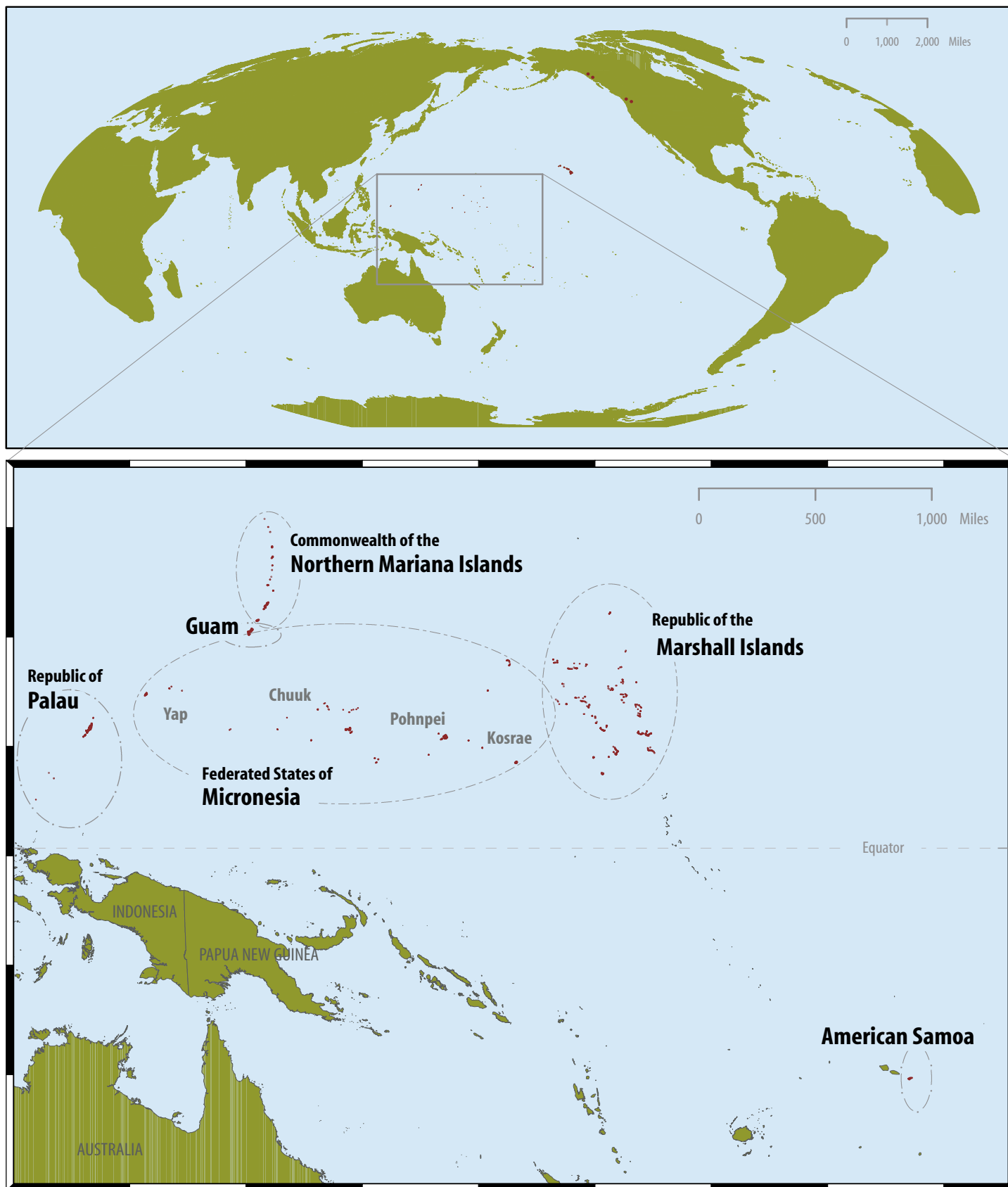


hours of contact. But before it could embark on this work, the PICCEP team invested a year in studying the

region's health care system and workforce and identifying needs and resources.



Cartography: Catherine Veninga

PICCEP Sites

THE PICCEP TEAM

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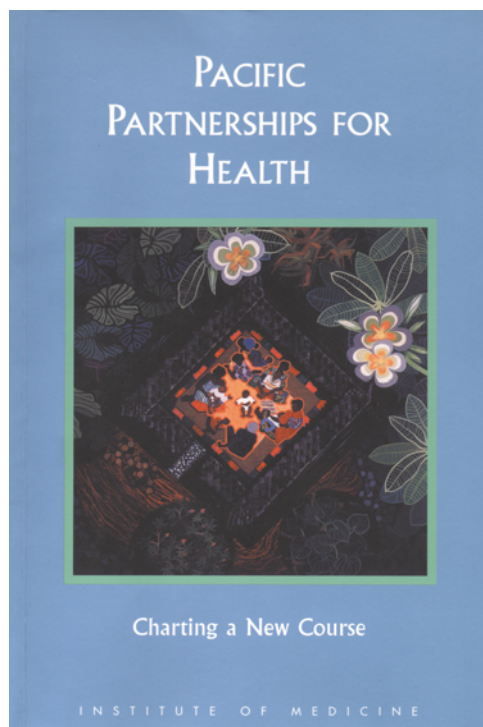
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Building the Foundation

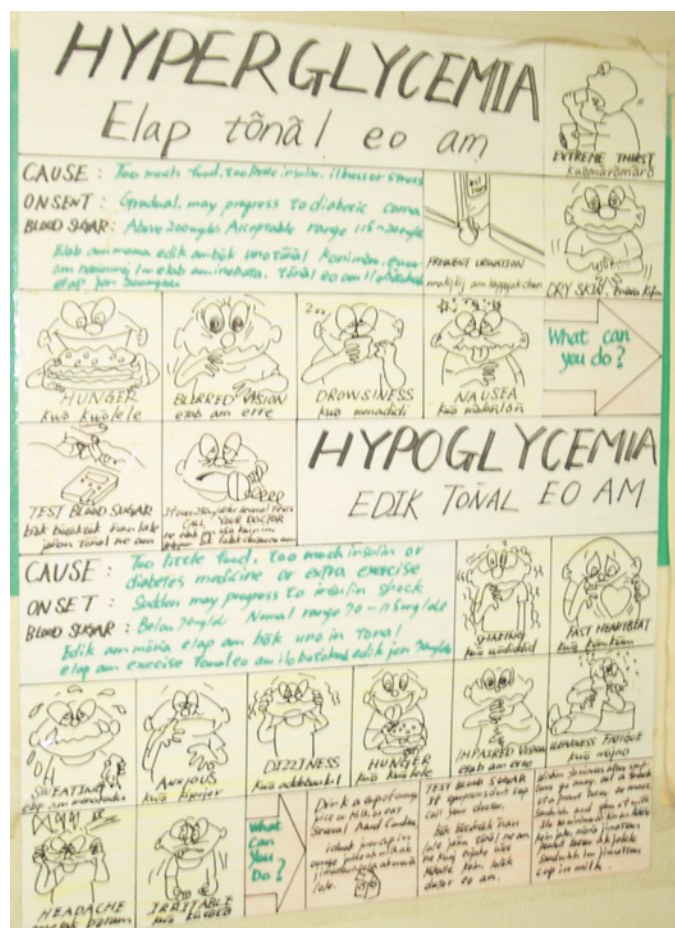
In *Pacific Partnerships for Health: Charting a New Course*, the IOM described a region with health problems typical of both the developing world (malnutrition, cholera) and the developed world (heart disease, cancer). In addition to “incredible population growth” since World War II (now tempered by out-migration), the islands have undergone a wrenching shift from subsistence island economies based on communal farming and fishing to modern cash economies—a transition that has caused radical changes in the population’s culture, family life, health practice, and health status—as well as dependence on foreign aid. More than 40 federal agencies, along with several international agencies, non-



profit organizations, and religiously affiliated groups are involved in the region, and by the late 1990s, the U.S. Department of Health and Human Services alone was providing about \$70 million a year to the jurisdictions’ health care systems, most of it invested in the flag territories. Nonetheless, in general the islands’ health status compared unfavorably with that of the mainland United States as measured by such indicators as life expectancy, infant mortality, oral health, and prevalence of diseases including diabetes, cancer, tuberculosis, and nutrition-related preventable diseases.

Responding to these needs, the IOM reported, was a workforce of some 3,100 physicians, nurses, dental professionals, mid-level practitioners, health assistants, and allied health workers. This workforce reflects large numbers of expatriate clinicians working on contracts, an inadequate ratio of dentists and other dental clinicians to total population through much of the region, a widespread nursing shortage, and disproportionate investment (as much as a fourth of some island health budgets) in off-island patient referrals. Centralized hospitals—many of which have deteriorating capital plants and shortages of essential supplies—were the primary venue for health services delivery. This was a legacy of the 1950s, when the U.S. Navy set up field hospitals in each state, and a rebuilding program conducted during the 1970s and ‘80s. All of these factors made as formidable challenge of the IOM’s recommendation to improve “prevention and primary care and...population-based public health care in the region.”

With funding from the HRSA Bureau of Health Professions and the Bureau of Primary Health Care, PICCEP convened a study team in September 1999 to begin developing a sustainable CCE program for health professionals. The team compiled available written materials on the region, contacted other programs providing health-related services in the region, and made at least one site visit to each of the jurisdictions,



Poster in Majuro Hospital, Republic of the Marshall Islands

including the four FSM states, during September 1999–September 2000 as part of its initial needs assessment. During this period, team members also attended meetings of the regional medical, dental, and nursing associations to discuss the region’s health workforce training needs. They began to build collaborative relationships with hospital administrators and staff, clinic and public health providers, policy makers, and patients—a process continued throughout PICCEP’s four years duration to collect information about needs, resources, and current training options.

The PICCEP team communicated insights from these visits and solicited expertise from health system representatives from the region at a meeting on Guam during July 20–21, 2000. Participants included more than 30 representatives from clinical training institutions, provider professional organizations, and other health policy leaders from the region. Among the health organizations identified as “sources of strength” in the region were the Western Pacific Health Nets (telehealth system), the Pacific Basin Medical Association, the Pacific Islands Health Officers Association, the American Pacific Nurse Leaders Council, and the Micronesia Medical Council. Participants shared their experiences with local CME and identified characteristics of successful programs and barriers to success (see next column).²



PICCEP planning meeting participants, Guam, 2000

CHARACTERISTICS OF SUCCESSFUL CCE PROGRAMS

- Positive incentives: financial (promotion), release time/coverage to attend sessions, etc.
- CCE requirement for re-licensure or certification
- Local determination of priorities
- Available resources for local coordination of the CCE
- Courses facilitated by the learners themselves, relevant to their expertise, local conditions and resources
- Courses built on those already in progress
- Culture of life-long learning
- Effective teaching methods
- Courses that are scheduled and structured (e.g. weekly rounds)
- Lectures that involve both local and distant/visiting consultants
- Support from administration
- Modular, to achieve a further qualification

BARRIERS TO SUCCESSFUL CCE PROGRAMS

- Lack of resources
- Lecture-only format
- Clinical responsibilities that interfere with attendance
- Distance too great to CCE venue
- No reward (no recognition of CCE participation in promotion or career path)
- Confusion about what CCE actually is (e.g., a morning report?)
- Poor logistical support (timing, scheduling, publicity)
- Inadequate reference resources or library support
- Assumption that love of knowledge is sufficient motivation for successful CCE
- Lack of local control
- Lack of coordination among visiting consultants and programs
- Topics and methods that are irrelevant to local situations

²Thompson MJ, Skillman SM, Schneeweis R, Hart LG, Johnson K, and PICCEP study team. The University of Washington Pacific Islands continuing education program (PICCEP): Guam conference on continuing clinical education programs in the U.S.-associated jurisdictions. *Pacific Health Dialogue*, 2002. 9:1, 119–122