A group of participants reviewed the status of telecommunications resources in the region, concluding that e-mail, phone, and fax were the most effective current methods and that internet communication in the region was still "complicated to use," expensive, and slow. By the conclusion of the meeting, participants had agreed on a vision of integrated clinical and public health CCE characterized by local involvement in design and implementation, content relevant to local clinical problems, and inclusion of all health care professions.

PICCEP's third significant task during its first year was an assessment of physicians' CME needs. The PICCEP surveyed all physicians in the region about their training, experiences with CME and priorities for medical education in their jurisdictions. It achieved response rates ranging from 18% in CNMI to 85% in Kosrae (FSM). Nearly two-thirds (64%) of the 143 physicians responding had attended a CME event during the two previous years, and 71% had access to local CME at least once a week. But most of these events were of short duration (1-2 hours)—suggesting that they were regular local CME sessions rather than structured CME conferences—and were of variable utility. The physicians identified priority learning needs that included updates on non-communicable diseases such as diabetes and hypertension and communicable diseases such as tuberculosis and HIV/AIDS. The survey also revealed the importance of training in practice skills that are essential in remote island environments, such as interpretation of EKGs and X-rays and management of trauma and obstetric complications. Specific skill-training requests varied by jurisdiction.[3]

The PICCEP team compiled available statistics on the health workforce of each jurisdiction, including the numbers of clinicians (physicians, nurses, oral health care providers, and allied health professionals), the state of its CCE, medical reference and telecommunications resources, and practice conditions. It considered these data, the physicians' survey, and insights from interviews with providers from the region, along with recommendations for CME collected from the Pacific Basin Medical Association and Pacific Islands Health Officers' Association. By the end of the first year of the project, the PICCEP team concluded that the r egion's health care providers were hampered by provider shortages (especially nurses and allied health professionals), inadequate financial resources for facilities and supplies, insufficient referral networks, low salaries and generally inadequate professional incentives, and limited resources for training. It identified the long-term need for sustainable CCE, directed—largely or entirely—by the jurisdictions themselves, preferably with incentives (such as promotion and/or license renewal) linked to participation. The PICCEP team translated these findings into a set of guiding principles for the PICCEP program (see box, below).

PICCEP GUIDING PRINCIPLES

PICCEP's guiding principles are to develop and implement a program that:

- addresses the stated and observed CCE needs of the region's health care providers,
- uses educational interventions that have a high likelihood of increasing the clinical skills of providers to improve the quality of care they deliver,
- helps create a sustainable CCE program that coordinates and collaborates with CCE resources of the Pacific region, is feasible within the resource constraints of PICCEP and the jurisdictions, cultivates local CCE norms, and fosters an ongoing regional infrastructure for coordinating future CCE planning and implementation, and
- emphasizes primary care physician CME, in particular for graduates of the Pacific Basin Medical Officers Training Program, but also strategically addresses the CCE needs of other types of health care providers.

[3] *Thompson MJ, Skillman SM, Johnson K, Schneeweis R, Ellsbury K, Hart LG, and PICCEP study team. Assessing physicians' continuing medical education (CME) needs in the U.S.-associated Pacific jurisdictions.* Pacific Health Dialogue, *2002. 9:1, 11-16*

PICCEP was prepared to organize and deliver CCE in the Pacific region over the course of the next 3-5 years and to coordinate the resources and logistics to support these activities. It also made plans to develop the program with substantial input from the region and to coordinate these activities with other federal and international programs delivering health system support in the Pacific, including professional organizations, education programs of the University of Hawaii, the University of Guam, Fiji School of Medicine, the University of Auckland, the National Institutes of Health, the U.S. Centers for Disease Control and Prevention, and with the health workforce-related efforts of the federal Department of Health and Human Services (Region IX) and the World Health Organization.

American Samoa

Continuing Clinical Education

PICCEP's design for CCE incorporated the wisdom the team members gathered from the needs assessment, their own experiences with CCE, a review of literature, and discussions with clinicians during site visits. The CCE designed for clinicians had the following characteristics:

- Teams of at least two faculty for each jurisdiction for 2-3 days of CME activities for physicians. (Slightly different models were employed in Guam and CNMI to accommodate their health system structure).
- Teaching sessions coordinated with participants' clinical responsibilities
- Problem-based and other interactive learning methods
- Use of didactic presentations, cases, discussions, and practical skills workshops
- Recognition of *ad hoc* educational needs
- Use of existing ward rounds for bedside teaching sessions
- Use of local staff for lectures and case presentations, where appropriate
- Emphasis on population-based medicine and public health precepts, where appropriate
- Practical match of sessions with high-priority topics identified by physicians in the needs assessment

Chuuk, FSM

> "I think this is the first time that doctors and nurses and other people get together. It used to be like the nurses go and train in one workshop, but that's because we never get together. So I think this is a start for us."
>
> –course participant

The PICCEP team anticipated unique challenges implementing CCE in the Pacific region. The teaching settings often had limited facilities. Audiences included both physicians with a wide range of medical training (both PBMOTP and medical school graduates from Fiji, the Philippines, Burma, Sri Lanka, Nepal, and China as well as the United States and other developed countries) and non-physician practitioners such as nurses, health assistants, pharmacists, and dentists. PICCEP welcomed this mix of clinicians in the classroom as a device to help promote communication among the health care team. Although the PICCEP team made every effort to coordinate the teaching sessions with local clinical responsibilities, occasional disruptions occurred such as the closure of outpatient facilities to release clinicians for the training. The team saw these occurrences as evidence of the enthusiastic support by clinicians for PICCEP's CCE programs. The box on the next page lists PICCEP faculty.

PICCEP FACULTY

NAME	TITLE	AFFILIATED INSTITUTION	DEPARTMENT	CITY
Marco Alberts, DMD, MPH	Director	University of WA, Harborview Medical Center	Dental/OralSurgery Clinic	Seattle, WA
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Kay Bauman, MD, MPH		University of HI	Family Medicine	Honolulu, HI
Dennis Butcher, MD	Clinical Instructor	University of WA	Medicine	Jackson, WY
Jack Carr, PhD, ABPP	Professor Emeritus	University of WA	Psychiatry and Behavioral Sciences	Seattle, WA
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Don Downing, RPh.	Clinical Associate Professor	University of WA	Pharmacy	Seattle, WA
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Tim Evans, MD, PhD	Assistant Professor, Medical Director	University of WA	Medicine,MEDEX	Seattle, WA
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Dan Hunt, MD	Professor and Associate Dean	University of WA	Psychiatry and Behavioral Science, Medicine	Seattle, WA
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