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Part 1 of 2

The Future of Medical Relicensure and the Responsibility of CME

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Relicensure Today

In most states in the US, the current landscape of health care practitioner relicensure, including that for physicians, is largely administrative. Relicensure requirements enable physicians to maintain their licenses by completing a requisite number of state medical board-required CME credits. The requirements vary by state, with some states not requiring CME. In addition, few of the state medical boards require that the CME be directly related to the physician's scope of practice.

In contrast to the rigorous process of obtaining initial licensure, physicians are held to a much less strenuous standard for relicensure. Relying heavily on the historical constitutions of attestation and trust, they are assumed competent unless a reported event indicates otherwise.[1] This may lead one to question whether CME in itself, the fulfillment of which is typically accounted for in relicensure documentation by way of a simple checkbox or signed attestation (and only randomly audited), is a sufficient means of physician demonstration of continued competence as it relates to quality and safe care for their patients. To put it simply, as the *Federation of State Medical Boards Special Committee on Maintenance of Licensure Draft Report* states, *As currently mandated by state medical boards, CME is not sufficient to verify or ensure continued competence.*[1]

The American Medical Association's *State Medical Licensure Requirements and Statistics, 2009* provides a comprehensive view of the diversity of state medical boards' CME requirements for relicensure. Figures 1–3 summarize the various requirements.[2]

Relicensure Tomorrow

Given the current debate about health care and health care reform in the US, the future landscape of medical relicensure will likely change as a number of health care community stakeholders and independent agencies continue to collectively reexamine how physicians can and should more accurately demonstrate competency, as well as how best to facilitate data storage and transfer as it relates to documentation of these requirements. CME may no longer serve as a surrogate for physicians to prove their competence and, in turn, become relicensed in their states. Rather, this *seat time* approach relying on traditional CME activities will likely be replaced by a more rigorous, standardized evaluation system. This new system will be designed to more accurately measure competence and answer the public's demands for accountability and genuine, ongoing demonstration of the physician's ability to provide quality medical care. The Federation of State Medical Boards (FSMB) has taken the lead in developing a model policy that will assist states in this effort.[3] The FSMB has identified *the continued competence of licensed physicians as one of its primary strategic priorities* since 2002.[4]

FSMB and the Physician Accountability for Physician Competence Summit

For many years, the FSMB has engaged in discussions with its member state medical boards regarding measurement of competence. A resolution was submitted, at the FSMB House of Delegates Meeting in 2004, which enacted a policy that the Federation would support the development and implementation of a requirement that physicians demonstrate continuing competency for relicensure.[1]

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Educational Opportunities

CME: The Basics
June 25–26, 2009
Hyatt Regency O'Hare
Rosemont (Chicago), IL

Alliance 35th Annual Conference
January 27–30, 2010
Establishing Continuing Medical Education as a Pathway to Better Patient Care
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The adoption of this policy recommendation, together with a number of activities by other organizations, led the FSMB to host the first semi-annual Physician Accountability for Physician Competence (PAPC) Summit in March 2005, in conjunction with InnovationLabs and a number of other medical organizations. A large group of health care professionals from a broad range of the US health care community gathered to explore how to effectively measure and evaluate physician competence over the course of a physician's career. The Summit's size and the diversity of the group have expanded as efforts have continued over the years. Summit participants continue to discuss the topic of secure data-sharing for documentation and reporting purposes. The problems that have been identified and are being addressed have made it clear that an effective interface needs to be developed between the various components in this system.[5]

National Alliance for Physician Competence and *Guide to Good Medical Practice–USA*

A tangible outcome of the Summits has been the establishment of the National Alliance for Physician Competence (NAPC). Its objective is to support consistency and help resolve gaps in the regulatory system in order to reduce the administrative and regulatory burden on the physician. An underlying purpose of the NAPC is to facilitate data exchange. The much-discussed concept of a *trusted agent* platform involves standardizing data exchange between data providers and physicians who need to report their data to multiple regulatory boards and agencies. A secure, web-based system can help ensure confidentiality and physician control of the documentation and evidence they are required to submit upon request from medical boards.[6]

Defining Competence

One of the initial challenges is how to define competence. To do so, the NAPC has developed *Good Medical Practice–USA*[7]—a tool intended to clarify the expectations of what makes a good doctor and provide *a common framework for how organizations responsible for educating, training, and regulating physicians think about competence.* Version 1.0 of the guide was approved for broad dissemination in late 2008, and is being followed by another working document as an output of the sixth PAPC Summit, held in July 2008, the aim of which was to articulate the dynamics involved in the medical profession's views on competence and, ultimately, provide the springboard for enhanced responsibility on the part of various medical professional organizations in the future.[8] In addition, at the seventh PAPC Summit, held in February 2009, discussions continued regarding a *shift document which articulates the shifting paradigm of physician competence.*[9]

Subspecialty Licensure

The NAPC has explored requiring licensure only in the physician's area of demonstrated competency in a specialty or subspecialty,

Figure 1: Overview of CME for Relicensure

General Requirements

Summary

- 62 of 69 medical licensing boards require CME for license reregistration, specifically:
  - 44 of the 50 state MD boards
  - Four of the four US territory MD boards
  - 14 of the 15 state DO boards
- Other mandates by states may include:
  - Specific CME content, such as HIV/AIDS, risk management, or end of life palliative care
  - A certain percentage of CME be American Medical Association (AMA) Physician's Recognition Award (PRA) Category 1

Average Requirements by State

State Averages and Terms

- The average CME credits per year required by states:
  - For MD boards is 25
  - For DO boards is 31
- Required credits per year vary in terms of how they are specified; some are over a period of one year, others are up to three years (ie, 150 hours required over three years)

Maximum

- 11 states require an average of 50 credits per year (MD boards)
- Five states require credits every year (MD boards), which could be considered most stringent; since the terms are not on a rolling/multi-year basis, the impetus to wait until the last of multiple years to *catch up* on credits is eliminated

Minimum

- Six states do not require any CME for license reregistration for MDs:
  - Colorado
  - Indiana
  - Montana
  - New York
  - South Dakota
  - Vermont

although this outcome is unlikely. *Good Medical Practice–USA*, among other things, establishes guidelines for physicians to demonstrate up-to-date knowledge, apply that knowledge in their practice, and maintain proficiency in clinical skills relevant to their practice. *Good Medical Practice–USA* also notes that the scope of a physician's practice should remain within his or her own competence, while recognizing that physicians may migrate into another area or subspecialty/niche. Thus, certification may not be perfectly aligned with the specific area of

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Figure 2: CME Requirements by State (Descending Order by Average Credits per Year)

State Board—MD	Average Credits per Year	Terms
Illinois	50	150/3 yrs
Kansas	*50*	*50/1 yr*
Maine	50	100/2 yrs
Massachusetts	50	100/2 yrs
Michigan	50	150/3 yrs
New Hampshire	50	150/3 yrs
New Jersey	50	100/2 yrs
North Carolina	50	150/3 yrs
Ohio	50	100/2 yrs
Pennsylvania	50	100/2 yrs
Washington	50	200/4 yrs
Virginia	30	60/2 yrs
Alaska	25	50/2 yrs
California	25	100/4 yrs
Connecticut	25	50/2 yrs
Maryland	25	50/2 yrs
Minnesota	25	75/3 yrs
Missouri	25	50/2 yrs
Nebraska	25	50/2 yrs
New Mexico	25	75/3 yrs
West Virginia	25	50/2 yrs
Texas	*24*	*24/1 yr*
Arizona	20	40/2 yrs
Arkansas	*20*	*20/1 yr*
Delaware	20	40/2 yrs
Florida	20	40/2 yrs
Georgia	20	40/2 yrs
Hawaii	20	40/2 yrs
Idaho	20	40/2 yrs
Iowa	20	40/2 yrs
Kentucky	20	60/3 yrs
Louisiana	*20*	*20/1 yr*
Mississippi	20	40/2 yrs
Nevada	20	40/2 yrs
North Dakota	20	60/3 yrs
Oklahoma	20	60/3 yrs
Rhode Island	20	40/2 yrs
South Carolina	20	40/2 yrs
Tennessee	20	40/2 yrs
Utah	20	40/2 yrs
Wyoming	20	60/3 yrs
Wisconsin	15	30/2 yrs
Alabama	*12*	*12/1 yr*
Oregon	7 (by 2009)*	
Colorado	0	
Indiana	0	
Montana	0	
New York	0	
South Dakota	0	
Vermont	0	
Average	**25**	

State Board—DO	Average Credits per Year	Terms
California	50	150/3 yrs
Maine	50	100/2 yrs
Michigan	50	150/3 yrs
Pennsylvania	50	100/2 yrs
Washington	50	150/3 yrs
Nevada	*35*	*35/1 yr*
New Mexico	25	75/3 yrs
Arizona	20	40/2 yrs
Florida	20	40/2 yrs
Tennessee	20	40/2 yrs
Utah	20	40/2 yrs
Oklahoma	*16*	*16/1 yr*
West Virginia	16	32/2 yrs
Vermont	15	30/2 yrs
South Dakota	0	
Average	**31**	

State Board—MD (Territories)	Average Credits per Year	Terms
Guam	50	100/2 yrs
DC	25	50/2 yrs
Puerto Rico	20	60/3 yrs
Virgin Islands	*25*	*25/1 yr*
Average	**30**	

Legend: *Italics*—Credit terms = per 1 yr **Bold**—States that don't require CME
*As of the most recent AMA *State Medical Licensure Requirements and Statistics, 2009*

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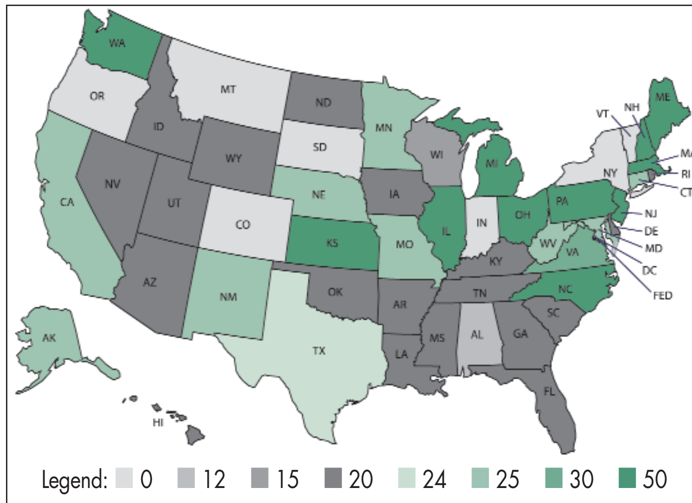
Figure 3: CME for License Reregistration—Average Credits per Year, by State



specialty or subspecialty. Individual licensing boards are not in favor of moving to a system of specialty licensing because of the expense. However, if standards are established for physicians who practice in a specialty or subspecialty area, then competence in that area must be demonstrated.

Special Populations

The FSMB is also looking into a sizeable physician licensee cohort that presents unique challenges as to how to objectively establish maintenance of competence, especially where it's not required. This subset includes both the population of physicians who are lifetime certificate holders (who have not been recertified) and the approximately 20% of practicing physicians who are not board-certified by the American Board of Medical Specialties (ABMS) or American Osteopathic Association-Board of Osteopathic Specialists (AOA-BOS).[4] Also worth mentioning are those physicians who are clinically inactive and thus ineligible for maintenance of certification (MOC) even if they are board-certified.

National Licensure

A long debated subject related to licensure is the possibility of nationalization of the classic state-regulated licensure requirements. The FSMB's position is that national licensure is not realistic, mainly due to the uniqueness of each state's medical practice acts. However, considering that nearly 25% of US licensed physicians hold licenses in two or more states,[10] the importance of developing maintenance of licensure (MOL) requirements that are as consistent as possible between states, while capitalizing on the efficiencies of technology,[6] is even more apparent. Establishing some type of reciprocity, as the next best thing, and developing license portability seem more feasible. Significant advancements have been made in the past few years, including implementation of standardized license application components and common credentials verification across states, both of which serve to reduce redundancies and alleviate administrative burdens, ultimately reducing the cost for both the physician and the medical board.[10] However, difficulties will likely continue to exist in the enforcement of licensure regulation as it varies from state to state.

Watch for Part 2 of this article in the June 2009 *Almanac*, which will cover in more detail the FSMB's recommendations as well as CME providers' responsibility as it relates to MOL and MOC.

Acknowledgement

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Points for Practice

1. CME providers must understand and embrace the importance of physicians accurately demonstrating competence, and be prepared to help facilitate the documentation and transfer of this information.
2. The CME of the future must focus on competency-based assessment and assuring maintenance of physician competence in order to both meet requirements of various health care community stakeholders and independent agencies and answer the public's demands for accountability and genuine, ongoing demonstration of the physician's ability to provide quality medical care.
3. As the definition of *competence* continues to be refined and strides are made toward standardizing requirements, CME providers must be poised to interpret and act upon the latest data and provide timely, relevant interventions for physician learners.

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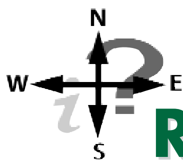

Reality CME

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Managing When Printed Live Activity Material Goes Missing

Even in this day and age of fast computers, easy to use software, faxes, Fed Ex and overnight delivery, many a CME planner for a live activity has had to deal with the vexing problem of missing on-site materials, including syllabi with activity certification information, faculty disclosures and other critical materials. What can you do if this happens to you?

To avoid the problem of missing on-site materials, follow the adage *Be prepared!* First and foremost, have a detailed and well-thought out contingency plan in advance of the activity. As part of the plan, have a CD-ROM or portable hard drive on-site that contains all the *printer-ready* files of your activity. In this way, should your activity materials go missing, you'll have all you need to reprint them and won't have to spend any time or effort tracking down the files. Second, ensure that you locate a local printer within reasonable distance of your venue prior to getting on-site. Record its location, hours of operation and cost. Between having the files and locating the printer, you should be able to print the core materials for your learners should any materials be missing. Don't worry whether what you print *looks pretty*. It is more important for you to be able to have copies to distribute that have the basic activity information. Third, as part of the contingency plan, identify what are *must haves* to distribute, such as learning objectives, faculty information/disclosures/conflict of interest resolutions, accreditation/credit designation statements, and any other reference materials. If you can't print enough copies of all the pertinent information for each attendee, be sure to print a sufficient number to be distributed on tables and shared among the participants. An additional step is to verbally announce learning objectives, faculty information disclosures and accreditation/credit designation information. Last, If possible, post your meeting materials on your website and refer attendees there so they can download the files for their own records and reference.

by Marissa Seligman, PharmD, CCMEP, Associate Editor and Kristin Fludder, BS, CCMEP, Pri-Med Institute

Alliance Competency Area 3: Performance Measurement

Nancy Davis, PhD
Executive Director, National Institute for Quality Improvement and Education

Close your eyes and blow up your office! No, not the mortar and bricks, but the old philosophies, processes and paradigms. Welcome to the Office of Continuing Performance Improvement (OCPI). It may not be a physical office, but rather a coordination of multiple resources to improve practice and health care delivery. Things we don't do in the OCPI include: meeting planning, catering, burdensome bureaucracy, or counting hours. Our focus is much different. Let's examine the roles of the new office.

Assessment/Measurement/Analysis

Data are important on a number of levels. Physician practice data are important for needs assessment, identifying performance gaps, and remeasurement following improvement interventions. Data are important for the OCPI, which should collect data to assess its own gaps and needs for improvement.

Education Brokering

The OCPI doesn't always need to develop new activities to meet identified needs. There are many resources already available. Based on identified performance improvement needs, existing resources can be bundled into useable packages that are easily accessible and will help the individual physician make improvements in practice. These resources will include educational activities along with systems-based process tools for improvement.

Coaching

It's been shown many times that one-time interventions don't lead to practice change.[1] Even the most well intentioned practitioner will need

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assistance to implement new processes. Coaches can help new practices become routine. These coaches needn't be clinical experts, but they need an understanding of practice needs and redesign.

Collaboration

The OCPI cannot be expected to have all the resources and expertise necessary to facilitate performance improvement. They will need to collaborate with quality *management professionals* to obtain necessary practice data and implement quality improvement processes, *adult education and instructional design experts* to develop effective educational content and format, *logistics experts* to facilitate live activities, and *information technology experts* to design high quality online learning, reporting and other support.

Culture of Improvement

The OCPI must create a culture of improvement in practice as well as teach these methodologies to its constituency of learners. Quality rhetoric isn't enough. They must practice the philosophy.

Alliance Competency Area 3 outlines the necessary competencies for advancing performance measurement in both the CME office as well as learners in CME activities. The major competency headings are:

3.1 Develop, use, and support an effective data management system for educational and administrative purposes.

3.2 Use measurement data to assess educational outcomes/results of the learning intervention as a basis for determining future learning needs and the application of the educational knowledge and skills.

3.3 Use data to assess the performance of the CME office in meeting its mission and organizational goals.

3.4 Promote continuous improvement and performance measurement as skills for physicians during educational interventions.

3.5 Promote continuous improvement as an administrative skill for the staff of the CME office.

3.6 Provide measurement tools and utilize reliable data to enable physician-learners to compare present levels of performance with optimum performance.

Whether the focus is on the learner or CME professionals, there are specific processes for the use of measurement to improve quality and performance. Let's explore some simple examples for both CME and clinical practices.

Start with Performance Measures

Performance Measures should be evidence-based, specific and measureable—in order to know when improvement has occurred.

- CME example: Use multiple instructional techniques compared to single instructional techniques to improve clinical outcomes.[2]
- Clinical example: Order HgbA1C twice a year for patients with diabetes.[3]

Collect Data to Measure Current Practice

Data should be as objective as possible and from reliable sources.

- CME example: Annual report documents 95% of CME activities use a single instructional technique—live, lecture-based format.
- Clinical example: Claims data for the practice document that 75% of patients with diabetes in the practice receive orders for HgbA1C testing twice a year.

To see how well you have achieved Competency 3, take the Competency Self-Assessment on the Alliance website at: www.acme-assn.org.

Implement Interventions for Improvement

Interventions might be educational, or they might be systems-based process improvements.

- CME example:
  1. Training session for CME staff, including brain-storming for new techniques in delivering CME
  2. Faculty development to train faculty on new instructional techniques
  3. Set goal that all lecture-based CME activities will include at least one of the following: participant chart review to measure practice prior to activity; discussion of cases provided by learners; small group activity; quality improvement tools for implementing in practice postactivity.
- Clinical example:
  1. In-service training for clinic staff regarding the importance of routine HgbA1C testing
  2. Staff input on processes for improvement
  3. Checklist attached to all diabetic patient charts that includes date of last HgbA1C and due date for the next one.

Remeasure

Collect data again to assess and reflect upon changes in practice.

- CME example: Next annual report documents 90% of CME activities include at least two unique instructional techniques in each activity.
- Clinical example: Claims data for the practice document that 95% of patients with diabetes in the practice receive orders for HgbA1C testing twice a year.

This continuous performance improvement process, based on the *Alliance Competency Areas for CME Professionals*, will help improve

CME Career Center

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the quality of CME administration as well as educational activities. To that end, consider this *To Do List* for your new office:

- Learn more about quality improvement processes and techniques
- Use performance measures for needs assessment and outcomes measurement
- Collect and analyze data
- Use technology to advance systems
- Foster a culture of improvement
- Think beyond CME to continuous performance improvement.

Thinking of CME as a part of a broader process for performance improvement will create the value proposition for the new Office of Continuous Performance Improvement.

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Recommended Reading

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It's Time to Apply for the 2010 Alliance Awards

Brochures describing the 2010 Alliance Awards Program are now available on the Alliance home page at www.acme-assn.org. These awards are open to any CME professional who is engaged in innovative CME activities worthy of recognition. These individuals and activities exemplify the best practices many are striving toward in the profession of CME.

The Alliance encourages you to reflect on the activities you've planned and implemented, CME professionals who have impacted your job, or some innovation you feel is worthy of recognition, and then invites you to submit an application for one or more of the Alliance awards.

Questions can be addressed to Debrah Fisher, Manager of Member Services, at 205-453-0441 or dfisher@acme-assn.org.

Email your comments and ideas to the *Almanac* Editors at: almanac@acme-assn.org.

Alliance Board Seeks Nominees

Jann Balmer, PhD, President,
Alliance for Continuing Medical Education

George Mejicano, MD, Chair,
Governance Committee
Alliance for Continuing Medical Education

The Alliance is seeking members with demonstrated leadership skills and strategic vision, as well as service to the Alliance, to apply to serve on the Board of Directors, for terms beginning at the 2010 Annual Conference. Each year the Board identifies selection criteria, that can help to strengthen the leadership characteristics and facilitate our service to the Alliance membership. Members may nominate themselves or an interested colleague. Nominations must be submitted in writing by July 3, 2009. Members will vote for the new Board members in writing or online in the fall. Specific criteria and expectations may be found on the Alliance website at www.acme-assn.org.

How to Apply for a Position on the Board

Written nominations must be received by July 3, 2009 and addressed to the Chair, Governance Committee, at the Alliance office. The candidate must complete and submit the *Fact Sheet*, with a brief biographical sketch and answers to questions addressing how the candidate meets the desired attributes. The *Fact Sheet* must be accompanied by curriculum vitae and three letters of reference from individuals who know the candidate in a professional capacity. *Candidates will not be considered if this information is not submitted by July 3, 2009.*

Process of Election

The Governance Committee will select a slate of candidates from the nominations submitted. Alliance members will be asked to vote for these candidates on a ballot mailed or available on the website in October. If you have questions, please contact the Alliance office at 205-824-1355 or acme@acme-assn.org.

Share your thoughts on Alliance issues by contacting the Board at: acmeboard@acme-assn.org.

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Alliance for Continuing Medical Education
CME: The Basics
Hyatt Regency O'Hare, Rosemont (Chicago), IL

September 9-11, 2009
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Intercontinental Chicago O'Hare
Rosemont (Chicago), IL
www.niqie.org

October 14-16, 2009
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