HOD ACTION: Council on Medical Education Report 11 adopted and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 11-A-12

Subject: Impact of Maintenance of Certification, Osteopathic Continuous Certification, Maintenance of Licensure on the Physician Workforce (Resolution 328-A-11)

Presented by: David E. Swee, MD, Chair

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

At the 2011 Annual Meeting, the AMA House of Delegates referred Resolution 328, Impact of Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC), and Maintenance of Licensure (MOL) on the Physician Workforce, which was introduced by the Young Physicians Section. Resolution 328-A-11 asked our American Medical Association (AMA) to actively work with stakeholder organizations (i.e., Association of American Medical Colleges [AAMC], Federation of State Medical Boards [FSMB], American Board of Medical Specialties [ABMS], American Osteopathic Association [AOA], and Accreditation Council for Graduate Medical Education [ACGME]) to study the potential impact of MOC, OCC, and MOL on the physician workforce, including medical students entering into residency; resident physicians entering into unsupervised practice; and practicing physicians who are near retirement, are not board certified, or do not actively practice clinical medicine but may wish to re-enter the physician workforce in the future and to report back to the House of Delegates (HOD) on an ongoing basis with regular updates starting at the 2012 Interim Meeting, for a period of 5 years.

This report builds on the information provided in two previous Council on Medical Education (CME) reports to the HOD (CME Report 3-A-10 and CME Report 16-A-09) and addresses the potential impact of MOC, OCC, and MOL on the physician workforce.

BACKGROUND

The MOC, OCC, and MOL processes will be unfolding over the next decade, and their impact on the physician workforce is still unknown. The requirements for MOC, OCC, and MOL should be aligned, but these requirements 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 meeting MOC and OCC requirements. MOC and OCC are not intended to become mandatory requirements for state licensure renewal 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 are not engaged in MOC or OCC, may fulfill a state board's MOL requirements.[1] The AMA has provided significant input and policy related to MOC, OCC, and the principles of MOL, and the Council is committed to monitoring these issues 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 AMA raised concerns in the following areas: costs to physicians, the compressed timeline for implementation of MOC, continuous documentation of measures, the impact on the physician workforce, inflexibility in career pathways, competing MOC modules, physician-specific data collection, patient satisfaction surveys, redundancy of physician reporting requirements to multiple venues, team performance criteria, and patient safety issues. In December 2010, the AMA also provided comments to the MOL Implementation Group in support of their efforts to refine the framework and process of MOL to meet the needs of the public as well as to avoid unnecessary burdens on physicians to maintain their licenses while serving their patients and the public.

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.

AMA HOD POLICY

AMA Policy H-275.924 (5), "Maintenance of Certification," (AMA Policy Database) states that MOC requirements should not reduce the capacity of the overall physician workforce, and that it is important to retain a structure of MOC programs that permit physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.

BARRIERS TO INITIAL BOARD CERTIFICATION

The AAMC projects that the United States faces a shortage of 62,900 physicians in 2015 that will double to 130,000 across all specialties by 2025. Contributing to the physician shortage is continued growth of the US population; a projected 36% increase in the Medicare population; expansion of insurance coverage to more than 32 million US citizens under the Affordable Care Act; and nearly one-third (250,000) of currently practicing physicians will reach age 60 and likely retire in the next 10 years.[2] Although new medical schools are opening and many existing schools are expanding their enrollments to meet the increased need for physicians, graduate medical education (GME) core training programs leading to initial board certification have not grown due to limited funding—a problem that will exacerbate the existing physician shortage.

Because the 1997 Balanced Budget Act capped the number of Medicare-funded GME positions at 1996 levels, competition for initial residency slots has intensified.[3] Currently, the number of applicants seeking residency training outnumbers available residency positions. In the 2012 initial NRMP, there were 815 graduating MD seniors and 757 previous MD graduates from US medical schools as well as 596 graduates of osteopathic medical schools who did not match to a residency program. In addition, there were 2,177 US citizen graduates of international medical schools and 4,053 non-US citizen students/graduates of international medical schools that were eligible to enter

a residency program but did not match.[4] For individuals who were not matched to a residency position, the NRMP debuted the Supplemental Offer and Acceptance Program℠ (SOAP℠), a new process developed to streamline, equalize, and automate the process for applicants who are not matched initially. After processing the matching algorithm, 1,131 positions were placed in the SOAP, and of these, 1,033 were filled, mostly by US seniors, leaving many other applicants without a residency position.

Although physicians must complete a core residency training program as a requirement for initial certification by a specialty board, specialty board certification is not required for physician licensure. Furthermore, 50 of 68 state licensing authorities currently will grant a license to US-trained MDs and DOs who have completed only 1 year of GME.[5]

A 2010 analysis of FSMB data showed that 25.5% of actively licensed physicians (MDs and DOs) were not certified by an ABMS specialty board.[6] The analysis did not indicate whether the noncertified physicians had ever been certified or recertified. Depending on the physician's professional activities, some physicians may have chosen not to proceed with specialty board certification even though they may have fulfilled all requirements to do so.[7]

IMPACT OF MOC ON PHYSICIANS' DECISION TO RETIRE

Most physicians with time-unlimited ("grandfathered") specialty certificates issued prior to circa 1990 have chosen not to become recertified, perhaps due to the time and expense involved.[8,9] A recent AAMC/AMA survey found that more than one third (36%) of US physicians in practice are age 55 or older and likely to retire in the next 10 to 15 years.[10] Of currently active physicians aged 50 or older, 61% anticipate they will stop providing patient care by the age of 65. However, only 15% cited "recertification requirements" as a very important factor in the decision to retire.[10] This study was conducted before the economic downturn, and no recent studies were found in the literature.

Published studies on the impact of MOC on an older physician's decision to retire are limited. However, certifying agencies, such as the American Board of Orthopaedic Surgery, have not seen evidence that the MOC process is forcing surgeons into retirement.[11] A national survey of "inactive" physicians in the United States showed that a majority of fully retired (56.1%) physicians kept their specialty/subspecialty board certifications current.[12]

PHYSICIAN RE-ENTRY INTO CLINICAL PRACTICE

A growing number of physicians are leaving the clinical practice of medicine for various reasons, including family leave, caretaking responsibilities, personal relationship issues, health issues, career dissatisfaction, pursuit of alternative careers, and humanitarian leave. Following a break in practice, many seek to return at some point.[13,14] The status of a physician's medical license is a key factor in the re-entry process. Those with an active license have more options. Physicians whose licenses are inactive or have lapsed, or physicians who are not currently active in clinical practice may need to meet state licensure requirements as part of their re-entry process.[13]

The AMA has published recommendations on physician re-entry (available at: *www.ama-assn.org/resources/doc/med-ed-products/physician-reentry-recommendations.pdf*). The recommendations are a product of a 2010 conference titled, "Physician Re-Entry to Clinical Practice: Overcoming Regulatory Challenges," sponsored by the AMA, in collaboration with the FSMB and AAP. The overall goal of these recommendations is to ensure that there is a comprehensive, transparent, and feasible regulatory process that also ensures public safety for use

with physicians who desire to return to clinical practice. The recommendations are designed for medical licensing boards to consider as they develop and implement physician re-entry policies.

The FSMB is currently working with state licensing agencies to develop re-entry guidelines to avoid unnecessary duplication with its plans for MOL.[13] Additionally, 58% of state licensing boards have developed a policy on re-entry in order to assure citizens of their respective states that physicians who leave clinical practice are qualified to return.[15]

DISCUSSION

On February 8, 2012, the AMA Physician Masterfile showed that 77.8% (638,249) of the approximately 820,465 active practicing physicians (not including resident physicians) were certified by one of the 24 Member Boards of the ABMS. Of the total certified, 58.6% were initial certifications, 31.7% were recertifications, and 9.6% had multiple certifications.[16] In addition, nearly 40% of DOs are certified through one of the 18 specialty boards of the American Osteopathic Association's Bureau of Osteopathic Specialists.[6]

Specialty board certification is becoming a frequent requirement for credentialing by hospitals, health systems, and health insurance plans. Physicians without specialty boards have difficulty obtaining hospital privileges and are usually precluded from serving on medical school faculties. Board certification is usually a requirement to serve on committees or boards that accredit medical education programs (e.g., ACGME's Residency Review Committees).[7,9]

Lack of certification might reflect a delay or break in training or the fact that some boards require documentation of actual practice before board certification. For some physicians, participation in MOC and OCC may ultimately fulfill requirements for MOL and avoid unnecessary duplication of work.[6]

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 328-A-11 and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy H-275.924 (5), Maintenance of Certification (MOC), to reinforce that MOC requirements should not reduce the capacity of the overall physician workforce, and that it is important to retain a structure of MOC programs that permit physicians to complete modules with temporal flexibility, compatible with their practice responsibilities. (Reaffirm HOD Policy)

2. That our AMA encourage the Federation of State Medical Boards to continue to work with state licensing boards to accept physician participation in maintenance of certification (MOC) and osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and that MOC or OCC not be the only pathway to MOL for physicians. (Directive to Take Action)

3. That our AMA encourage the American Board of Medical Specialties to use data from maintenance of certification to track whether physicians are maintaining certification and share this data with the AMA. (Directive to Take Action)

4. That our AMA reaffirm Policy D-300.984, Physician Re-entry, to reaffirm AMA's Guiding Principles on Re-entry and ensure that the AMA takes a leadership role to assure that its re-

entry recommendations, including studying the workforce implications of a system that supports re-entry, are fully considered in any future initiatives on physician re-entry. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

References

1. Chaudhry H, Rhyne J, Waters S, et al. Maintenance of Licensure: Evolving from Framework to Implementation. Journal of Medical Regulation. 2012;97(4). Available at: www.fsmb.org/pdf/jmr-mol.pdf (accessed 4-2-12)
2. Physician Shortages to Worsen Without Increases in Residency Training. Association of American Medical Colleges. Available at: *www.aamc.org/download/150584/data/physician_shortages_factsheet.pdf* (accessed 1-23-12).
3. Salsberg E, Rockey PH, Rivers KL, et al. US Residency Training Before and After the 1997 Balanced Budget Act. *JAMA*. September 10, 2008;300(10): 1174-1180.
4. Advance Data Tables: 2012 Main Residency Match. National Resident Matching Program. Available at: www.nrmp.org/data/datatables2012.pdf (accessed 3-23-12)
5. Rockey PH, Donini-Lenhoff F, Welcher C. Health Reform, Primary Care, and Graduate Medical Education. *N Engl J Med*. November 25, 2010;363(22): 2176-2177.
6. Young A, Chaudhry HJ, Rhyne, J, et al. A census of Actively Licensed Physicians in the United States, 2010. *Journal of Medical Regulation*. 2011;96(4):10-20.
7. Jeffee DB, Andriole DA. Factors Associated With American Board of Medical Specialties Member Board Certification Among US Medical School Graduates. *JAMA*. 2011;306(9):961-970.
8. Levinson W, King TE Jr. Enroll in the MOC program as currently configured. *N ENG J Med*. March 11, 2010; 362(10):949-950.
9. Xierali IM, Rinaldo JC, Green LA, et al. Family Physician Participating in Maintenance of Certification. *Annals of Family Med*. May/June 2011;9(3):203-210.
10. Rockey PH, Erikson CE, Welcher CM, Salsberg ES. Physician Morale in the United States. International Medical Workforce Collaborative. 2008 September. Available at: *http://rcpsc.medical.org/publicpolicy/imwc/Physician_Morale_in_the_United_States(7).pdf* (accessed 2-6-12)
11. OrthoSuperSite. Maintenance of Certification and Licensure remains inevitable, but controversial. Available at: *www.orthosupersite.com/print.aspx?rid=90259* (accessed 1-19-12).
12. Jewett EA, Brotherton SE, Ruch-Ross, H. A national survey of "inactive" physicians in the United States of America: enticements to reentry. Human Resources for Health, 2011. Available at: www.human-resources-health.com/content/9/1/7 (accessed 3-22-12)
13. Report for the Special Committee on Re-entry to Practice. Federation of State Medical Boards. September 20, 2011.
14. Kenagy GP, Schneidman, BS, Barzansky B, et al. Physician Re-entry into Clinical Practice: Regulatory Challenges. *Journal of Medical Regulation.* 2011;97(1):10-15.
15. Lenhoff F. *State Medical Licensure Requirements and Statistics, 2012*. American Medical Association. 2012.
16. AMA Physician Masterfile, February 8, 2012.

ATTACHMENT

AMA HOD Policies regarding Maintenance of Certification and Physician Re-entry

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)

D-300.984 Physician Re-entry
Our AMA:
1. Will continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs.
2. Will work collaboratively with the American Academy of Pediatrics and other interested groups to convene a conference on physician reentry which will bring together key stakeholders to address the development of reentry programs as well as the educational needs of physicians reentering clinical practice.
3. Will work with interested parties to establish a physician reentry program (PREP) information data base that is publicly accessible to physician applicants and which includes information pertaining to program characteristics.
4. Will support efforts to ensure the affordability and accessibility, and to address the unique liability issues related to PREPs.

5. Will make available to all interested parties the physician reentry program (PREP) system Guiding Principles for use as a basis for all reentry programs:
a. Accessible: The PREP system is accessible by geography, time and cost. Reentry programs are available and accessible geographically across the United States and include national and regional pools of reentry positions. Reentering physicians with families or community ties are not burdened by having to relocate to attend a program. The length of time of reentry programs is standardized and is commensurate with the assessed clinical and educational needs of reentering physicians. The cost of reentry programs is not prohibitive to the physician, health care institutions or the health care system.
b. Collaborative: The PREP system is designed to be collaborative to improve communication and resource sharing. Information and materials including evaluation instruments are shared across specialties, to the extent possible, to improve program and physician performance. A common nomenclature is used to maximize communication across specialties. Reentry programs share resources and create a common repository for such resources, which are easily accessible.
c. Comprehensive: The PREP system is comprehensive to maximize program utility. Physician reentry programs prepare physicians to return to clinical activity in the discipline in which they have been trained or certified and in the practice settings they expect to work including community-based, public health, and hospital-based or academic practice.
d. Ethical: The PREP system is based on accepted principles of medical ethics. Physician reentry programs will conform to physician licensure statues. The standards of professionalism, as stated in the AMA Code of Medical Ethics, must be followed.
e. Flexible: The PREP system is flexible in structure in order to maximize program relevancy and usefulness. Physician reentry programs can accommodate modifications to program requirements and activities in ways that are optimal to the needs of reentering physicians.
f. Modular: Physician reentry programs are modularized, individualized and competency-based. They are tailored to the learning needs of reentering physicians, which prevents the need for large, expensive, and standardized programs. Physicians should only be required to take those modules that allow them to meet an identified educational need.
g. Innovative: Innovation is built into a PREP system allowing programs to offer state of the art learning and meet the diverse and changing needs of reentry physicians. Physician reentry programs develop and utilize learning tools including experimenting with innovative and novel curricular methodologies such as distance learning technologies and simulation.
h. Accountable: The PREP system has mechanisms for assessment and is open to evaluation. Physician reentry programs have an evaluation component that is comparable among all specialties. Program assessments use objective measures to evaluate physician's competence at time of entry, during the program and at time of completion. Program outcomes are measured. Reliability and validity of the measures are established. Standardization of measures exist across programs to assess whether or not national standards are being met.
i. Stable: A funding scheme is in place to ensure the PREP system is financially stable over the long-term. Adequate funding allows physician reentry programs to operate at sufficient and appropriate capacity.
j. Responsive: The PREP system makes refinements, updates and other changes when necessary. Physician reentry programs are equipped to address systemic changes such as changes in regulations. Additionally, the PREP system is prepared to respond efficiently to urgent health care needs within society including mobilizing clinically inactive physicians temporarily into the workforce to attend to an acute public health crisis, such as a terrorist, biological, chemical, or natural disaster.
6. Will, as part of its Initiative to Transform Medical Education strategic focus and in support of its members and Federation partners, develop model program standards utilizing PREP system Guiding Principles with a report back at the 2009 Interim Meeting. (CME Rep. 6, A-08)