Report to
The Vermont Legislature

Board of Medical Practice Report on Required Continuing Medical Education
2017 Report to the Legislature

In Accordance with Act 60 (2011) Section 8,
An act relating to hospice and palliative care

Submitted to:	**House Committee on Human Services** **Senate Committee on Health and Welfare**
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Introduction
Section 8 of Act 60 (2011) tasked the Board of Medical Practice to report to the House Committee on Human Services and the Senate Committee on Health and Welfare regarding the implementation and overall impact of the continuing medical education requirement set forth in 26 V.S.A. § 1400(b).

Until the passage of Act 60 (2011), physicians were not required to complete Continuing Medical Education (CME) as a condition of renewing their MD licenses. The law created a minimum requirement of 10 hours of CME and called upon the Board to establish rules regarding further requirements. The law also specified that the Board should require evidence of professional competence on treatment options such as hospice, palliative care, and pain management services. The Act instructed the Board to have a rule in effect by August 31, 2012. By law, the requirements were to apply to licenses expiring after August 31, 2014. All Vermont MD licenses expire on November 30 of even-numbered years, so the requirement was in place for the first time during the renewal period for licenses that expired on November 30, 2014.

CME Requirements
As noted, the statute sets a minimum requirement of 10 hours per licensing period. Through rulemaking, the Board set the requirement at 30 hours per two-year licensing period. The Board also added a subject-specific requirement; if a licensee has a DEA license to prescribe controlled substances, he or she must complete at least an hour of CME on safe prescribing. That is in addition to the above-mentioned hour on treatment options such as hospice, palliative care, and pain management, which is found in the statute. The requirements originally set forth in the law were modified again in 2016. Pursuant to Act 173, licensees who hold a DEA license will need to complete at least 2 hours of CME on controlled substances that covers: abuse and diversion, safe use, appropriate storage and disposal, use of the Vermont Prescription Monitoring System, risk assessment, pharmacological and non-pharmacological alternatives to opioids, tapering and cessation of controlled substances, and State and federal laws and regulations on opioid prescribing.

Qualifying CME Activities
By rule, the Board recognizes only CME activities that are approved for American Medical Association Physician's Recognition Award Category 1 Credit™ (AMA PRA Category 1 Credit™). The AMA PRA system is a program that reviews CME activities to ensure that standards for quality and independence from commercial interests are followed. It is the system used throughout the United States for recognition of CME activity.

Administration of the Requirement
To qualify to renew, a licensee must do one of the following:

a. Certify compliance with the CME training requirements.
b. Certify that he or she is exempt from the requirements for one of the reasons established in the rule (newly licensed or on a military activation for a significant portion of the period).
c. Submit a makeup plan that meets the requirement of the rule.

Licensees are not required to submit documentation of their CME activities at the time of renewal. However, in accordance with the Rule, licensees are subject to audit. The Board approved an audit plan at its December 7, 2016 meeting. The plan is based upon guidelines for sampling of the American Institute of Certified Public Accounts. The AICPA guidelines include tables with calculated sample size based upon the risk of deviation. Thus, a significant factor in determining the appropriate sample size is the fact that most licensees have an obligation to do CME apart from the Vermont requirement. Many licensees are licensed in two or more states, and most states have a CME requirement. Many hospitals require CME to maintain credentialing for the hospital. Also, approximately 90% of licensees maintain specialty board certification, which means that they have a preexisting requirement to document at least as much CME as is needed for license renewal.[1] Hence, the risk of non-compliance is quite low.

Taking into consideration the low risk of non-compliance and the total number of licensees required to certify completion of CME, the AICPA guidelines suggested a sample size of 59. These 59 licensees are randomly selected to submit documentation of the qualifying CME activities underlying the licensee's certification of compliance. If no more than five licensees are found to have shortcomings in the documentation, that will be the end of the audit process. If six or more of the 59 licensees are found to have been inaccurate in their certification on compliance, then an additional round of 93 licensees will be selected for audit. The number for the additional round is also based upon the AIPCA guidelines. According to the plan, the results for that second round will be presented to the Board for a decision as to how to proceed. Licensees will be selected from among all who were required to certify completion of CME using an automated process. The plan specifies that licensees who complete CME late under a make-up plan will be audited at a higher rate and not included among the sample groups described above.

Impact of CME Implementation

Has Imposition of Mandatory CME Led to a Loss of Licensed Physicians?
One impact of implementation of a CME requirement may have been the loss of licensed MDs. Going into the 2014 renewal there were 3,600 licensed physicians. A total of 554 did not renew, which represents over 15% of all licensees who did not renew at that first renewal event when a requirement for CME came into effect. The rate of non-renewal had been very close to 10% for the licensing cycles preceding the 2014 renewal. Closer analysis of the 2014 figures showed that

[1] Within some specialties, physicians who attained Board certification before a certain date (which varies by specialty, but typically is somewhere in the 1980s or 90s), are "grandfathered" and are not required to complete CME. That is not true for all specialties. It would be very difficult to determine how many Vermont physicians are grandfathered and thus not obligated to do CME to maintain certification. Nonetheless, the Board is confident that the number of physicians who must complete CME to maintain specialty board certification is quite high.

the non-renewal rate for licensees over 80 years old was 51%. The rate for those over 70 was 35%. Looking only at physicians under 70, the non-renewal rate was 11.6%. Without surveying former licensees for why they did not renew we cannot know their motivations, but the numbers suggest that older physicians may have opted to drop their licenses because of the new requirement for CME.

The Board has recently completed the second renewal period since CME became a requirement for license renewal. Of 3,731 physicians licensed at the time of reentry, 491 did not renew, which amounts to about 13% of licensees. It is difficult to draw conclusions, but for each of the two licensing periods occurring since imposition of the requirement for CME Vermont-licensed physicians chose to not renew their licenses at a rate higher than before mandatory CME.

While the total number of licensees dropped significantly upon implementation of mandatory CME, it is unlikely that the fall off had a meaningful impact on access to physician services. It would be reasonable to assume that many of the older physicians who chose not to renew were not practicing anyway.

Has Mandatory CME Increased CME Training Among Vermont Physicians?

One area where implementation of mandatory CME made a clear difference was the requirement for training on topics such as hospice, palliative care, and pain management services. There has been expanded availability of instruction on those topics. Hospitals offer much of the CME presented within Vermont, and they responded to the requirement. UVM Medical Center and the College of Medicine offered several programs presented through Grand Rounds at the main campus and events at regional hospitals, some of which were recorded and made available to physicians online. Likewise, there has been increased availability of programs on prescribing of controlled substances, which are required for every licensee who has a DEA permit to prescribe.

Turning to the general requirement, if the goal in enacting mandatory CME was to promote better practice among Vermont physicians by increasing training, the impact of the requirement likely was confined to about 10% or less of Vermont-licensed MDs. As discussed above, many physicians already were obligated to complete CME. Many are licensed in additional states, most of which have CME requirements. Many physicians are on staff or have privileges at hospitals that require CME. And, about 90% maintain specialty board certification that carries a requirement to engage in CME. Thus, for most Vermont physicians, the new requirement was not new at all. It was just an additional source for the requirement and a means for the Board to ensure all licensees make an effort to stay current through educational activities.

The fact that 90% or more of licensees would do CME regardless of the Board's requirement does not mean that the Board's requirement is not meaningful. When mandatory CME was enacted, it was understood that the requirement would not change the amount of CME taken by most physicians licensed by the Board. The reason for adding the requirement was to ensure that CME would be completed by those in the group of 10% or fewer who did not have a preexisting requirement to complete CME. If one accepts the fact that more and more current education about medical practice promotes good care, then the establishment of the requirement has helped to promote good care and patient safety for patients who receive care from Vermont MDs.