients and think about them as you're developing your education. How do you want them to be treated by the provider? Develop the education with that person in mind and you can't go wrong. They're the end customer, if you will, of everything that we're doing.

Alicia Sutton:
Very valid point. Absolutely, because it does focus on the patient who's been the recipient of healthcare and turns them into the influencers of good healthcare education.

Scott Webber:
Alicia, the other point around this is, as somebody passionate about our industry and the work that we do because I know we make a difference, I see our data, I see other organization's datasets. We're making a difference. But if you get outside of the CME enterprise, most people don't know what we do. We always joke around. Have you ever tried to tell somebody what you do for a living? The moment that we figure out that if we can advocate to the patients what we do and we get them to understand and then ultimately become our advocates I think the whole concept of why we matter takes on brand new meaning. I think it's then believable that this enterprise is truly going to be able to make a difference with quality and performance improvement education.

Alicia Sutton:
Scott, thank you. Thank you for your insights today. You've been very, very generous with giving us some great things to think about

with quality improvement. This is Lifelong Learning on ReachMD. I'm Alicia Sutton and you've been listening to Scott Webber as we talked about QI, quality improvement education. Thank you for joining us.