HOD ACTION: Council on Medical Education Report 2 adopted and the remainder of the report filed.

REPORT 2 OF THE COUNCIL ON MEDICAL EDUCATION (A-16)
Update on Maintenance of Certification and Osteopathic Continuous Certification
(Resolutions 309-A-15, 318-A-15, 903-I-15, 924-I-15 and 925-I-15)
(Reference Committee C)

EXECUTIVE SUMMARY

The Council on Medical Education has monitored the implementation of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC) during the last year. This annual report, mandated by Policy D-275.954, provides an update on some of the changes that have occurred as a result of American Medical Association (AMA) efforts with the American Board of Medical Specialties (ABMS) to improve the MOC process. The following activities are highlighted in this report.

MOC Activities

- AMA participation in meetings and conferences to improve the MOC process (page 2)
- Emerging data and literature related to the value of MOC (page 2)
- Implementation of the new ABMS MOC Directory powered by MedEdPORTAL (page 4)
- Alternatives to the MOC Part III secure, high-stakes examination (page 5)
- An update on the requirements for maintaining underlying specialty board certifications (page 6)
- An update on MOC Part IV, practice performance assessment (page 7)
- MOC Part IV pilot programs/innovations (page 8)
- The ABMS Multi-Specialty Portfolio Program (page 8)
- Cost effectiveness of MOC (page 9)

Resolutions 924-I-15 and 925-I-15 asked the AMA to review alternative pathways to board recertification that can assist physician credentialing and recredentialing entities such as medical staffs, hospitals, employers and third parties to determine whether alternative mechanisms, i.e., the National Board of Physicians and Surgeons (NBPAS) Recertification, are equivalent in quality to established pathways. As a first step, this report provides background information about recertification programs in the United States as well as in other countries. The report looks at professionalism and the public's perspective and the need to evaluate new pathways to board recertification.

An update on OCC is also provided in this report. The American Osteopathic Association-Bureau of Osteopathic Specialists (AOA-BOS) is currently reviewing the entire OCC process with an eye toward ensuring the effectiveness of the OCC process while making it less onerous for its diplomates.

HOD ACTION: Council on Medical Education Report 2 adopted and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-A-16

Subject: Update on Maintenance of Certification and Osteopathic Continuous Certification (Resolutions 309-A-15, 318-A-15, 903-I-15, 924-I-15 and 925-I-15)

Presented by: Darlyne Menscer, MD, Chair

Referred to: Reference Committee C
(Albert M. Kwan, MD, Chair)

Resolution 309-A-15, Maintenance of Certification, introduced by the New York Delegation and referred by the American Medical Association (AMA) House of Delegates (HOD), asked that our AMA advocate for a moratorium on the maintenance of certification (MOC) requirements of all medical and surgical specialties until it has been reliably shown that these programs significantly improve patient care.

Resolution 318-A-15, Maintenance of Certification, introduced by the American College of Cardiology, Society for Cardiovascular Angiography and Interventions, American Society for Echocardiography and Heart Rhythm Society, and referred by the AMA HOD, asked that our AMA congratulate the American Board of Medical Specialties (ABMS) and its member boards on their century of service to our profession and our patients, and to engage the ABMS and its member Boards to conduct an independent, external review process to examine the performance and impact of Board policies, procedures, organizational structure and governance.

Resolution 903-I-15, Maintenance of Certification, introduced by the Indiana Delegation and referred by the AMA HOD, asked that our AMA oppose further requirements for physician board certification of physicians beyond the 10-year board recertification exams, placing on hold any additional MOC requirements until objective study of the validity and cost-effectiveness of such additional requirements is complete.

Resolution 924-I-15, Alternative Pathways to Board Recertification, introduced by the Washington Delegation and referred by the AMA HOD, asked that our AMA 1) review alternative pathways to board recertification that can assist physician credentialing and recredentialing by entities such as medical staffs, hospitals, employers and third party payers, and 2) support alternative mechanisms for board recertification that are determined to be equivalent in quality to established recertification pathways.

Resolution 925-I-15, National Board of Physicians and Surgeons, introduced by the Georgia Delegation and referred by the AMA HOD, asked that our AMA advocate that the National Board of Physicians and Surgeons (NBPAS) be recognized as an alternative to ABMS boards for recertification for physicians nationally.

Policy D-275.954 (1), Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), requires our AMA to prepare a yearly report regarding the MOC and OCC processes.

Reference Committees C and K at the 2015 Annual and Interim HOD Meetings heard limited and mixed testimony on Resolutions 309-A-15, 318-A-15 and 903-I-15. The process of MOC contains many elements, and suspension of the entire program as recommended in Resolution 309-A-15 would have included removal of components such as continuing medical education (CME) and fulfillment of licensing requirements. Also, a moratorium would have affected all 24 ABMS member boards, even though a number of these boards are viewed favorably by their diplomates. It is not the role of the AMA to oversee ABMS member board policies, procedures, organizational structure and governance processes as recommended in Resolution 318-A-15. The Council on Medical Education has been actively engaged in discussions with various stakeholders, including the ABMS, to make meaningful and effective changes in the methodology of maintenance of professional competency, and some specialties have already implemented alternative methods of MOC that meet the goals of Resolution 903-I-15. Reference Committee K felt that the study of alternative mechanisms for board recertification called for in Resolution 924-I-15 should be completed before supporting alternative pathways to recertification, as called for in Resolutions 924-I-15 and 925-I-15.

BACKGROUND

The Council on Medical Education has prepared reports covering MOC and OCC for the past seven years.[1,2,3,4,5,6,7] This report addresses Resolutions 309-A-15, 318-A-15, 903-I-15, 924-I-15 and 925-I-15 as well as the mandate of Policy D-275.954 (1) as it relates to MOC/OCC, and also provides an update on the most recent activities on this topic. As shown in the Appendix, the AMA has extensive policy on MOC and OCC.

The Council on Medical Education continues to monitor the implementation of MOC and OCC. Council members, along with the Board of Trustees and AMA staff, have participated in numerous meetings with the ABMS and its member boards during the last year, including:

- ABMS Committee on Continuing Certification (a Council member is appointed to this committee, which develops and oversees implementation of MOC standards. The Council member appointee facilitates bidirectional communication between the AMA and ABMS regarding MOC Standards and policies)
- ABMS Forum on Organizational Quality Improvement
- ABMS 2015 Conference
- Maintenance of Certification Summit
- ABMS Board of Directors Meeting

MAINTENANCE OF CERTIFICATION (MOC): AN UPDATE

The AMA congratulates the ABMS and the ABMS member boards on their century of service to the profession and its patients.

Update on the Emerging Data and Literature Regarding the Value of MOC

The Council on Medical Education reviewed recently published literature and emerging data as part of its ongoing efforts to objectively review MOC issues. Published data supporting behavioral changes resulting from participation in MOC is limited; however, recent studies show that MOC activities are resulting in quality care and performance improvement initiatives and programs.

One such example is an online activity developed by the Annenberg Center for Health Sciences at Eisenhower Medical Center (Rancho Mirage, CA) which addressed gaps in osteoporosis management; provided practice improvement options based on recognized models for such activities (e.g., the METRIC Diabetes Module offered by the American Academy of Family Physicians, a provider of MOC for Family Physicians Part IV, Improvement in Medical Practice, credit); and evaluated the impact of the activity in improving practice attributes and adherence to national standards of care. This practice improvement intervention to optimize fracture prevention resulted in significant improvements in all key performance measures other than the percentage of patients receiving a diagnosis of osteoporosis. Results were consistent with other practice improvement initiatives for osteoporosis and other areas of medicine. Improvements demonstrated in this activity support the benefit of performance improvement initiatives and provide a foundation for ongoing research including associations between performance improvement and health outcomes.[8]

A quality improvement (QI) intervention implemented at the University of California Davis Children's Hospital, which included stakeholder involvement, clinician education, standardization of documentation, policy changes, and the provision of American Board of Pediatrics Part IV MOC credits, improved the quality and timeliness of discharge summaries. This intervention demonstrated that the timelines and quality of discharge summaries can be markedly improved by actively engaging physicians in integrating improvement goals with QI education and practice.[9]

An MOC Part IV project that was created on the basis of an existing hypertension improvement program at the Permanente Medical Group allowed its participants to improve the care of their patients without an increased perceived burden to their practice. There was no association between the choice of improvement option and either the level of improvement or the perception of workload. This project also demonstrated that this MOC project was an effective way to document practice performance improvement.[10]

The American Board of Surgery recognizes participation in a registry that tracks patient outcomes as meeting the practice assessment requirement for MOC. Two recent studies provided evidence that active participation in a national or state registry can improve quality of care, often through the identification of best practices:

- Participation in the American College of Surgeons, National Surgical Quality Improvement Program (ACS NSQIP) is associated with reductions in adverse events after surgery. The results from this study confirm that participation in ACS NSQIP, for up to eight years, is associated with declining observed/expected ratios (improving performance); thus, QI increases with time in the program.[11]

- Registries in 47 hospitals in Washington State were used to evaluate the relationship between postoperative NSAID administration and anastomotic complications. This study showed that among patients undergoing non-elective colorectal resection, post-operative NSAID administration was associated with a significantly increased risk for anastomotic complications, with the prediction that these data may be enough for some surgeons to alter practice patterns. The results of this study, taken in the context of prior literature, emphasize the importance of a learning health care system to determine the proper role of drugs, devices and interventions.[12]

QI projects within the MOC Multi-Specialty Portfolio Program that were presented during the 2015 Forum on Organizational Quality Improvement (QI Forum), hosted by the ABMS, ranged from those involving large health systems with thousands of physicians, and cooperative projects

between systems in different states, to small, single-center pilot programs. The QI Forum featured 34 improvement efforts from organizations including the Mayo Clinic, University of Vermont College of Medicine, Carolinas HealthCare System and many others (abms.org/initiatives/delivering-organizational-quality-improvement/forum-on-organizational-quality-improvement/2015-qi-forum/). The goal of the QI Forum was to share findings, results and best practices to expand QI and measure value to patients, practitioners and organizations. An emerging theme during the 2015 QI Forum was the value that practicing physicians found in the MOC-integrated QI projects.

- One initiative at Johns Hopkins focusing on cardiovascular disease and improving hypertension control rates included the development of an updated checklist to emphasize several evidence-based interventions.[13]

- Another MOC-integrated initiative at the University of Michigan focused on improving workflow, which ultimately improved rates of tetanus, diphtheria and pertussis (Tdap) immunizations and diabetic foot exams.[14]

- In an initiative at the University of Nebraska, nearly 80 percent of physicians said that participation in the initiative helped them implement strategies to improve the immunization rates of children and adolescents.[15]

The literature also shows that despite the recent criticism about the value of MOC, participation in this process by board-certified family physicians has been consistent with historic participation rates and remains robust.[16] Similarly, a study that looked at all physicians whose original certification was granted in internal medicine from 1990-1993 showed that keeping up-to-date and fulfilling their professional obligations to patients appears to be most important to certified internists. Participation in the ABIM MOC program seems to be high, and most participants are completing the MOC requirements in a timely manner.[17] Another study that examined the career paths, disciplinary actions and ABMS certification status of internal medicine physicians who trained a decade ago suggests that policymakers could use board certification as a potential marker of higher performance and fewer disciplinary actions in practice.[18]

Because MOC has been introduced gradually during the last decade, the evidence that results from longitudinal data collection is just beginning to emerge. The ABMS Research and Education Foundation has been engaged in research efforts to support a range of national initiatives that have significant impact on the delivery of quality health care and improved outcomes. The ABMS Evidence Library, which houses the references and annotations of the research compilation, is available at evidencelibrary.abms.org. Continuous study of its evidence will be important in identifying improvements to the program as advances in clinical practice, technology and assessment occur.

ABMS MOC Directory Powered by MedEdPORTAL

The ABMS, in collaboration with the Association of American Medical Colleges, has developed the ABMS MOC Directory, which is powered by MedEdPORTAL (mededportal.org/abmsmoc/continuingeducation), an online repository of competency-based MOC activities that have been reviewed and approved by the ABMS and appropriate participating member boards. Physicians are able to use the directory to identify MOC activities in a single portal that may be appropriate for their needs and provide continuing medical education (CME) credit. The listing includes activities approved for multiple specialties and/or practice settings. CME providers can expedite the review and approval process for their activities by ABMS member

boards to ensure that CME activities are available to meet MOC requirements relevant to their specialty. The CME community will be allowed to submit relevant educational activities for approval to the portal on a rolling submission cycle (with no submission deadline). The directory provides a common platform for MOC activities and resources to assist diplomates in fulfilling their MOC Parts II and IV requirements.

Alternatives to the Secure, High-stakes Examination for Assessing Knowledge and Cognitive Skills in MOC

An ABMS Task Force on Innovations in the Assessment of Knowledge, Judgment and Skills has been meeting since last year to evaluate how innovations in assessment and adult learning can inform the delivery and design of MOC examinations offered by ABMS member boards. The task force is exploring a number of innovations that could address diplomates' concerns about MOC Part III cognitive knowledge: blueprinting and modularization techniques that facilitate customizing of exam content to reflect focused practices within the disciplines; access to materials similar to those used at the point of care; remote access to test material, which would alleviate the need for examinees to travel to testing centers; performance feedback mechanisms to guide educational and development plans; and movement toward frequent, low-stakes, formative testing in place of infrequent, high-stakes, summative testing. The task force also is reviewing innovations in test development that simulate clinical scenarios and assess diagnostic acumen and clinical judgment rather than recall.

Concurrent with these efforts, some ABMS member boards are also looking at ways to innovate assessment of medical knowledge, and some have implemented alternatives to the traditional high-stakes secure examination.[19]

- The American Board of Anesthesiology (ABA) developed MOCA 2.0 to create a tool for ongoing low-stakes assessment and provide more extensive, question-specific feedback. It was also designed to provide focused content that could be reviewed periodically to refresh knowledge and document cognitive expertise. To help ABA diplomates achieve a better understanding of this model, ABA developed a free web application known as the MOCA Minute™. The MOCA Minute is a longitudinal assessment tool that requires diplomates to answer 30 questions per calendar quarter, or 120 per year, in lieu of taking a 10-year exam. Participation in the MOCA exam pilot was voluntary and did not guarantee a passing score on the MOCA Exam and had no impact on the volunteer's program requirements. Analysis of the July 2014 MOCA examination showed that MOCA Minute was associated with improved exam performance.[20] Further analysis of the pilot data is underway to determine whether participants accessed the links to additional resources, learned the material, and improved performance in the content knowledge areas represented in the MOCA Minute Pilot.

- The American Board of Dermatology (ABD) emphasizes the learning experience by making test preparation material available six months before the examination. The material includes diagnoses from which the general dermatology clinical images will be drawn as well as questions that will be used to generate the subspecialty modular examinations. All examinees are required to take the general dermatology module, consisting of 100 clinical images designed to assess diagnostic skills. The diplomate can then choose among 50-item subspecialty modules in medical dermatology, dermatopathology, pediatric dermatology or dermatologic surgery. Passing scores are required for the general and subspecialty modules. The ABD also successfully completed trials employing remote proctoring technology to monitor examination administration in the diplomates' homes or offices.

- The American Board of Plastic Surgery (ABPS) developed a secure, modular, computer-based exam for its 10-year MOC cycle. The ABPS offers its diplomates an MOC Study Guide with more than 2,300 multiple-choice question (MCQs) items derived from the same sources used for the MOC exam. Diplomates can study the entire guide or focus on specialty-specific practice content. For each 200-item MOC exam, 25 percent of the items address core principles and 75 percent are specialty-based. Performance results are provided to examinees to help focus future learning.

- The American Board of Internal Medicine (ABIM) has enhanced its exam by including new fidelity features, such as a zoom feature for images, presentation of realistic laboratory reports with normal ranges, embedded audio clips of heart sounds, and video clips of patient presentations. A new web-based, geographic score report presents more clearly the performance results for a given examinee, to highlight areas of strength and weakness for specific exam questions that were missed. Some of the exams allow the examinee to select the best of two or best of three options instead of being limited to a single option response. The ABIM is also researching and developing the use of external or web resources during the examination, computer-based simulation with patient avatars, and the introduction of adaptive testing techniques, where the exam advances differently depending on an examinee's response to each situation and where the examinees might be able to leave early based on their performance.

- The American Board of Obstetrics and Gynecology (ABOG) will begin a pilot program in 2016 to integrate the self-assessment and external assessment MOC requirements to allow diplomates to continuously demonstrate their knowledge of the specialty. The pilot will also allow diplomates to earn an exemption from the current computer-based MOC examination in the sixth year of the program if they reach a threshold of performance during the first five years of the self-assessment program. Currently, the secure, external assessment is offered in the last year of each ABOG diplomate's six-year cycle in a modular test format, and physicians are allowed to choose two selections that are the most relevant to their current practice.

The ABMS is initiating a pilot project to test assessment models for the recertification examination, similar to the ABA's MOCA Minute described above. The ABA's announcement to replace its current MOCA Examination with the MOCA Minute in 2016 has stimulated interest among ABMS member boards to develop similar assessment approaches for their disciplines. Within a general framework for the assessment models being tested, there is substantial room for board-specific differences in program emphasis and assessment formats. For example, the ABA's MOCA Minute uses question-based assessments, but other options include article-based assessments and problem/topic-based assessments that group items around a theme, such as management of asthma in children, or a combination of the two. Member boards will decide which approaches are most appropriate for their specialty.

Update on the Requirements for Maintaining Underlying Specialty Board Certifications

Some of the larger ABMS member boards that offer numerous subspecialty certifications have made changes to their MOC requirements for maintaining underlying primary or initial specialty board certification to allow physicians the option to focus only on MOC activities relevant to their practice. For example, ABIM diplomates no longer need to maintain underlying subspecialty certificates in a foundational discipline to remain certified in any of the ABIM's 20 subspecialties. All ABIM diplomates are now able to choose the certification they wish to maintain. This policy change, effective January 1, 2016, affected the nine subspecialties that previously had this requirement: adolescent medicine, adult congenital heart disease, advanced heart failure and

transplant cardiology, clinical cardiac electrophysiology, hospice and palliative medicine, interventional cardiology, sleep medicine, sports medicine and transplant hepatology. For instance, interventional cardiology diplomates will no longer need to maintain cardiovascular disease certification in order to maintain certification in interventional cardiology. Similarly, the American Board of Pediatrics (ABP) allows its diplomates to maintain subspecialty certification without simultaneously maintaining certification in general pediatrics. However, there is one exception—pediatricians who wish to maintain certification in pediatric transplant hepatology are required to maintain certification in pediatric gastroenterology. These policies will not change the ABP requirements for initial certification in these subspecialties.

Update on MOC Part IV, Practice Performance Assessment

The ABMS is conducting a comprehensive review of the Improvement in Medical Practice (IMP) element of MOC. The goals of the review are to: 1) clarify IMP's purpose and intent; 2) align requirements across the 24 ABMS member boards; 3) integrate IMP with other physician professional assessment activities; and 4) deliver more value to practicing physicians.

An ABMS task force has been appointed to conduct the review and develop a statement of principles to be considered by the Board of Directors in June 2016. Several work streams will inform the task force's deliberations, including:

- A Review of Member Board IMP activities: To be led by the ABMS Committee on Continuing Certification, the review of member boards' IMP activities will inform the task force about best practices, concerns, and other observations and recommendations of this group;

- Stakeholder Input: Input from both internal and external stakeholders will be gathered to understand their expectations of the MOC process as it relates to QI;

- Review of Information: A comprehensive review of public materials from websites, articles, etc., will be conducted to identify which IMP activities have been reported as most problematic for diplomates and which activities have been identified as most helpful/appropriate; and

- Facilitated Board Discussion: The ABMS Board of Directors will engage in a facilitated and structured discussion about IMP and the key issues to be determined.

Since adopting the IMP requirement as programmatic policy in 2000, the ABMS member boards have taken different approaches to its implementation, which has raised important questions about what ABMS board certification should signify relative to medical practice improvement. Some diplomates, specialty societies, and others have recently expressed dissatisfaction with current IMP requirements as time-consuming and burdensome, out-of-sync with current medical practice, poorly aligned with other professional assessment and improvement activities, and highly variable among the boards. Some specialty societies have called for the elimination of the IMP requirement altogether.

The ABMS believes that the task force's review of the IMP requirement will lead to a community-wide conclusion on IMP's role and purpose and will guide the boards in the design and delivery of their MOC programs. Issues for discussion include:

- What is the purpose and value of the IMP requirement;

- Whether the AMA PI-CME model is appropriate for all physicians and all improvement activities;

- Whether and how personal improvement relates to system improvement;

- What constitutes meaningful engagement of physicians in system-level improvement activities; and

- What specific value is added to the certificate (credential to practice in a specialty) by including a requirement to demonstrate improvement in medical practice.

At its October 2015 meeting, the ABMS Board of Directors reaffirmed its commitment to the IMP component of the ABMS Program for MOC. The Board continued its discussion on QI and the purpose and intent of IMP during its retreat and meeting in February 2016, and the task force will report its findings to the Board at its meeting in June 2016.

MOC Part IV Pilot Programs/Innovations

Several member boards have taken steps to make MOC Part IV meaningful but less onerous for physicians while developing new programs.

- The American Board of Radiology has expanded options for Part IV requirements that focus on giving credit for activities that diplomates are already performing as part of their practices or voluntary professional efforts (theabr.org/moc-prt4-activities).

- The American Board of Thoracic Surgery replaced the requirement for mandatory database participation with PI and required its diplomates to participate in a practice QI project by January 2016. For those who do not participate in a board-approved database/registry, the board will continue to require participation in the Professional Portfolio Program until the practice QI process starts.

The ABIM has extended the policy announced on February 3, 2015 and will not require Practice Assessment, Patient Voice and Patient Safety in its MOC program through December 31, 2018.

ABMS Multi-Specialty Portfolio Program

The ABMS Portfolio Program (mocportfolioprogram.org) provides a streamlined approach for hospitals, health care organizations and professional societies to support physician involvement in QI initiatives by allowing physicians the opportunity to receive MOC Part IV credit. Because the Portfolio Program allows hospitals and health care organizations to apply Part IV MOC to team-based, multi-specialty projects that physicians are already engaging in at their organizations, it eases the burden on physicians by reducing duplication of QI projects and promotes organizational effectiveness and efficiency through team-based initiatives. Many of these MOC activities satisfy other national, state and private-sector QI and reporting activities. Furthermore, there are no additional costs to physicians who participate in the program.

As of January 2016, 20 ABMS member boards are participating in the Portfolio Program and more than 1,300 QI projects have been approved for MOC Part IV from the 64 active Portfolio Sponsor organizations. Nearly 8,000 individual physicians have completed those projects, with some

physicians participating in more than one activity, for a total of over 10,000 MOC Part IV completions being awarded.

Applicant organizations are considered based on the maturity, strength, and support of their internal QI program, and must be able to ensure that physicians meaningfully participate in QI activities. In addition, they must meet the reporting requirement, as outlined in the Portfolio Program Standards and Guidelines. For more information on the application process, see mocactivitymanager.org.

In October 2014, the AMA launched the STEPS Forward™ (Solutions Toward Effective PracticeS) practice transformation series, a practice-based series that allows physicians to earn CME credit for completing online learning modules. The goal is to provide physicians with relevant strategies that can improve practice efficiency and achieve Triple Aim outcomes—better care, better health and lower cost, as well as greater professional satisfaction.

A two-year pilot program launched in April 2016 allows physicians in Portfolio Program sponsor-organizations who are certified by the 20 participating ABMS member boards to receive MOC credit for participating in live, CME-accredited, lifelong learning and self-assessment activities that are specifically and proactively linked to an IMP initiative.

Cost Effectiveness of MOC

The ABMS member boards recognize concerns that physicians have voiced over the cost of MOC. For example, in February 2015, the ABIM announced that MOC enrollment fees would remain at or below the 2014 levels through at least 2017. The MOC participation fee (which includes the cost of CME, time away from the office, etc.) varies depending on which activities are chosen to complete CME to meet MOC requirements.

In its 2015 Standards for Programs for MOC, the ABMS recognized that physicians have multiple expenses associated with ongoing learning and assessment, including the recertification exam and CME requirements, and is working with its member boards to identify learning and assessment redundancies among these multiple interests. The Portfolio Program (described above) represents one way in which the member boards are actively working to identify learning redundancies and streamline processes to reduce overall MOC costs. Moving to remote testing and modularization of exams may also have an impact on reducing costs.

ALTERNATIVE PATHWAYS TO BOARD RECERTIFICATION

AMA policy reinforces the need for ongoing learning and practice improvement and supports the need for an evidence-based certification process that is evaluated regularly to ensure physicians' needs are being met and that activities are relevant to clinical practice. The AMA has adopted extensive policy (H-275.924) that outlines the principles of the ABMS MOC and AOA-BOS OCC and supports the intent of these programs.

The ABMS MOC program, established by ABMS member boards in 2000, was designed to provide a comprehensive approach to physician lifelong learning, self-assessment and quality improvement and was based on sound theoretical rationale.[21] However, there have been differences of opinion about the efficacy of MOC implementation in improving physician care and patient outcomes.[22] As MOC has evolved, so too have the administrative obligations physicians face, and there is concern about external regulations related to payment and performance measurement, perceived loss of autonomy, and the time and administrative burdens of electronic medical records.[23] Some believe that recent changes requiring physicians to engage in various medical

knowledge, practice-assessment and patient-safety activities as well as periodic recertification exams do not constitute optimal use of the physician's time and that there is no convincing evidence that MOC has improved the quality of care.[22] There is also concern about the scope of the MOC examination for physicians whose practices have narrowed over time, the experience of testing in secure computer-based testing facilities, the financial and emotional costs of preparing for and taking the examination, and the challenges of finding performance-improvement activities that are relevant to physicians' practice and easily integrated into their clinical environment.[24]

Resolutions 924-I-15 and 925-I-15 ask the AMA to review alternative pathways to board recertification to determine whether alternative mechanisms, i.e., National Board of Physicians and Surgeons (NBPAS) Recertification, are in fact equivalent in quality to established pathways. As a first step, the following background information about recertification programs is provided below.

ABMS Maintenance of Certification Program

The ABMS (abms.org), founded in 1933 as the Federation of Independent Specialty Boards, bases its certification on collective standards of training, experience and ethical behavior as a means of identifying those physicians capable of delivering high-quality specialized medical care. Currently, each of the 24 ABMS member boards develops its specific standards for certification, and together they certify more than 800,000 allopathic and osteopathic physicians in 37 primary specialties and 123 subspecialties.[23] The wide-scale use of ABMS board certification is reflected in both training and delivery systems, and based on core competencies developed and adopted by the ABMS and the Accreditation Council for Graduate Medical Education (ACGME).

Once board certified, physicians maintain their medical specialty expertise by participating in a continuous professional development program called the ABMS Program for MOC, a system of ongoing professional development and practice assessment and improvement. The program involves ongoing measurement of six core competencies defined by the ABMS and ACGME: practice-based learning and improvement, patient care and procedural skills, systems-based practice, medical knowledge, interpersonal and communication skills, and professionalism. These competencies, which are the same ones used in the ACGME's Next Accreditation System, are measured in the ABMS Program for MOC within a four-part framework:

- Part I: Professionalism and Professional Standing (maintain a valid, unrestricted medical license)

- Part II: Lifelong Learning and Self-Assessment (complete a minimum of 25 CME credits per year [averaged over 2 to 5 years])

- Part III: Assessment of Knowledge, Judgment, and Skills (pass a secure examination to assess cognitive skills at periodic intervals)

- Part IV: Improvement in Medical Practice (participate in practice assessment and quality improvement every 2 to 5 years)

Diplomates with lifetime (grandfathered) certification are not required to participate in the MOC program. However, they are strongly encouraged to enter the MOC program. While those member boards that have lifetime certificates will not rescind them, some payers and those who grant clinical privileges may not accept them to meet their board certification requirements.[25,26]

To ensure that MOC meets the needs of patients, physicians and the community in general, the ABMS periodically reviews the MOC program standards. The ABMS 2015 Standards for MOC were developed over two years, with input from physician leaders, practicing physicians, and the public, including a representative from the Council on Medical Education. The updated Standards provide a more flexible framework for ABMS member boards to develop their own programs for MOC. The Standards include elements common to MOC for all boards and define a patient-centric perspective, addressing professionalism, patient safety, and performance improvement. Member boards were also encouraged by the ABMS, in the development of the 2015 Standards, to accept distinctions in learning and assessment appropriate for the specialty and to provide feedback to physicians on their examination performance.

AOA Osteopathic Continuous Certification

The AOA Bureau of Osteopathic Specialists (AOA-BOS) (osteopathic.org/inside-aoa/development/aoa-board-certification/Pages/bos-history.aspx) was organized in 1939 as the Advisory Board for Osteopathic Specialists to meet the needs resulting from the growth of specialization in the osteopathic profession. Today, 18 AOA-BOS specialty certifying boards offer osteopathic physicians the option to earn board certification in a number of specialties and subspecialties, and together these boards have certified more than 27,500 physicians (with some of these physicians holding multiple certifications).

Each of the 18 specialty certifying AOA-BOS member boards has implemented OCC, effective January 1, 2013. All osteopathic physicians who hold a time-limited certificate are 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 three-year CME cycle (three certifying boards require 150 hours). Of these 120 plus CME credit hours, a minimum of 50 credit hours must be in the specialty area of certification. Self-assessment activities are also designated by each of the 18 specialty certification boards. If an osteopathic physician holds subspecialty certification(s), a percentage of their specialty credit hours must be in their subspecialty certification area.

- 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 health care.

- 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 the physician's medical specialty.

- Component 5 - Continuous AOA Membership.

Specific requirements for each specialty are available at osteopathic.org/inside-aoa/development/aoa-board-certification/occ-requirements.

Osteopathic physicians who hold non-time-limited (non-expiring) certificates are not required to participate in OCC. However, to maintain their certification, they must continue to meet licensure, membership, and CME requirements (120-150 credits every three-year CME cycle, 30 of which are in AOA CME Category 1A).

National Board of Physicians and Surgeons

The National Board of Physicians and Surgeons (NBPAS) (nbpas.org) describes itself as an independent "grass roots initiative." The NBPAS offers a two-year certification program in all current ABMS specialties for physicians (MDs and DOs) who meet its criteria. The NBPAS has more than 2,000 certificants, and is working to gain acceptance by hospitals and payers. As of January 1, 2016, 24 hospitals (credentials committees, medical executive committees and/or hospital boards) had voted to accept the NBPAS as an alternative to ABMS recertification.

To be eligible for NBPAS certification, candidates must meet the following criteria:

- Be previously certified by an ABMS member board (currently, NBPAS certifies physicians in non-surgical ABMS specialties).

- Hold a valid, unrestricted license to practice medicine in at least one U.S. state. Candidates who only hold a license outside of the U.S. must provide evidence of an unrestricted license from a valid non-U.S. licensing body.

- Have completed a minimum of 50 hours of CME within the past 24 months, provided by a provider recognized by the ACCME. CME must be related to one or more of the specialties in which the candidate is applying. Re-entry for physicians with lapsed certification requires 100 hours of CME within the past 24 months. Physicians in or within two years of training are exempt.

- For some specialties (interventional cardiology, electrophysiology, critical care), candidates must have active privileges to practice that specialty in at least one U.S. hospital licensed by a nationally recognized credentialing organization with deeming authority from the Centers for Medicare & Medicaid Services (CMS), i.e., The Joint Commission, Healthcare Facilities Accreditation Program, and DNV (Det Norske Veritas) Healthcare.

- A candidate who has had their medical staff appointment/membership or clinical privileges in the specialty for which they are seeking certification involuntarily revoked and not reinstated must have subsequently maintained medical staff appointment/membership or clinical privileges for at least 24 months in another U.S. hospital licensed by a nationally recognized credentialing organization with deeming authority from CMS, as listed above.

Physicians who are grandfathered and whose certification has not, by definition, expired must have completed at least 50 hours (not 100 hours) of CME in the past 24 months.

American Board of Physician Specialties

The American Board of Physician Specialties (ABPS) (abpsus.org) is a multi-specialty board certifying body of the American Association of Physician Specialists (AAPS), Inc., which was founded by surgeons in 1950. The member boards of the ABPS offer specialty certification examinations for qualified physicians (MDs and DOs). The ABPS is governed by a board of

directors and chief executive officer, who oversee eligibility requirements and testing standards. The 12 member boards of the ABPS award certification in 18 specialties. The ABPS does not post the number of physicians who hold ABPS certificates.

The eligibility requirements for physician board certification differ among the various member boards; however, at minimum, ABPS member boards require that physicians have:

- An undergraduate college degree;
- Four years of medical school;
- Substantial, identifiable training, such as a three- to five-year residency in an ACGME-accredited program and several years of experience and proven competencies in the specific specialty or subspecialty; and
- A license to practice medicine.

ABPS offers periodic recertification and notes on its website that a physician's credentials should always reflect a dedication to CME in his or her area or areas of expertise, mastery of that newly gained knowledge and a willingness to adhere to a code of ethics and professionalism.

American Board of Facial Plastic and Reconstructive Surgery

The American Board of Facial Plastic and Reconstructive Surgery, Inc.® (ABFPRS) (abfprs.org) was established in 1986 to improve the quality of medical and surgical treatment available to the public by examining for professional expertise in facial plastic and reconstructive surgery. As of June 2015, the total number of active ABFPRS diplomates was 1,143.

To be eligible for certification, a surgeon must:

- Have completed a residency program approved by the ACGME or the Royal College of Physicians and Surgeons of Canada in one of the two medical specialties containing identifiable training in facial plastic and reconstructive surgery: otolaryngology/head-and-neck surgery or plastic surgery.
- Have earned prior certification by the American Board of Otolaryngology, American Board of Plastic Surgery or Royal College of Physicians and Surgeons of Canada in otolaryngology/head-and-neck surgery or plastic surgery.
- Have been in practice a minimum of two years.
- Have 100 operative reports accepted by a peer review committee.
- Successfully pass an 8-hour written and oral examination.
- Operate in an accredited facility.
- Hold the appropriate licensure and adhere to the ABFPRS Code of Ethics.

Since January 1, 2001, the certificates issued by the ABFPRS have been valid for 10 years only. Diplomates who were certified since then and who want to maintain their certification must participate in the ABFPRS Maintenance of Certification in Facial Plastic and Reconstructive Surgery® (MOC in FPRS℠) program. All diplomates, even those holding lifetime certificates, are encouraged to participate. The specific components of the MOC in FPRS℠ Program are similar to the four principles approved by the ABMS, and include evaluation of professional standing, evidence of lifelong learning, demonstration of cognitive expertise, and assessment of practice performance. (Detailed requirements are available at abfprs.org/applying/maintain.cfm)

American Board of Cosmetic Surgery, Inc.

The American Board of Cosmetic Surgery (ABCS) (americanboardcosmeticsurgery.org), established more than 30 years ago, offers board certification to qualifying surgeons. As of February 2, 2016, 374 surgeons held general cosmetic surgery certificates.
To be eligible for certification, a surgeon must:

- Hold at least one recognized board certificate in one of seven medical specialties related to cosmetic surgery before he or she can take the ABCS exam. The certifying board must be recognized by the ABMS or the equivalent from the AOA or American Board of Oral & Maxillofacial Surgery.

- Have completed a comprehensive fellowship training in cosmetic surgery.

- Pass a two-day written and oral exam covering all aspects of cosmetic surgery.

(Detailed requirements available at: americanboardcosmeticsurgery.org/wpcontent/uploads/2009/11/ABCS_2014_Certification_Requirements.pdf)

ABCS certification is valid for ten years. ABCS diplomates must be re-examined and complete all MOC requirements prior to completion of their 10th year of certification. Diplomates who are unsuccessful in passing the first recertification examination have one year to successfully challenge the exam, which includes two testing sessions. Diplomates who are unsuccessful after three attempts are required to retake the initial certifying examination, which includes the written and oral examination sessions. Diplomates must also complete 150 hours of CME and demonstrate a high level of patient satisfaction based on surveys.

Other Recertification Programs

Other developed countries are integrating career-long learning and assessment programs into their systems of professional regulation, showing that the emphasis on ongoing professional development is not exclusive to the United States. Examples of countries that have implemented MOC programs are included in CME Report 2-A-15, available at: www.ama-assn.org/ama/pub/about-ama/our-people/ama-councils/council-medical-education/reports.page.

Other health care professions are also implementing MOC programs. For example, the National Commission on Certification of Physician Assistants (NCCPA) (nccpa.net/CertificationProcess), established in 1974 and currently the only certifying organization for physician assistants (PAs) in the United States, transitioned to a 10-year recertification process for PAs in 2014. During every two-year period, certified PAs must earn and log a minimum of 100 CME credits. They are also required to pass a recertification exam to assess general medical and surgical knowledge. PAs who

fail to maintain their certification must meet CME requirements and take and pass the Physician Assistant National Recertifying Exam to regain it.

How the Licensing Boards, Hospitals, Employers and Third Parties View Alternative Pathways for Board Recertification

AMA policy H-275.924 (14) states that "the MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, network participation, or employment." However, the AMA advocates that MOC be recognized as meeting some or all of a state's requirements for licensure, for physicians who are participating in MOC, to minimize the burden and avoid unnecessary duplication of work.

Many hospitals have independently made the decision to require board certification for staff privileges. Their leadership recognizes that diagnostic and treatment knowledge changes rapidly and learned skills in medicine can decline over time. They value the competencies for medical practice set by the profession and create procedures for their own institutions with respect to those competencies.

Various quality organizations and health care purchasers are also committed to increasing the value of patient care. They support the ABMS specialty certification system to help them identify excellence, commitment to professionalism, and continuous performance assessment and improvement.

Professionalism and the Public's Perspective

Society relies on members of the medical profession to establish standards for entering the profession to practice medicine and to ensure that they are maintaining certification throughout their practice careers.[27] Patients expect that their physician's certification reflects ongoing education and practice improvement. The ABMS reports that patients check their physician's certification via the ABMS website (certificationmatters.org) over one million times per year. Generally, patients and the public do not know about the intricacies of ABMS specialty board certification or MOC, or that board certification and MOC are not required of all physicians. The only requirement to practice medicine legally is a valid active state license.

Professional health care providers, both physicians and non-physicians alike, are generally allowed to advertise to the public their training, education, experience and expertise. Twenty states have enacted legislation prohibiting deceptive or misleading advertising, communication or other deceptive or misleading conduct concerning the professional health care provider's skills, education, training, professional competence or licensure.

Some physicians may advertise that they are board certified or "board eligible." The AMA opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of ABMS or AOA-BOS board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety (H-275.926 (1), Maintaining Medical Specialty Board Certification Standard). Similarly, the AMA's "Truth in Advertising" campaign highlights the need to improve transparency, clarity and reliability for the patient and public. Through this campaign, the AMA developed materials including a model bill, the "Health Care Professional Transparency Act," for use by state and specialty societies (ama-assn.org/go/tia). The campaign provides medical societies with tools and resources to develop and advocate for Truth in Advertising legislation to help ensure that patients are promptly and clearly informed of the training and qualifications of their health care practitioner.

A drafting note in the model legislation, which was developed by a multi-specialty coalition of national medical associations, provides language that can be used to govern advertising of board certification status. The language requires that physicians not represent themselves in any manner as being certified by a public or private board, including, but not limited to a multi-disciplinary board, or designated as "board certified," unless (1) the advertisement states the full name of the certifying board and, (2) the board is a member board of either the ABMS or AOA; or that such board requires successful completion of a graduate medical education program accredited by the ACGME or the AOA that provides complete training in the specialty or subspecialty certified, followed by prerequisite certification by the ABMS or AOA board for that training field and further successful completion of an examination in the specialty or subspecialty certified. This requirement is to ensure not only clarity and transparency, but also consistent, reliable standardization. Otherwise, any physician would be able to advertise as being "board certified" without identifying the board that granted the certification or otherwise specifying the nature and rigor required to achieve that certification.

Need for Further Evaluation

Some medical specialty organizations, including the American College of Cardiology and American Gastroenterology Association, have announced their plans to develop alternative pathways to board recertification.[28,29] The American College of Physicians (ACP) Board of Regents recently approved a resolution to evaluate all certifying boards related to internal medicine against the College's accountability principles for certifying boards. These principles are part of a larger document that looks broadly at professional accountability, including physicians, health systems and regulatory agencies. It may be prudent for the AMA to review the plans and activities of these specialty organizations as well as establish criteria and, if needed, construct an evaluation tool that can be used to evaluate alternative methods for board recertification.

UPDATE ON OSTEOPATHIC CONTINUOUS CERTIFICATION

The requirements for OCC, which were implemented on January 1, 2013 by all 18 specialty certifying member boards of the AOA-BOS, are noted above. The AOA-BOS is currently reviewing the entire OCC process with an eye towards ensuring the effectiveness of the OCC process while making it less onerous for diplomates. The AOA-BOS continues to discuss the ACGME's single GME accreditation system for allopathic and osteopathic residency programs as it relates to AOA board certification, including possible policy changes that may be necessitated by the new system.

SUMMARY AND RECOMMENDATIONS

During the last year, the AMA Council on Medical Education has continued to monitor the development of MOC and OCC and work with the ABMS, AOA, and ABMS member boards to identify and suggest improvements to the MOC and OCC programs. The Council on Medical Education is committed to ensuring that MOC and OCC support physicians' ongoing learning and practice improvement as well as to assure the public that physicians are providing high-quality patient care in their practice settings. The AMA will continue to advocate for a certification process that is evidence-based and relevant to clinical practice as well as cost-effective and inclusive to reduce duplication of work.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolutions 309-A-15, 318-A-15, 903-I-15, 924-I-15 and 925-I-15 and the remainder of the report be filed.

1. That our American Medical Association (AMA) 1) examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification, and 2) determine if there is a need to establish criteria and construct a tool to evaluate if alternative methods for board recertification are equivalent to established pathways. (Directive to Take Action)

2. That our AMA reaffirm Policy D-275.954 (9), Maintenance of Certification and Osteopathic Continuous Certification, which asks the American Board of Medical Specialties (ABMS) to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting maintenance of certification (MOC) and certifying examinations. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-275.954 (4), which encourages the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC. (Reaffirm HOD Policy)

4. That our AMA ask the ABMS to encourage its member boards to review their MOC policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on MOC activities relevant to their practice. (Directive to Take Action)

Fiscal Note: $2,500

APPENDIX

Maintenance of Certification H-275.924

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 that specialty 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 permits 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 are neither 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. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. 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 PRA Category 1 Credit™, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. MOC should be used as a tool for continuous improvement.
15. The MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, network participation or employment.
16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. MOC activities and measurement should be relevant to clinical practice.
19. The MOC process should not be cost prohibitive or present barriers to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
(CME Rep. 16, A-09 Reaffirmed: CME Rep. 11, A-12 Reaffirmed: CME Rep. 10, A-12 Reaffirmed in lieu of Res. 313, A-12 Reaffirmed: CME Rep. 4, A-13 Reaffirmed in lieu of Res. 919, I-13 Appended: Sub. Res. 920, I-14 Reaffirmed: CME Rep. 2, A-15 Appended: Res. 314, A-15 Modified: CME Rep. 2, I-15)

Maintenance of Certification and Osteopathic Continuous Certification D-275.954
Our AMA will:
1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements.

9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations.
10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI® Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification.
(CME Rep. 2, I-15 Appended: Res. 911, I-15)

Medical Specialty Board Certification Standards H-275.926
Our AMA:
1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.
3. Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
4. Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
5. Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.
(Res. 318, A-07 Reaffirmation A-11 Modified: CME Rep. 2, I-15)

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