AOA Continuing Medical Education

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The author provides an update on the current continuing medical education (CME) cycle, which began on January 1, 2013, and will end on December 31, 2015. The author also highlights changes to the CME process and the re-engineering of the CME program for the current cycle. Topic areas include recent changes in CME policies and the challenges associated with awarding and recording credits for the 2013-2015 CME cycle. In addition, the article provides information regarding online CME.

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Continuing medical education (CME) refers to a specific form of continuing education that helps physicians maintain competence and learn about new and developing areas of their fields. Continuing medical education is not a new concept. Since the beginning of institutionalized medical instruction (ie, instruction affiliated with medical colleges and teaching hospitals), physicians have continued their learning by meeting with their peers through grand rounds, case discussions, and meetings to review published medical literature. Today, these activities may take place as live events, written publications, online programs, or audio, video, or other electronic media. Content for these programs is developed, reviewed, and delivered by faculty who are experts in their individual clinical areas.

In the United States, many states require CME for physicians to maintain their licenses. (Visit http://www.osteopathic.org/osteopathic-health/about-dos/do-licensing/Pages/default.aspx for additional information on licensure.) Continuing medical education activities are developed and delivered by a variety of organizations, including professional associations, medical education agencies, hospitals, educational institutions (including universities and medical schools), and home-study (or self-study) activities. These CME activities may be classified as formal learning (eg, live planned programs) or less formal learning (eg, Web-based activities that are not live or interactive). Continuing medical education is a requirement for membership in the American Osteopathic Association (AOA).

Re-engineering the AOA CME Program

The AOA has a unique structure in that it is 1 organization that operates as 3:

1. a membership association
2. an accrediting body for CME sponsors (similar to the Accreditation Council for CME and the American Academy of Family Physicians)
3. a certification body (similar to the American Board of Medical Specialties Maintenance of Certification)

These 3 primary functions are linked by CME requirements. Membership in the AOA requires 120 CME credits in a 3-year accreditation cycle, with 30 credits being from Category 1-A (most of this credit is available from CME sponsors accredited by the AOA). In January 2013, the AOA began the implementation of the new osteopathic continuous certification (OCC) requirements.[1] At that time, each of the AOA's 18 specialty certifying boards began requiring that all physicians who hold time-limited certification participate in the 5 components of the OCC process to maintain osteopathic board certification.[1] One of these components is that physicians must fulfill a minimum of 120 CME credits during each 3-year CME cycle (ie, the same amount required of standard AOA membership). However, to meet the OCC requirements, of these 120 or more CME credits, a minimum of 50 credits must be in the specialty area or areas of certification. In other words, OCC requires both AOA membership (with its CME credit requirement) and 50 credits in the specialty of the osteopathic physician (ie, DO) every 3 years.

If a DO fails to participate in CME or have CME recorded, then his or her AOA membership will lapse and he or she will not meet certification requirements. Or, if a member in good standing does not earn the required 50 credits in his or her specialty, his or her certification requirements will not be met. Thus, physician certification (which often is required for hospital and third-party payer credentialing) is incumbent on participation in appropriate CME and on having that CME properly recorded by the Division of CME. Therefore, the need for accuracy and efficiency in processing credit is pronounced.

Because of these changes, the AOA committed to the development of a new electronic platform for recording and maintaining physician CME records. These new requirements, with the launch of the new CME software (CECity), have necessitated a change in supporting administrative processes. Because the AOA's existing CME software did not allow the recording of CME credit for more than 1 specialty, the AOA upgraded its software to allow recording of credit for multiple specialties. Lifelong Learning Services was contracted to assess current administrative practices and has offered recommendations for re-engineering those processes to support the software transition and to increase the efficiency of records-processing. The recommendations are currently being reviewed by the AOA and the Council on CME (CCME).

The AOA Division of CME does not produce CME activities (although it does administer 1 activity per year about CME accreditation requirements for sponsors). Instead, approximately 85% of resources are dedicated to maintaining records related to the CME activity of DOs (both members and nonmembers) and approximately 15% of resources are dedicated to administering the accreditation role of the AOA (ie, accrediting sponsors of Category 1-A credit).

The Division of CME started the process of recording and processing CME credits for the 2013-2015 CME cycle in April 2013, with actual inputting of data in August 2013. The Division of CME is working diligently to record all CME credits in a more timely fashion.

Trend Data

For the 2010-2012 CME cycle, the AOA Division of CME has recorded a total of 17.6 million CME credits. Of these credits, 12.9 million were recorded in AOA Category 1-A, and the remaining 4.7 million credits were recorded in Category 1-B, Category 2-A, and Category 2-B.

In the 2007-2009 CME cycle, the Division of CME recorded an additional 2.4 million CME credits than in the 2004-2006 CME cycle. The total number of CME credits recorded by the AOA for past CME cycles may be found in last year's CME article.[2] An extension for submitting CME credits was granted until November 30, 2013. The total number of DOs whose AOA memberships will be dropped for the 2010-2012 CME cycle has not yet been determined.

Changes That Will Impact the AOA CME Program in 2014

The following upcoming changes will impact the AOA CME program based on the AOA Board of Trustees' approval of the CCME's recommended changes during its midyear meeting and retreat in Renaissance La Concha, Puerto Rico, as follows:

- **Awarding of CME Credits for AOA National CME Sponsors Conference.** Category 1-A credit from the AOA is to be awarded to DOs who attend the CME Sponsors Conference in 2014 and future meetings. The members of the CCME have exempted themselves from receiving credit.
- **Needs Assessment for AOA Category 1-A or Category 1-B Programs.** For any programs to be approved for AOA Category 1-A or 1-B credit, a needs assessment must accompany the request for approval before or after the program.
- **Who May Apply to Be an AOA Category 1 CME Sponsor.** States or regions are not allowed to become Category 1 CME sponsors if they do not have osteopathic training programs or AOA CME opportunities available.

Online CME: Innovation and Outcomes

The Internet is a powerful communication system that offers a different format for providing CME. The use of online CME for physicians is a growing expectation of US physicians. It is a flexible, efficient, and effective method to maintain and build expertise. For busy physicians, particularly those with few local opportunities to obtain CME credit, the Internet is a viable option. Many physicians use the Internet as part of their daily lives and expect online CME to be available when they have the time to participate in a CME activity, not a set time that interferes with patient care or other medical responsibilities.

The AOA awards up to 9 Category 1-A CME credits per cycle for live, interactive CME programs, which must include a pretest and a posttest with a passing grade of 70%.[3] Home study, which includes activities such as journal reading with a posttest (including *The Journal of the American Osteopathic Association* and other approved affiliate publications), is awarded 1-B credit. To meet the CME requirement for AOA membership, 90 credits can be submitted from online CME as 2-B credit. A resolution at the AOA House of Delegates' 2010 annual meeting (H 201) called for the AOA to consider Category 1-A credit that is not live or interactive. It was referred to the CCME for review.

Category 1-A is defined as formal didactic educational programs that promote a deeper understanding of the profession. In addition, Category 1-A was designed to encourage DOs to maintain osteopathic manipulative medicine skills, develop osteopathic research skills, and educate other DOs.

Evidence-based research[4-6] shows that CME on the Internet can be as effective as standard live CME offerings in outcomes-based learning, particularly with the use of case presentations. Distinctively osteopathic content may be added by incorporating osteopathic philosophy in patient care or including video content demonstrating the use of osteopathic manipulative treatment for the topic discussed. However, there have been many barriers to the implementation of such programs, including cost and technology considerations, lack of standardization of online CME, and a general unawareness that it may be considered for Category 1-A credit. Providers of live CME may fear loss of revenue to their program if online content is available.

The CCME conducted a pilot program and selected 7 AOA-accredited CME sponsors or collaborative teams to develop an online CME program for 1-A credit using the CECity platform with an AOA revenue-sharing model. Each team was awarded $5000 from the AOA to assist in developing the program. Using the technology available, it may be possible to maintain the interactive

nature of live CME programs in the online format. Category 1-A was approved for a set period and sponsors were able to charge participants as they would for attendance at a live presentation. The goal was to demonstrate that providing online CME is feasible, is cost effective, and will not lead to loss of revenue. A survey of the participants of the pilot program revealed that online providers did not suffer loss of revenue and were able to provide quality programs.

Conclusion

The CCME will continue to study the changing environment of medicine and adjust the AOA's CME program to respond to the needs of members, the public, and the AOA. In addition, the CCME appreciates members' patience as it makes the transition to update and record CME credits in a more timely manner. The CCME encourages members to submit suggestions on CME issues to cme@osteopathic.org for consideration.

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