

# Physician Performance Improvement Continuing Medical Education: New Tools for Compliance and Quality

It Is Time to Align and Make Sure All Parts Are Working Toward Improved Quality of Care

**W**ait a minute! Did that title put continuing medical education (CME), physician, performance improvement (PI), compliance, and quality all in the same line? Yes, it did.

Over the last year, this column has challenged compliance officers to think outside the compliance “box” and incorporate elements of risk management and reduction, quality improvement, and regulatory compliance in a combined multidisciplinary approach. It is clear that pay for performance (P4P), value-based reimbursement, and Office of Inspector General (OIG) investigations are focusing compliance into a discipline that must include quality of care components and not simply accuracy in complying with reimbursement and regulatory guidelines.

Recent developments in the field of CME accreditation may place new quality tools in the hands of compliance officers. A compliance program that grasps these opportunities can improve effectiveness at the individual physician level while enhancing understanding of quality issues and improving performance in quality of care. These steps could lead to improvements in patient outcomes as well.

## **MOTIVATION THROUGH (CONTINUING MEDICAL) EDUCATION**

To many compliance officers, CME is a world apart. Conventional thinking places CME in a totally clinical setting. Using this thought process, CME programs typically are geared toward thorny medical problems like diagnosing pulmonary embolism, for example. Not exactly a place compliance programs typically touch.



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New changes in the way CME is structured and credit is awarded have opened a door of opportunity to organizations that want to impact quality and compliance through physician education.

Physicians are motivated to complete CME programs to maintain (a) a medical license issued by a State Board of Medical Examiners, or (b) a board certification. In some cases, hospitals, health systems, academic health centers, or even professional liability insurance companies may require completion of CME programs to fulfill annual requirements for medical staff membership or insurance renewal.

Accepted CME programs are accredited by the American Council on Continuing Medical Education (ACCME), through direct or joint sponsorships that involve an organization that holds ACCME accreditation (e.g., most academic medical centers are ACCME accredited and can issue credits for completion of CME programs). Credits may be recognized by the American Medical Association (AMA) Physician Recognition Award (PRA) system or the American Osteopathic Association (AOA) as meeting requirements for license. State Boards of Medical Examiners typically accept these credits, although each state board has the ability to determine the number and level of credits needed for re-licensure.

The most widely accepted level of credit is an AMA/PRA Category One Credit™ as approved by ACCME. The Category One Credit™ is a gold standard for CME accreditation. Most State Boards of Medical Examiners require a certain number of Category One Credits™ and a few require that all credits used for license renewal meet this standard.

Recent developments in the CME world are leading accredited sponsors and organizations that develop and distribute CME to a new set of goals for education. For the past 50 years, CME was a didactic learning experience. The value of this educational process has been questioned widely by medical, academic, and government regulation communities.<sup>1</sup>

In 2002, the American Academy of Family Practice (AAFP) introduced evidence-based learning CME as a new CME process. The concept took root, and by 2007, five national performance improvement CME programs were in place.<sup>2</sup> Most medical schools have now implemented PI CME programs as well. In addition, the Physician Consortium for Performance Improvement and the National Committee for Quality Assurance (NCQA) have developed dozens of disease state specific performance improvement measures.

### **THE COMPLIANCE CONNECTION**

So how does PI CME connect with compliance? One answer may lie in working with physicians to accomplish quality improvement tasks that combine clinical improvement and medical records review, for example. These programs also may qualify as P4P measures that can be used by hospitals and physicians to earn additional payments based on quality improvement data. In *Compliance Today* from January 2009, Janice Anderson, Richard Rifenburg, and Anil Shankar record the Department of Health and Human Services (HHS) Office of Inspector General (OIG) Advisory Opinion 08-16, which approved a hospital program that includes approval of a quality enhancement professional services agreement between a hospital and a physician-owned professional limited liability corporation (PLLC).<sup>3</sup>

Readers are cautioned that any OIG advisory opinion covers only a particular arrangement between the parties requesting the opinion. Hospitals, however, can learn from this arrangement how to better connect and work with physicians to improve quality of patient care. Physicians can share in the economic benefit of increased P4P-based value-based purchasing (VBP).

VBP is the new reimbursement methodology adopted by the Centers for Medicare & Medicaid Services (CMS) and considered by Congress through the Quality FIRST Act of 2008 (HR 7067, 9/25/2007, introduced

by Jason Altmire, D-Pennsylvania). The Act will allow hospitals to receive quality payments based on four specific currently reported conditions — (1) acute myocardial infarction (acute MI), (2) heart failure, (3) pneumonia, and (4) surgical care improvement/infection prevention.

Hospitals with positive performance in these clinical measures can receive 0.5 percent of Medicare payments, with gradual increases to a full 2 percent of Medicare payments. Data generated after October 2009 can be used for the 2010 reporting period, and payments will be received in 2011 by participating hospitals.

### **ENFORCING QUALITY**

Enforcement of poor quality of care and unnecessary procedures is already a fact in OIG investigations. Multimillion dollar settlements have been reached with investigators, as in the case of *US vs Rogan* (459 F. Supp. 2d 692, N.D. Ill., 2006). A review of the 2009 OIG work plan reveals that review of hospital quality reporting measures and payments made for “never events” will be a prime focus of OIG activity.

Hospitals face the need to monitor and improve quality of care. That improvement is virtually impossible without the alignment and participation of hospital physicians. Doctors are the ultimate patient quality of care advocates; empathy for patients is a core part of their profession and forms the basis for their career. By identifying ways to touch quality, hospitals can partner with physicians, meet the requirements of VBP, and address OIG investigation concerns.

### **TYING IT ALL TOGETHER**

Measuring clinical performance typically requires a retrospective analysis of quality improvement — generally accomplished through a review of patient medical records. PI CME requires a retrospective analysis of quality improvement — readily accomplished through a review of patient medical records. “PI CME programs give health care an opportunity to legitimately

award greatly increased ACCME Category One Credits™ to physicians participating in a structured program. In addition, the program could meet requirements of P4P and VBP needed to gain increased Medicare reimbursement,” said Chris King, executive director of the not-for-profit Physician Performance Improvement Institute (PPII).<sup>4</sup> “PPII develops structured PI activities that may qualify for ACCME accreditation.”

In PI CME, the learner is expected to complete specific PI activities in addition to a didactic learning program. The combination is designed to identify, record, and improve adherence to specific quality standards in patient care. By 2010, ACCME and AMA hope to convince state boards to require PI CME as opposed to simple current day didactic CME when approving medical license. This represents a major shift toward measuring quality improvement in physician performance.

To encourage physicians to complete PI CME programs, ACCME is willing to allow a greater number of credits for these efforts than could be earned through a didactic learning experience. For example, completing a didactic hour of study coupled with periodic reviews of medical record documentation may be approved for a package of as many as 20 credits. A physician can earn 20 hours of credit for what is projected to be approximately 5 hours of detailed effort, as opposed to 20 hours of credit for 20 hours of didactic learning.

The AMA Council on Medical Learning has issued a specific set of rules governing how these PI CME programs should be structured.<sup>5</sup> Doctors who feel pressed for time can envision a more efficient way to earn their CME credits. Hospitals interested in VBP reimbursement can envision a way to legitimately award physicians with increased CME credits if they establish a valid PI CME program.

### **WIIFM ANALYSIS**

Many readers who are compliance officers may now be thinking of the WIIFM (What's

In It For Me) analysis. From a compliance program standard, the answer is simple. PI CME gives your program the opportunity to award physicians CME hours for activities like quality review of medical records geared toward identifying specific instances of compliance and VBP.

From a health care organization perspective, PI CME gives your existing CME program the opportunity to focus on specific VBP episodes of care and defined, approved clinical indicators of quality. From the physician perspective, PI CME offers the opportunity to earn the credits needed for license or certification with fewer hours of effort, studying a more interesting set of outcomes — usually their own treatment of patients. PI CME is a win-win-win for all parties involved and can be a valuable part of the VBP and P4P reimbursement program.

### **STRUCTURING A PI CME AND COMPLIANCE MONITORING PROGRAM**

Setting up a PI CME program that contributes to improved compliance is both the easy and difficult part of the equation. It is easy because there is such a direct need and because so many organizations (AMA, ACCME, state boards) are encouraging (and mandating) participation. It is difficult because this type of program will require both CME writers and compliance officers to again “think outside the box.”

Setting up an effective PI CME program may require advice from experts. Combining it with VBP performance measures will require additional analysis of information such as that contained in OIG Advisory Opinion 08-16. As Anderson, Rifenburg, and Shankar note in *Compliance Today*:

The advent of P4P as a dominant trend in health care reimbursement makes alignment with physicians a business necessity for hospitals.<sup>6</sup>

### **TIME TO ALIGN**

It is time to align. Quality, compliance, continuing medical education, and VBP reimbursement are all parts of the move toward focusing on improved quality of care.

### **Endnotes:**

1. American Medical Association (AMA), AMA CPPD Report, Winter 2007, No. 21.
2. AMA, AMA CPPD Report, Spring 2007, No. 22.
3. Anderson, J., Rifenburg, R., Shankar, A., “OIG Issues Green Light to Hospital Pay for Quality Arrangement,” *Health Care Compliance Association, Compliance Today*, Vol. 11, Number 1, Jan. 2009.
4. Interview, not-for-profit Physician Performance Improvement Institute (PPII), Tucson, Arizona, Chris King, executive director. Mr. King can be reached at [cking@ppiinst.org](mailto:cking@ppiinst.org) or by phone at 520/818-3037.
5. AMA, [www.ahme.org/councils/ccme/AMA\\_PRA\\_Rules.pdf](http://www.ahme.org/councils/ccme/AMA_PRA_Rules.pdf).
6. Anderson, *supra* n. 3 t 6.

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