HOD ACTION: Council on Medical Education Report 10 adopted as amended and the remainder of the report filed.

REPORT 10 OF THE COUNCIL ON MEDICAL EDUCATION (A-12)
An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure
(Resolutions 331-A-11, 326-A-11, 316-A-11, and 911-I-11)
(Reference Committee C)

EXECUTIVE SUMMARY

In an effort to address the resolutions and policies in this report, it became apparent that the requirements for maintenance of certification (MOC), osteopathic continuous certification (OCC), and maintenance of licensure (MOL) should be aligned and that the activities that would meet a requirement for one process should also be accepted for meeting similar or identical requirements of the others. However, MOC, OCC, and MOL are distinctly different processes, designed by independent organizations with different purposes and mandates. Currently, the guiding principles for MOL, adopted by the Federation of State Medical Boards (FSMB), recognize the value of active engagement in meeting MOC and OCC requirements. MOC and OCC are not intended to become mandatory requirements for medical licensure but should be recognized as meeting some or all of a state's requirements for MOL to avoid unnecessary duplication of work. The guiding principles and framework developed for MOL will be pilot tested with 11 state medical and osteopathic boards in the near future. Implementation of MOL is several years away, and the pilots will likely be designed to determine and identify multiple options and pathways by which physicians, including those who are not specialty-certified or not engaged in MOC or OCC, may fulfill a state board's MOL requirements.

The American Medical Association (AMA) Council on Medical Education has provided strong input and policy related to MOC, OCC, and the principles of MOL. AMA policy encourages the American Board of Medical Specialties (ABMS) and its member boards to continue to improve the validity and reliability of procedures for the evaluation of candidates for certification. The AMA is not responsible for regulating the certification and licensure processes but is committed to monitoring the development and research being conducted in these areas on a regular basis. Although there have been concerns about the integrity of certification examinations, the ABMS has taken steps to address security and copyright issues. Some ABMS member boards are also utilizing standardized simulation-based competencies and modular examinations to accommodate for relevancy to practice.

AMA policy opposes the public reporting of individual practice performance data that is collected to comply with the MOC Part IV Practice Performance Assessment. The AMA is working with the appropriate accrediting and certification organizations to ensure that the concerns of physicians related to the privacy of their data are addressed.

The ABMS, many certification boards, state/specialty medical societies, AMA, and American Osteopathic Association (AOA) provide tools and/or services that facilitate individual physician efforts to complete MOC and OCC, and a state medical society is developing an awareness campaign for its upcoming MOL pilot project. The AMA is also considering developing unique products and services that benefit AMA members.

The AMA, American Academy of Family Physicians, and AOA continuing medical education (CME) credit systems fulfill MOC Parts II and IV, are accepted by 63 of the 69 U.S. licensing jurisdictions that require certified CME credits for licensure renewal, provide evidence that a physician has maintained a commitment to participate in appropriate CME activities, and should be considered during the development of MOL to avoid duplication of work.

HOD ACTION: Council on Medical Education Report 10 adopted as amended and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 10-A-12

Subject: An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure
(Resolutions 331-A-11, 326-A-11, 316-A-11, and 911-I-11)

Presented by: David E. Swee, MD, Chair

Referred to: Reference Committee C
(J. Mack Worthington, MD, Chair)

This report responds to four resolutions and two policies of the American Medical Association (AMA) related to maintenance of certification (MOC), osteopathic continuous certification (OCC), and maintenance of licensure (MOL).

Resolution 331-A-11, Legitimacy of the American Board of Medical Specialties (ABMS), introduced by the Connecticut Delegation, asked that our AMA study the validity, the methodology, cost, and effectiveness in documenting physician competence, of the re-credentialing system for board certification and report back to the House of Delegates (HOD) at the 2012 Annual Meeting.

Resolution 326-A-11, AMA Facilitation of MOL, introduced by the Young Physicians Section, asked that our AMA:

1. In coordination with state and specialty societies, study the feasibility and potential impact of an AMA member benefit program designed to: (1) act as a central repository for MOL, MOC, and/or OCC completion activities for an individual physician; and (2) facilitate an individual physician's efforts to complete required MOL, MOC, and/or OCC activities; and

2. Examine those state and specialty societies who have become actively engaged in facilitating the MOL implementation processes with a goal of identifying "best practices" regarding policy language, implementation programs, coordination activities, and other useful information that could be used by federation societies as they examine MOL implementation as it pertains to their society and report back to the HOD at the 2012 Annual Meeting.

Resolution 316-A-11, Continuing Medical Education (CME) for MOC, introduced by the New York Delegation, asked that our AMA:

1. Support the current CME accrediting system which provides high quality CME activities, thus ensuring continuous professional development as well as educational and practice improvement tools and resources;

2. Support the position of the Alliance for CME, which opposes the ABMS plan as stated because it would undermine the existing interdisciplinary approach to education and would also redirect important resources away from existing educational programs; and

3. Support the position of the Accreditation Council for Continuing Medical Education (ACCME), which opposes the creation of new systems that would impose unnecessary burdens upon ACCME-accredited providers, recognized accreditors, intrastate providers, and physician learners.

Resolution 911-I-11, Elimination of the Secured Examination Requirement for MOC, introduced by the Minnesota Delegation, asked that our AMA work with the ABMS to remove the requirement for a secure examination as part of their MOC program.

Policy D-275.961, Coordinated Efforts of Federation of State Medical Boards (FSMB), ABMS, and American Osteopathic Association (AOA) regarding MOL, directs our AMA to:

1. Encourage state medical boards to accept enrollment and participation in MOC and OCC as satisfactorily meeting the requirements of MOL, despite varying certification and licensing timeframes;

2. Continue to communicate with the FSMB, ABMS, and AOA the extent to which these organizations are working together (with regards to MOC and MOL) and report back to the HOD at the 2012 Annual Meeting; and

3. Encourage the FSMB and state medical boards to recognize, with regards to MOL, that active allopathic and osteopathic licenses should not be revoked on the basis of MOC or OCC requirements not being fulfilled in a timely fashion because of the varying time frames for certification and licensure.

Policy H-406.989, Work of the Task Force on the Release of Physician Data, calls for our AMA to:

1. Oppose the public reporting of individual physician performance data collected by certification and licensure boards for purposes of MOC and MOL;

2. Support the principle that individual physician performance data collected by certification and licensure boards should only be used for the purposes of helping physicians to improve their practice and patient care unless specifically approved by the physician; and

3. Report on how certification and licensure boards are currently using, or may potentially use, individual physician performance data (other than for individual physician performance improvement) that is reported for purposes of MOC, OCC, and MOL and report back to the HOD at the 2012 Annual Meeting.

INTRODUCTION

In an effort to address the resolutions and policies in this report, it became apparent that the requirements for MOC, OCC, and MOL should be aligned and that the activities that would meet a requirement for one process should also be accepted for meeting similar or identical requirements of the others. However, MOC, OCC, and MOL are distinctly different processes, designed by independent organizations with different purposes and mandates. Currently, the guiding principles for MOL, adopted by the FSMB, recognize the value of active engagement in meeting MOC and

OCC requirements. MOC and OCC are not intended to become mandatory requirements for medical licensure but should be recognized as meeting some or all of a state's requirements for MOL to avoid unnecessary duplication of work.[1] The FSMB guiding principles and framework developed for MOL will be pilot tested with 11 state medical and osteopathic boards in the near future. Implementation of MOL is several years away, and the pilots will likely be designed to determine and identify multiple options and pathways by which physicians, including those who are not specialty-certified or not engaged in MOC or OCC, may fulfill a state board's MOL requirements.[1]

The MOC, OCC, and MOL processes will be unfolding over the next decade; the AMA has provided strong input and policy related to MOC, OCC, and the principles of MOL. This report builds on the information provided in two previous Council reports to the HOD (Council on Medical Education Report 3-A-10 and Report 16-A-09) and addresses the resolutions and policies listed above by providing:

1. An update on professional and regulatory bodies that are conducting research on methodologies to measure physician competency and to regulate certification examinations.
2. An update on how the ABMS is taking steps to improve the security of certifying examinations and how the ABMS member boards are utilizing standardized simulation-based competencies and modular examinations to accommodate for relevancy to practice.
3. An update on the progress that has been made in developing MOC, OCC, and the policies and framework for MOL, which is intended to provide guidance to state medical boards as they consider participation in MOL pilot projects.
4. A description of the purposes for which physician practice performance data will be collected and used for MOC, OCC, and MOL.
5. An update on some of the tools and resources available to physicians to facilitate their completion of MOC and OCC, as well as an update on how state medical societies, in collaboration with state medical boards, are collaborating to develop an awareness campaign for MOL pilot projects.
6. An update on CME requirements for MOC, OCC, and MOL.

PHYSICIAN COMPETENCE

The AMA has extensive policy on MOC as well as policy to support the principles of MOL. The AMA advocates for balancing these requirements with a sensitivity to physicians' valuable time and resources, ensuring physician input into the ongoing development of MOC and MOL, and making both processes as efficient, effective, and evidence-based as possible.

Competence is assessed in a number of ways and can vary from specialty to specialty. Board certification generally includes successful completion of an approved core residency training program and both written and oral examinations. The ABMS partnered with the Accreditation Council for Graduate Medical Education (ACGME) to develop a set of six competencies that are important for physicians to possess and maintain throughout their professional careers: Professionalism, Patient Care and Procedural Skills, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communications Skills, and System-based Practice. Although specialty board certification is not required to practice medicine, this measurement provides assurance to hospitals and health plans, government and the public that the physician has met specific criteria. The AMA supports this process and its intent but is not responsible for regulating the process.

As representatives of the people of the state, usually appointed by state officials (e.g., governor), state medical and osteopathic boards are sworn to protect the public and promote quality medical licensure and discipline. Any improvements or changes in licensure renewal should logically and appropriately be led and guided by state medical and osteopathic boards.[2] Other professional and regulatory organizations include: The Joint Commission, National Committee for Quality Assurance (NCQA), Agency for Health Care Research and Quality (AHRQ), Ambulatory Care Quality Alliance (AQA), National Quality Forum (NQF), Physician Consortium for Performance Improvement (PCPI/AMA), and the federal government (Centers for Medicare and Medicaid Services [CMS]).

There is a body of literature on the research being conducted in this area, and the ABMS has begun to compile the list of references (Appendix). More studies will be needed to determine the full impact of MOC.

MOC SECURED EXAMINATION REQUIREMENT

Certification examinations are intended to confirm that the physician has the necessary knowledge and in some cases competence to claim expertise in the respective specialty area. Accordingly, the examinations cover both core and the more focused content of a specialty practice. The general purpose is to ascertain whether there is a sound base of specialty-relevant knowledge and skills and the ability to exercise discernment and judgment. It is the responsibility of the certification boards to ensure that their examinations are relevant, meaningful, and measure competence.[3] Furthermore, the ABMS and certification boards should be encouraged to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients as an alternative to high stakes closed book examinations.

AMA HOD Policy H-405.974, Specialty Recertification Examinations, (AMA Policy Database) states (1): that our AMA encourages the ABMS and its member boards to continue efforts to improve the validity and reliability of procedures for the evaluation of candidates for certification.

Integrity of Secured Examinations

Recently, there have been concerns about the integrity of secured high-stakes examinations. This may be due to identity theft, cheating on certification examinations, and copyright infringement that has occurred. Two recent examples include:

- In February 2009, the FSMB and the National Board of Medical Examiners (NBME), joint sponsors of the United States Medical Licensing Examination (USMLE) filed a federal suit requesting an injunction and other relief against Optima University for using test preparation materials that were obtained illegally. The federal complaint claimed that Optima exposed the students who attended review courses to examination questions that were improperly obtained by using examinees who recorded the tests' questions.[4] As a result, individuals who attended Optima's programs or who are considering doing so, risk having their USMLE scores delayed and/or classified as indeterminate. They may also be subject to other consequences, including charges of irregular behavior, as a result of their participation.[5]

- In 2009, the American Board of Internal Medicine (ABIM) sued a test-prep firm, Arora Board Review, for soliciting and compiling copyrighted test questions from the ABIM certification examination.[6]

The USMLE Committee on Irregular Behavior has taken steps to maintain the integrity of its examination so that state medical boards may continue to rely on it as an integral part of their decision-making process for licensure. The Committee recently reviewed cases that involved falsified information (including misrepresentation of educational status), dissemination of test content (including reconstruction of questions from memory and communication of test material to other examinees), solicitation of test content through Internet posting, and disruptive behavior.[7]

The ABMS has also taken steps to address security and copyright issues, and on its website states that, "It should be made abundantly clear that recalling and sharing questions from exams violates exam security, professional ethics, and patient trust in the medical profession. When it happens, the practice should be addressed swiftly and decisively. Whether someone is providing or using test questions, ABMS member boards enforce sanctions that may include permanent barring from certification, and/or prosecution for copyright violation."[8]

Technology and Resources for Secured Examinations

Traditional assessment methods have relied mostly on multiple-choice examinations or continuing medical education exercises. However, the certification boards are beginning to incorporate standardized simulation-based competencies assessment and examinations that more closely represent how practicing physicians diagnose and treat patients. Levine et al. noted that "Simulation enables assessment of physician competencies in real time and represents the next step in physician certification in the modern age of healthcare."[9]

Currently, only the American Board of Anesthesiology (ABA) requires participation in a simulation-based educational course for recertification.[10] Other certification boards provide these activities as an option to satisfy MOC requirements. For example, in 2008, ABIM introduced interventional-cardiology simulations as an option for diplomates to earn credit toward completion of the self-evaluation of medical knowledge requirement of MOC.[11] MOC for family physicians uses a computer-based simulation system similar to the USMLE system to facilitate comprehensive candidate evaluation.[12]

Approximately one-third of the ABMS member boards who responded to an ABMS survey conducted in October 2011 said they use a modular examination approach to accommodate for relevancy to practice. These boards administer an MOC Part III examination that represents the practice content of that particular specialty and includes a combination of core content of their specialty and modules that focus on specific practice area(s). The number of modules incorporated into the MOC Part III examination varies among the member boards that utilize the modular approach. In some cases, the number of modules incorporated into one MOC examination may be dependent on the subspecialty characteristics of a diplomate's practice. Modules may vary in length dependent upon the number of questions needed to satisfy reliability and validity requirements. Some of the boards offering modular examination choices allow diplomates to choose which modules to take along with the core exam.

Although the certification board examinations are purposely designed to test cognitive processing, not factual recall, certification boards, such as the ABIM, recognize that there are times resources within an examination may be useful. The ABIM recognizes that the current research in this area is conflicting and plans to study the effects of providing selected resources to examinees.[13]

PROGRESS REPORT ON MOC, OCC, AND THE MOL INITIATIVE

The Council on Medical Education is committed to monitoring the development of MOC, OCC, and the MOL initiative on a regular basis. AMA staff, Council members, and the Board of Trustees have participated in meetings to discuss the development of MOL that date back to 2003 and include: the Special Committee on Maintenance of Licensure (2003 – 2008), the Advisory Group on Continued Competence of Licensed Physicians (2009 – 2010), Maintenance of Licensure Implementation Group (2010 – present), MOL Workgroup on Non-Clinical Physicians (2011 – present), and CEO Advisory Council conference calls (2010 – present).

In 2009, the AMA provided a constructive critique of the modified MOC standards to the ABMS. The concerns identified by the AMA included costs to physicians, the compressed timeline for implementation of MOC, continuous documentation of measures, the impact on the physician workforce, flexibility in career pathways, flexibility with competing MOC modules, physician-specific data collection, the patient satisfaction survey, redundancy of physician reporting requirements to multiple venues, team performance, and patient safety. Similarly, in 2010 the AMA provided comments to the FSMB MOL Implementation Group.

During the November 11, 2011 Council on Medical Education General Session Meeting, the Council held an interactive session on MOC/MOL with representatives from the American Academy of Family Physicians, Alliance for Continuing Medical Education, FSMB, Council of Medical Specialty Societies, Accreditation Council for Continuing Medical Education, National Board of Medical Examiners, American Academy of Pediatrics (AAP), AAMC, National Resident Matching Program (NRMP), and ABMS. During the session, participants discussed their responses to MOC/MOL initiatives.

Future Direction for ABMS MOC

To guide the next iteration of the MOC program, a MOC Committee comprised of the ABMS and its member boards are proposing to periodically reassess the MOC program. The Committee developed a conceptual framework for MOC program standards by 2015 to reduce burdens for diplomates who must meet multiple demands for professional accountability by professional and regulatory organizations that share the same goal of promoting patient-care safety and quality and reducing burdens for diplomates that underlie the proposed changes to MOC.

The ABMS MOC Committee's main principles underlying the next iteration of MOC Elements and Standards include:

- Aligning with other professional and regulatory requirements for physician accountability;
- Providing evidence of ongoing professional development, clinical competence, quality of practice, and measurement of improvement in practice;
- Enabling diplomates to communicate meaningful and valid information to the public regarding the assessment of their continuing professional development and the quality of care;
- Facilitating diplomates as they obtain useful and specialty appropriate feedback from peers, patients, and other users about the services provided (with respect to their professionalism and communication);
- Facilitating public disclosure of important conflicts of interest in the physician-patient relationship; and

- Helping diplomates meet their needs for guided self assessment, providing evidence of ongoing competence, and pursuing continuous quality improvement.

American Osteopathic Association's Bureau of Osteopathic Specialists Board Certification

Each of the 18 specialty certifying member boards of the American Osteopathic Association's Bureau of Osteopathic Specialists (AOA-BOS) is currently developing OCC, and they will have the OCC process in place and implemented by January 1, 2013. All osteopathic physicians who hold a time-limited certificate will be required to participate in the following five components of the OCC process in order to maintain osteopathic board certification:

- Component 1 - Unrestricted Licensure: requires that physicians who are board certified by the AOA hold a valid, unrestricted license to practice medicine in one of the 50 states, and adhere to the AOA's Code of Ethics.

- Component 2 - Life Long Learning/CME: requires that all recertifying diplomates fulfill a minimum of 120 hours of CME credit during each 3-year CME cycle (some certifying boards have higher requirements). Of these 120+ CME credit hours, a minimum of 50 credit hours must be in the specialty area of certification. Self-assessment activities will be designated by each of the 18 specialty certification boards.

- Component 3 - Cognitive Assessment: requires provision of one (or more) psychometrically valid and proctored examinations that assess a physician's specialty medical knowledge as well as core competencies in the provision of healthcare.

- Component 4 - Practice Performance Assessment and Improvement: requires that physicians engage in continuous quality improvement through comparison of personal practice performance measured against national standards for his or her medical specialty.

- Component 5 - Continuous AOA Membership.

Osteopathic physicians who hold non-expiring certificates will not be required to participate in OCC at this time. However, AOA is strongly encouraging physicians to participate because the FSMB has agreed to accept OCC for MOL. Physicians who do not participate may have additional requirements for MOL as prescribed by the state(s) where physicians are licensed.[14]

Federation of State Medical Boards – MOL Initiative

The FSMB has adopted policy and a framework for MOL that is intended to provide guidance to the state medical boards about how to assure the continued competence of licensed physicians. The framework consists of three major components reflecting what is known about effective lifelong learning in medicine:

1. Reflective Self-Assessment (What improvements can I make?): Physicians must participate in an ongoing process of reflective self-evaluation, self-assessment, and practice assessment, with subsequent successful completion of appropriate educational or improvement activities.

2. Assessment of Knowledge and Skills (What do I need to know and be able to do?): Physicians must demonstrate the knowledge, skills and abilities necessary to provide safe,

effective patient care within the framework of the six general competencies as they apply to their individual practice.

3. Performance in Practice (How am I doing?): Physicians must demonstrate accountability for performance in their practice using a variety of methods that incorporate reference data to assess their performance in practice and guide improvement.

In May 2010, the FSMB established a CEO Advisory Council comprised of CEOs and other executive staff from 14 key stakeholder organizations within the medical community to serve as an advisory body to the FSMB Board of Directors and the MOL Implementation Group. The Group began development of a template proposal for state medical boards' use to implement MOL, identified potential challenges to implementation of MOL programs, and proposed possible solutions to overcome these challenges. The Group also conducted, collected, and disseminated research on the evidence for the need to initiate a MOL program and the effects of such a program on patient care and physician practice.

In November 2010, the draft report of the MOL Implementation Group was distributed to FSMB member medical and osteopathic boards and external stakeholders, including the AMA, for comment. The AMA Council on Medical Education and the AMA Young Physicians Section provided the following comments to the MOL Implementation Group.

- The AMA supports the concept of accepting MOC/OCC as meeting MOL requirements for relicensure.
- The AMA agrees with the FSMB's description of the challenges that will be encountered in the implementation of MOL, even with a phased approach; the description reads:

  "Maintenance of Licensure:
  - will impact every licensed physician in the United States;
  - must reasonably address a more heterogeneous physician population;
  - relies upon financial resources and support that are in short supply at this time; and
  - is subject to variable state laws and regulations that may require medical practice act amendments to permit MOL."

- The AMA recommended that the term "certified CME" be used in place of "accredited CME" when referring to the three CME Credit Systems (the *AMA Physician Recognition Award Category 1 Credit*™, American Academy of Family Physicians Prescribed Credit, and AOA Category 1A and Category 1B Credit) that meet MOL requirements.
- The AMA recommended that the FSMB clarify the terms "*germane* to his or her actual practice" and "*a substantial portion* of which is relevant and supports performance improvement" when referring to the CME requirements for MOL.
- The AMA opposes clinical skills examinations for the purpose of physician medical relicensure; however, AMA supports continuous quality improvement of practicing physicians, and supports research into methods to improve clinical practice, including practice guidelines, and quality improvement through local professional, non-governmental oversight.
- The AMA recommended that MOL component III, which references national benchmark data, be clarified.
- The AMA recommended that the need for additional data from physicians not involved in patient care not place an undue burden on physicians or further increase the cost of MOL to the licensing boards and physicians.

- The AMA recommended that the periodicity of MOL requirements be consistent across states and in line with current MOC requirements, and avoid licensure revocation due to MOC and OCC timeframes.
- The AMA recommended that the costs of implementing MOL not place a significant burden on physicians.

In February 2011, the FSMB Board of Directors approved the final Report of the Maintenance of Licensure Implementation Group: A MOL Proposal Template available at: *www.fsmb.org/pdf/mol-implementation.pdf*.

Pilot Projects

Currently, a variety of pilot projects that will advance the FSMB's understanding of the process, structure, and resources necessary to develop an effective and comprehensive MOL system are in development. The MOL initiative is being advanced under the leadership of the FSMB. Current discussions are focused on ten potential pilot projects, which will be presented to interested state medical boards in early 2012, with implementation anticipated to start in early-to-mid 2012.

To date, 11 state medical and osteopathic boards have expressed an interest in participating in pilot projects, including: Osteopathic Medical Board of California, Colorado Medical Board, Delaware Board of Medical Practice, Iowa Board of Medicine, Massachusetts Board of Registration in Medicine, Mississippi State Board of Medical Licensure, State Medical Board of Ohio, Oklahoma State Board of Osteopathic Examiners, Oregon Medical Board, Virginia Board of Medicine, and Wisconsin Medical Examining Board.

Through the Implementation Group and future pilot projects with individual state medical boards, the FSMB expects to develop recommendations that will be consistent across state lines. MOL will be an "evolutionary" process and will require much thought such that it provides public protection while paying attention to the concerns of physicians and the resources available to state medical boards.[15] The FSMB will be developing a toolbox of resources to aid state licensing boards and licensees to better understand and implement MOL. Examples of some of the resources that may satisfy the various MOL component requirements are listed in the FSMB Maintenance of Licensure Implementation Group Final Report (available at: *www.fsmb.org/pdf/BD_RPT_1103_%20MOL.pdf*).

Other MOL Work

In addition to the participating pilot boards, numerous other groups are working with the FSMB to guide and develop MOL policy and pilot processes and to ensure that the concerns and input of the broad spectrum of physician education, training, and practice, as well as the public, are considered as the implementation of MOL progresses. In 2011, FSMB Chair, Janelle Rhyne, MD, established a MOL Workgroup on Non-Clinical Physicians to define the non-clinical physician and develop pathway(s) that non-clinical physicians may follow to successfully participate in a state member board's MOL program. The workgroup's report is expected to be available for comment in late 2012.

INDIVIDUAL PRACTICE PERFORMANCE DATA

To comply with MOC Part IV—Practice Performance Assessment, physicians are required to look at data in their practice and develop and implement a plan to improve. The AMA is opposed to public reporting of performance data. AMA HOD Policy H-275.924 (8), Maintenance of

Certification, states "Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation."

Report on Current Uses of Practice Performance Data by Certifying Boards and Licensing Boards

In August 2011, the ABMS began to display the MOC status of member board certified physicians online (*www.CertificationMatters.org*). This information is an enhancement to board certification status data that has been posted on the ABMS Web site. Patients can see if their doctors are working to maintain their board certification by meeting the requirements of the ABMS MOC program for a particular member board. The information displayed includes the physician's name, certifying boards and "yes" or "no" as to whether the physician is meeting MOC standards. Information is currently available on physicians who are board certified by the member boards of Dermatology, Family Medicine, Nuclear Medicine, Otolaryngology, Pediatrics, Physical Medicine and Rehabilitation, Plastic Surgery, and Surgery. The remaining members boards will make MOC status information on their physicians available on the ABMS website by August 2012.[16]

To date, all of the committees and workgroups that FSMB has convened to explore the issue of MOL have been very sensitive to the concerns of physicians about the privacy of their data. The FSMB's MOL recommendations emphasize physicians' privacy. Work to date has recommended that physicians would use their own practice data as a way to compare their performance with peers locally and nationally and for identifying opportunities for improvement (or as a demonstration of improvement). Comparison of data is something that physicians would do on their own; an individual physician's practice data would not be used by the state board to compare his/her performance with other physicians.[15] As a result, the final report and MOL recommendations that were adopted by FSMB as policy included the following statement:

> Practice performance data collected and used by physicians to comply with MOL requirements should not be reported to state medical boards. Third party attestation of collection and use of such data (as part of a professional development program) will satisfy reporting requirements.

The proposed system would eliminate redundancy by allowing MOC and OCC, as well as other defined educational activities to count toward fulfillment of MOL. Physicians could comply with MOL through participation in the same activities in which they are already participating (e.g., CME, procedural hospital privileging, 360 evaluations, medical professional society/organization clinical assessment/practice improvement programs, CMS, and other similar institutional-based measures). Participation in these activities could be verified by the state medical board through third-party attestation, rather than direct reporting of performance data. A more detailed listing of proposed activities that physicians could use to comply with each of the three components of MOL are provided in the MOL Advisory Group report (see pages 79-80 of the adopted MOL policy report available at: *www.fsmb.org/pdf/mol-board-report-1003.pdf*).

FACILITATING INDIVIDUAL PHYSICIAN EFFORTS TO COMPLETE MOC, OCC, AND MOL

AMA HOD Policy H-275.923 (7), Maintenance of Certification/Maintenance of Licensure, encourages members of our House of Delegates to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

The ABMS and many of the certification boards have developed tools to assist physicians with completing MOC Part IV—Practice Performance Assessment. Examples include:

- Practice Improvement Modules (PIMs℠), developed by the ABMS in 2003, to help physicians apply quality improvement principles in practice to evaluate the ABMS and ACGME competencies of system-based practice and practice-based learning and improvement. PIMs℠ is a Web-based learning and self-administered tool that utilizes medical record audits and patient feedback. Completion of the ABIM PIM has the benefits of 20 *AMA PRA Category 1 Credits*™, the option of using data collected through the Diabetes PIM to apply for NCQA's Diabetes Physician Recognition Program (DPRP), and possible pay for performance rewards.[17, 18]

- The American Board of Family Medicine (ABFM) Part IV Performance in Practice Modules (PPMs), are Web-based, quality improvement modules in health areas that generally correspond to the self-assessment modules. With these modules, a physician can assess his or her care of patients using evidence-based quality indicators. Using a menu of interventions available from various online sources, the physician designs a plan of improvement, submits the plan, and implements the plan in practice. The physician is then able to compare pre- and post-intervention performance, and compare his or her results to those of his or her peers. Evidence of improvement is not required to satisfy this MOC-Family Practice requirement.[18] Completed PPMs may be submitted as a Best Practice Initiative in the Highmark Blue Cross Blue Shield Quality BLUE program. Currently, 20 CME credits (AAFP Prescribed Credits) are awarded for successfully completing each PPM.[19]

- Diplomates of the American Board of Surgery (ABS) who hold multiple certificates do not have to repeat Part IV for each certificate; their Part IV activity should be related to their current practice. Diplomates are encouraged to find out what programs are available through their hospital. Many hospitals participate in national programs such as the Surgical Care Improvement Project (a list is available on the ABS Web site at: *www.absurgery.org/default.jsp?exam-mocpa*). If there are absolutely no hospital-based or other programs available, then diplomates maintain their own log of cases and morbidity outcomes for 30 days to assess their performance.[20]

- The American Academy of Pediatrics sponsors Education in Quality Improvement for Pediatric Practice (eQIPP) online courses to identify and close the gaps in a physician's practice using practical tools. Physicians can learn to document improved quality care on a continuous basis, earn CME credit, and meet MOC Part IV requirements all at once.[21]

- Under a contract from the U.S. Department of Health and Human Services and the Office of the National Coordinator, ABMS and the primary care member Boards of Family Medicine, Internal Medicine and Pediatrics developed tools and activities for the ABMS MOC program to enhance physician knowledge and use of health information technology (HIT) to improve care and outcomes. The American Board of Pediatrics developed knowledge self-assessment modules; the ABIM enhanced its PIMs to incorporate measures of meaningful use of HIT and use of electronic health records; and the ABFM created a simulation tool for the development of a registry. The modules were designed to educate physicians about the basics of HIT and how it can be used to improve care.[16]

In addition to providing tools to assist physicians with completing MOC Part IV, many of the certification boards, state/specialty medical societies, and AOA provide services that facilitate individual physician efforts to complete MOC and OCC. Examples include CME live educational sessions, self-assessment programs, Webinars, and publications (journals, enduring material, etc.). The Colorado Medical Society (CMS) established a Subcommittee on Maintenance of Licensure to work with the Colorado Medical Board to create a phased-in Colorado-specific pilot. CMS has taken the initiative to shape the program to reflect Colorado physicians' input and needs, and the Subcommittee has begun to develop a comprehensive awareness campaign as MOL takes on additional importance in the state.[22]

The AMA will continue to monitor state and specialty implementation programs as the MOL pilot projects are implemented. The AMA is also looking for ways to develop unique products and services that fill gaps and benefit AMA members. The AMA publishes state licensure requirements annually in its publication, *State Medical Licensure Requirements and Statistics.*

CONTINUING MEDICAL EDUCATION

The current CME system in the United States provides high quality certified CME activities to ensure the continuous professional development of physicians as well as providing them with educational practice improvement tools and resources.

Since 1968, the AMA Physician Recognition Award (PRA) has been awarded to recognize physicians who demonstrate their commitment to staying current with advances in medicine by accumulating a minimum of 50 CME credits per year. The credit system derived to support this award, which includes *AMA PRA Category 1 Credit*™ and *AMA PRA Category 2 Credit*™, has become a "common currency" for physicians of any specialty in the United States to meet CME requirements for multiple purposes and institutions. The AMA PRA credit system has evolved over time, particularly through the approval of additional certified learning formats to reflect physicians' needs, the changing practice environment, and new technologies. The two most recent examples include performance improvement continuing medical education (PI CME) and Internet Point-of-Care. The *AMA PRA Category 1 Credits*™ can fulfill Parts II and IV of MOC if approved by the specific specialty board.

The American Academy of Family Physicians (AAFP) credit system, instituted in 1948, awards "Prescribed" or "Elective" credit to family physicians for approved CME activities. The AOA, since 1971, allows its accredited organizations to award AOA CME credits, 1-A, 1-B, 2-A, and 2-B, to physicians. There is strong communication and cooperation among the AMA, AOA, and AAFP, and their CME rules are similar in many ways.

The three established credit systems facilitate the current renewal of licensure process by providing evidence that a physician has maintained a commitment to study, apply, and advance scientific knowledge through participation in appropriate CME activities. Furthermore, these activities, by one, two or all three credit systems, are currently accepted by 63 out of 69 licensing jurisdictions, states/territories, that require certified CME credits for renewal of medical licenses. In some cases, licensing jurisdictions may have specific requirements on the type of credit.

ABMS/ACCME Joint Working Group White Paper: CME for MOC

In spring 2011, the ABMS released a white paper developed by the joint ABMS and Accreditation Council for Continuing Medical Education (ACCME) working group, which was charged to serve as a "think-tank" to explore the concept of CME for MOC. The AMA Council on Medical

Education, along with the Alliance for Continuing Medical Education, Council of Medical Specialty Societies, and the Society for Academic CME, among others, provided formal feedback on this document.[23]

The AMA provided the ABMS/ACCME working group with constructive comments to address concerns about language in the document that could be interpreted as suggesting a new category of CME credit, "MOC-CME."

> The language about a "standard currency" is unclear to us. It could refer to a de facto new credit system or to another layer of measurement or quantification beyond the one already supplied by the CME credit systems. We suggest that a "standard currency" for CME for MOC already exists through the harmonization of the three credit systems (AAFP, AMA, and AOA), which have similar requirements for credit and learning formats. This "currency" already enjoys widespread acceptance within the profession as well as "consumers" of credit such as licensing boards, the Joint Commission, and certifying specialty boards and specialty societies.

Additional comments in the letter highlighted how the *AMA PRA Category 1 Credit*™ system can meet the standards of MOC as well as suggestions on further work on the discussion of CME for MOC. The AMA continues to work actively with the ABMS to clarify the role the *AMA PRA Category 1 Credit*™ system will have in the future of MOC. Currently, some boards are requiring preapproval of certified CME activities before they can be accepted for MOC, and some boards are providing their own educational activities.

A new joint ABMS/ACCME working group was formed comprised of ABMS and ACCME representatives and individuals from within the CME provider community and CME stakeholders, including the AMA. This group has begun a series of meetings and its work is expected to take 1-to-2 years to complete. The group's work will be informed by the results of a comprehensive survey on CME and self-assessment that each ABMS member board will be completing. In addition, focus groups reflecting on ABMS member boards and their educational collaborators will be asked to comment on several issues dealing with CME and the various components of the MOC program.

DISCUSSION

The AMA has extensive policy on MOC, OCC, and the principles of MOL and supports the intent of these programs. The requirements for MOC, OCC, and MOL should be aligned, and the activities that would meet a requirement for one process should also be accepted for meeting similar or identical requirements of the others. However, MOC, OCC, and MOL are distinctly different processes, designed by independent organizations with different purposes and mandates. The AMA continues to advocate for balancing these requirements and ensuring physician input to ensure that these processes are efficient, effective, and evidence-based. The AMA is not responsible for regulating the certification and licensure processes but will continue to monitor studies that are being conducted in these areas.

Certification examinations are intended to confirm that the physician has the necessary knowledge and in some cases competence to claim expertise in the respective specialty area. Although there have been concerns about the integrity of secured "high stakes" examinations, steps are being taken to address security and copyright issues. Some certification boards are beginning to utilize standardized simulation-based competencies and modular examinations that more closely represent how practicing physicians diagnose and treat patients. The ABMS and certification boards should

be encouraged to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients.

In 2011, the AMA provided comments to the MOL Implementation Group and strongly recommended that, if state medical or osteopathic boards move forward with the more intense MOL program, the periodicity of MOL requirements should be consistent across states and in line with current MOC requirements and avoid licensure revocation due to MOC and OCC timeframes for certification and licensure. The AMA will continue to work with the FSMB and the state medical and osteopathic boards to ensure that these processes do not cause an additional burden on physicians.

AMA policy opposes the public reporting of individual practice performance data that is collected to comply with the MOC Part IV Practice Performance Assessment. The AMA will continue to work with the appropriate accrediting and certification organizations to monitor the development of MOC, OCC, and MOL to ensure that the concerns of physicians related to the privacy of their data are addressed.

The ABMS, many of the certification boards, the state/specialty medical societies, AMA, and AOA have developed tools and/or services to assist physicians with completing components for MOC and OCC. In states where MOL pilot projects are being planned, some state medical societies are collaborating with their state medical boards (e.g. Colorado) to develop awareness campaigns and shape the pilot projects to reflect physicians' input and needs. On behalf of its members, the AMA will also continue to look for ways to develop unique products and services to fill gaps and help facilitate individual physician efforts to complete MOC, OCC, and MOL. The AMA will also continue to monitor state and specialty implementation programs as the MOL pilot projects are implemented.

The FSMB and the licensing boards are moving toward a process of MOL that is similar in some aspects to the ABMS MOC process. Current CME credit systems should be considered in the re-licensure process by the individual licensure boards, as suggested in the FSMB Maintenance of Licensure Implementation Group in "A MOL Proposal Template" to avoid duplication of work as physicians meet multiple requirements for licensure and board certification.

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolutions 331-A-11, 326-A-11, 316-A-11 and 911-I-11 and that the remainder of the report be filed.

1. That our American Medical Association (AMA) encourage the American Board of Medical Specialties and the specialty certification boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients as an alternative to high stakes closed book examinations. (Directive to Take Action)

2. That our AMA reaffirm Policy H-405.974, Specialty Recertification Examinations, to reinforce that AMA encourages the American Board of Medical Specialties and its member boards to continue efforts to improve the validity and reliability of procedures for the evaluation of candidates for certification. (Reaffirm HOD Policy)

3. That our AMA Policy D-275.961, Coordinated Efforts of Federation of State Medical Boards, American Board of Medical Specialties and American Osteopathic Association

Regarding Mainenance of Licensure, be amended by insertion and deletion to read as follows: Encourage~~s~~ the FSMB and state ~~licensing~~ medical and osteopathic boards to recoognize that, if state medical or osteopathic boards move forward with the Maintenance of Licensure program, each state medical board should not revoke ~~with regards to MOL, that~~ active allopathic and osteopathic licenses ~~should not be revoked~~ on the basis of MOC or OCC requirements not being fulfilled ~~in a timely fashion because of the varying timeframes for certification and licensure~~. (Modify HOD Policy)

4. That our AMA Reaffirm Policy H-275.924, Maintenance of Certification (MOC), to reaffirm that legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation to ensure that information released not violate the privacy or integrity of the patient/physician relationship. (Reaffirm HOD Policy)

5. That our AMA Reaffirm Policy H-275.923, Maintenance of Certification/Maintenance of Licensure, to reinforce that our AMA encourages members of our House of Delegates to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups. (Reaffirm HOD Policy)

6. That our AMA Reaffirm Policy H-275.923, Maintenance of Certification/Maintenance of Licensure (MOL), that our AMA will 1) advocate that if state medical boards move forward with the more intense MOL program, each state medical board be required to accept evidence of successful ongoing participation in the American Board of Medical Specialties Maintenance of Certification and American Osteopathic Association-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL if performed; and 2) also advocate to require state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians choices in what programs they participate to fulfill their MOL criteria. (Reaffirm HOD Policy)

7. That the AMA Council on Medical Education continue to monitor the evolution of Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure, continue its active engagement in the discussions regarding their implementation, and report back to the House of Delegates on these issues at the 2013 Annual Meeting. (Directive to Take Action)

Fiscal Note: Less than $500.

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APPENDIX

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AMA HOD Policies regarding Maintenance of Certification and Maintenance of Licensure

H-405.974 Specialty Recertification Examinations
Our AMA (1) encourages the American Board of Medical Specialties and its member boards to continue efforts to improve the validity and reliability of procedures for the evaluation of candidates for certification**;** and (2) believes that the holder of a certificate without time limits should not be required to seek recertification. (CME Rep. E, A-92; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09)

H-275.924 Maintenance of Certification
AMA Principles on Maintenance of Certification (MOC): 1.Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content. 2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation. 3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by each board for MOC. 4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones). 5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permit physicians to complete modules with temporal flexibility, compatible with their practice responsibilities. 6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey would not be appropriate nor effective survey tools to assess physician competence in many specialties. 7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research, and teaching responsibilities. 8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation. 9. The AMA affirms the current language regarding continuing medical education (CME): "By 2011, each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part 2. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate’s scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA Physician’s Recognition Award (PRA) Category 1, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and or American Osteopathic Association Category 1A)." 10. MOC is an essential but not sufficient component to promote patient-care safety and quality. Health care is a team effort and changes to MOC should not create an unrealistic expectation that failures in patient safety are primarily failures of individual physicians. (CME Rep. 16, A-09)

H-275.923 Maintenance of Certification / Maintenance of Licensure
Our AMA will:
1. Continue to work with the Federation of State Medical Boards (FSMB) to establish and assess maintenance of licensure (MOL) principles with the AMA to assess the impact of MOC and MOL on the practicing physician and the FSMB to study the impact on licensing boards.

2. Recommend that the American Board of Medical Specialties (ABMS) not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
3. Encourage rigorous evaluation of the impact on physicians of future proposed changes to the MOC and MOL processes including cost, staffing, and time.
4. Review all AMA policies regarding medical licensure; determine if each policy should be reaffirmed, expanded, consolidated or is no longer relevant; and in collaboration with other stakeholders, update the policies with the view of developing AMA Principles of Maintenance of Licensure in a report to the HOD at the 2010 Annual Meeting.
5. Urge the National Alliance for Physician Competence (NAPC) to include a broader range of practicing physicians and additional stakeholders to participate in discussions of definitions and assessments of physician competence.
6. Continue to participate in the NAPC forums.
7. Encourage members of our House of Delegates to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
8. Continue to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for post graduate medical education in the US, including the Performance Improvement CME (PICME) format; and continue to develop relationships and agreements that may lead to standards, accepted by all US licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME.
9. Collaborate with the American Osteopathic Association and its eighteen specialty boards in implementation of the recommendations in CME Report 16-A-09, Maintenance of Certification / Maintenance of Licensure.
10. Continue to support the AMA Principles of Maintenance of Certification (MOC).
11. Monitor MOL as being led by the Federation of State Medical Boards (FSMB), and work with FSMB and other stakeholders to develop a coherent set of principles for MOL.
12. Our AMA will 1) advocate that if state medical boards move forward with the more intense MOL program, each state medical board be required to accept evidence of successful ongoing participation in the American Board of Medical Specialties Maintenance of Certification and American Osteopathic Association-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL if performed, and 2) also advocate to require state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians choices in what programs they participate to fulfill their MOL criteria. (CME Rep. 16, A-09; Appended: CME Rep. 3, A-10; Reaffirmed: CME Rep. 3, A-10; Appended: Res. 322, A-11)

1 **D-275.961 Coordinated Efforts of Federation of State Medical Boards, American Board of**
2 **Medical Specialties and American Osteopathic Association Regarding Maintenance of**
3 **Licensure**
4 Our AMA:
5 1. Encourages state medical boards to accept enrollment and participation in Maintenance of
6 Certification (MOC) and Osteopathic Continuous Certification (OCC) as satisfactorily meeting
7 the requirements of Maintenance of Licensure (MOL), despite varying certification and
8 licensing timeframes.
9 2. Continues to communicate with the Federation of State Medical Boards (FSMB), American
10 Board of Medical Specialties (ABMS) and American Osteopathic Association (AOA) and
11 report back the extent to which these organizations are working together (with regards to
12 Maintenance of Certification and Maintenance of Licensure) no later than the 2012 Annual
13 Meeting.

3. Encourages the FSMB and state licensing boards to recognize, with regards to MOL, that active allopathic and osteopathic licenses should not be revoked on the basis of MOC or OCC requirements not being fulfilled in a timely fashion because of the varying timeframes for certification and licensure. (Res. 325, A-11)

H-406.989 Work of the Task Force on the Release of Physician Data

1. Our AMA Council on Legislation will use the Release of Claims and Payment Data from Governmental Programs as a basis for draft model legislation.
2. Our AMA will create additional tools to assist physicians in dealing with the release of physician data.
3. Our AMA will continue to monitor the status of, and take appropriate action on, any legislative or regulatory opportunities regarding the appropriate release and use of physician data and its use in physician profiling programs.
4. Our AMA will monitor new and existing Web sites and programs that collect and use data on patient satisfaction and take appropriate action when safeguards are not in place to ensure the validity of the results.
5. Our AMA will continue and intensify its extensive efforts to educate employers, healthcare coalitions and the public about the potential risks and liabilities of pay-for-performance and public reporting programs that are not consistent with AMA policies, principles, and guidelines.
6. Our AMA: A) opposes the public reporting of individual physician performance data collected by certification and licensure boards for purposes of MOC and MOL; B) supports the principle that individual physician performance data collected by certification and licensure boards should only be used for the purposes of helping physicians to improve their practice and patient care, unless specifically approved by the physician; and C) will report how certification and licensure boards are currently using, or may potentially use, individual physician performance data (other than for individual physician performance improvement) that is reported for purposes of Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC) and Maintenance of Licensure (MOL) and report back to the HOD no later than the 2012 Annual Meeting. (BOT Rep. 18, A-09; Reaffirmed: BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmed in lieu of Res. 808, I-10; Appended: Res. 327, A-11)