

Aligning continuing professional development with quality improvement

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Traditional continuing professional development (CPD) activities may increase physicians' knowledge, but usually fall short of the goal of changing clinical practice, let alone improving patient outcomes.¹ The Future of Medical Education in Canada recently called for a new approach to CPD to support practice improvement and improve the health of Canadians.² This new approach calls for a shift from passive learning, typified by attending lectures, to more active learning that engages physicians in processes of quality improvement (QI), such as measuring practice metrics, comparing these to benchmarks and developing measurable improvement plans, as appropriate. However, many physicians have not embraced QI in practice because of barriers that include a lack of interest, dedicated time, incentives and proficiency in QI methods, or the absence of relevant clinical data.³⁻⁶ We discuss how this is likely to change, given new incentives created by certification, professional regulation and system alignment with QI activities.

The Royal College of Physicians and Surgeons of Canada (RCPSC) requirements for maintenance of certification include a practice assessment with peer feedback or a comparison to benchmarks, a process associated with changes in physician practice patterns and improvement in patient outcomes.⁷ This assessment is known as "Section 3." The RCPSC provides incentives by giving specialists 3 hours of credit toward their maintenance of certification for every 1 hour spent participating in Section 3 activities. Many specialists may already be participating in QI work that qualifies for Section 3 credits. For example, about 150 Canadian hospitals are participating in a national QI effort that was recently launched to reduce the use of inappropriate red blood cell transfusions.⁸ This program engages multiple specialists, including surgeons, internists, hematologists, anesthesiologists and transfusion medicine physicians, in auditing and monitoring transfusion rates, comparing them with national benchmarks of appropriate use and making changes in their hospitals' transfusion practices. This QI work can count toward Section 3 credit.

Similarly, the College of Family Physicians of Canada (CFPC) requires family physicians to participate in the Mainpro+ CPD program.⁹ The CFPC is developing a "Professional Learning Plan" to encourage family physicians to measure their performance,

KEY POINTS

- Continuing professional development that incorporates quality improvement is likely more effective than passive learning approaches in changing clinical practice and improving patient outcomes.
- Quality improvement activities that physicians are doing presently may qualify for new regulatory requirements.
- Health care organizations, including hospitals and family medicine practices, are increasingly required to report on quality metrics, and physician leadership is critical to these efforts.

self-reflect and make changes to improve their practices. For example, family physicians can audit aspects of their practices, like antibiotic or opioid prescribing, and make changes to improve patient care. Although physicians should ideally compare practices to benchmarks or peers, this is not always feasible given the lack of readily available data.

Provincial regulators are moving in the same direction by replacing random peer audits, which likely lead to minimal practice change, with requirements that engage physicians in QI in their own practice. For example, the College of Physicians and Surgeons of Ontario (CPSO) replaced their peer audit program with a new program that allows physicians to count their contributions to hospital QI efforts toward CPSO requirements.¹⁰ In this program, hospitals submit evidence of improvement activities and certify to the CPSO that specific physicians were involved. A similar CPSO program is available for individual physicians working in community settings. Regulators in other provinces are designing comparable assessment programs as a requirement for licensure.

New funding agreements between provincial governments and health care organizations are also increasingly linked to quality benchmarks. For example, Alberta's primary care networks have funding linked to assessing primary care health quality indicators, including waiting times for appointments, achievement of screening and prevention practice standards and other selected metrics of quality (e.g., opioid prescribing).¹¹ In some provinces, hospitals are required to report on measures of quality, such as patient-reported

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Box 1: Examples of quality improvement activities that could count as continuing professional development

Family physicians

Audit charts on a topic of interest and reflect on opportunities for improvement, either individually or with colleagues

Complete an online self-assessment tool (e.g., UBC eCoach)

Reflect on EMR-generated practice reports that compare quality of care outcomes of the clinic with those of other comparable clinics

Review the results of patient experience surveys administered by the clinic

Implement toolkits designed for QI in primary care (e.g. Choosing Wisely Canada tools for deprescribing medications)

Attend a CPD program focused on QI methods

Hospital-based specialists

Review data requested from (or made available by) hospital decision supports to identify improvement opportunities

Attend morbidity and mortality rounds and participate in a patient safety incident review

Review performance reports that compare institutional patient outcomes to those of other hospitals (e.g., American College of Surgeons NSQIP program)

Reflect on the results of patient experience reports from a hospital unit

Contribute to an institutional QI initiative as a member of a multidisciplinary team

Attend a CPD program focused on QI methods

Note: CPD = continuing professional development, EMR = electronic medical record, NSQIP = National Surgical Quality Improvement Program, QI = quality improvement, UBC = University of British Columbia.

outcomes after hip and knee surgery.¹² These systems approaches can be successful only with engaged physicians providing leadership and establishing performance metrics that are based in evidence, clinically relevant and acceptable to peers.

This evolving picture of physician participation in QI has unresolved questions and challenges. Quality improvement is often multidisciplinary, yet accreditors measure individual physician performance. Physicians may need more training and support to conduct QI in their practices. In hospital settings, administrators are well positioned to provide physicians with data and support for QI efforts, but this support is often lacking in primary care settings. Data to measure performance are ideally generated automatically by the electronic medical record, but in the absence of such systems, simple chart audits may be useful. Furthermore, data comparing physicians with peers or benchmarks are not always available.

In this new alignment of CPD and QI, many opportunities exist in both ambulatory and hospital-based practice settings for physicians to benefit (Box 1), allowing them to simultaneously improve the care of their patients and count these efforts toward their own accreditation or regulatory requirements. Although challenges remain, the shared vision of certifying and regulatory bodies for CPD and QI is creating incentives for meaningful physician engagement in QI activities.

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