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

REPORT 2 OF THE COUNCIL ON MEDICAL EDUCATION (A-17)
Update on Maintenance of Certification and Osteopathic Continuous Certification
(Resolution 315-A-16)
(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 American Medical Association (AMA) Policy D-275.954, "Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC)," provides an update on some of the changes that have occurred as a result of AMA efforts with the American Board of Medical Specialties (ABMS) to improve the MOC process.

New activities are highlighted in this report:

- New studies published during the last year, in addition to several hundred studies available in the ABMS Continuing Certification Reference Center™, support the value of MOC and demonstrate how new assessment models and practice improvement activities have resulted in improved quality and patient care as well as physician satisfaction.
- Several ABMS member boards have taken steps to make the MOC Part III examination more constructive and less onerous for physicians. Some boards are looking at ways to innovate assessment of medical knowledge, and are testing new models or have implemented alternatives to the traditional secure, high-stakes examination. The table at the end of this report summarizes the new models being piloted and board activities underway to improve MOC Part III.
- The ABMS member boards have broadened the range of acceptable activities that meet the Improvement in Medical Practice component (MOC Part IV). New activities are being implemented by the boards related to registries, systems-based practice, and practice audits.

This report also includes updates on the following MOC activities:

- AMA participation in meetings and conferences to improve the MOC process (page 1)
- Implementation of the ABMS MOC Directory (page 4)
- Alternatives to the MOC Part III secure, high-stakes examination (page 5)
- Improvement in medical practice (MOC Part IV) (page 6)
- The ABMS Multi-Specialty Portfolio Program (page 7)
- Alternative pathways to board recertification (page 8)
- AMA policy related to discrimination due to nonparticipation in MOC (page 8)
- Osteopathic Continuous Certification (page 11)
- Recertification and assessment processes for other health care professions (page 12)

The Council on Medical Education is committed to ensuring that MOC and OCC support physicians' ongoing learning and practice improvement as well as to assuring the public that physicians are providing high-quality patient care in their practice settings. The Council continues to work with the ABMS, American Osteopathic Association, and ABMS member boards to identify and suggest improvements to the MOC and OCC programs. During the next year, the Council will also engage in cross council collaborations with the Council on Legislation and/or Council on Medical Service to review MOC alignment with legislative activities and quality, patient safety, and value qualifiers.

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

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-A-17

Subject: Update on Maintenance of Certification and Osteopathic Continuous Certification (Resolution 315-A-16)

Presented by: Patricia Turner, MD, Chair

Referred to: Reference Committee C (Kenneth Certa, MD, Chair)

Resolution 315-A-16, "Maintenance of Certification (MOC) and Licensure (MOL) vs. Board Certification, CME and Life-Long Commitment to Learning," introduced by the Tennessee Delegation and referred by the American Medical Association (AMA) House of Delegates (HOD), asks the AMA to: 1) oppose discrimination by any hospital or employer, state board of medical licensure, insurers, Medicare, Medicaid, and other entities, which results in the restriction of a physician's right to practice medicine without interference (including discrimination by varying fee schedules) due to lack of recertification or participation in a Maintenance of Licensure, Maintenance of Certification program, or due to a lapse of a time-limited board certification; and 2) develop an action plan to protect physicians when the Maintenance of Certification is punitively used as a requirement for licensure, credentialing, reimbursement, network participation, or employment with a report back at the 2016 Interim Meeting.

Policy D-275.954 (28), "Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC)," directs the AMA to: 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.

This annual report, mandated by Policy D-275.954 (1), addresses Resolution 315-A-16 and Policy D-275.954 (28) and provides an update on some of the changes that have occurred during the last year as a result of AMA efforts with the American Board of Medical Specialties (ABMS) and ABMS member boards to improve the MOC process.

INTRODUCTION

The Council has prepared reports covering MOC and OCC for the past eight years.[1,2,3,4,5,6,7,8] As shown in the Appendix, the AMA has extensive policy on MOC and OCC. During the last year, Council members, along with Trustees and AMA staff, have participated in numerous meetings with the ABMS and its member boards, including:

- ABMS Committee on Continuing Certification (a Council member is appointed to this committee, which develops and reviews principles and standards for MOC and oversees the review program for MOC and continuing certification programs; the Council member appointee facilitates bidirectional communication between the AMA and ABMS regarding MOC standards and policies)

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- August 2016 Council on Medical Education-ABMS Leadership Meeting
- ABMS Forum on Organizational Quality Improvement
- ABMS 2016 Conference
- Maintenance of Certification Summit
- ABMS Board of Directors Meeting
- ABMS Committee on Certification (COCERT)

MAINTENANCE OF CERTIFICATION (MOC): AN UPDATE

Update on the emerging data and literature regarding the value of MOC

The Council has continued to review published literature and emerging data as part of its ongoing efforts to critically review MOC and OCC issues. Some of the more important studies published during the last year are summarized below.

Two studies were related to the effectiveness of new MOC assessment models:

- An observational study showed that voluntary enrollment and participation in the Maintenance of Certification in Anesthesiology (MOCA®) Minute program, featuring frequent knowledge assessments accompanied by targeted learning resources, is associated with improved performance in the subsequent MOCA Cognitive (high-stakes) Examination when compared to the performance of individuals who do not participate.[9]
- The American Board of Family Medicine (ABFM) examined the impact of module selection on examination performance. The study showed that permitting candidates to select the content category for portions of their examination has a tendency to bias their scores in a systematic way, which is psychometrically undesirable and makes the meaning of the scores dependent on the particular modules selected.[10] However, selecting one module rather than two would likely increase both the psychometric stability of the examination and more closely align with the content of the physician's practice.[10]

A longitudinal study contributed to research on the predictive validity of examinations. The study showed how performance on the National Board of Osteopathic Medical Examiners' Comprehensive Osteopathic Medical Licensing Examination of the United States of America (COMLEX-USA), predicted performance on the ABFM Maintenance of Certification-Family Practice (MC-FP) examination. This study demonstrated how examination scores can provide an early glimpse into a prospective physician's probability of success on future examinations.[11]

To better understand the time and effort put forth by diplomates to prepare for the MOC Part III high-stakes examinations, the American Board of Emergency Medicine (ABEM) conducted a survey of emergency physicians taking the 2014 ABEM ConCert examination. The survey results showed that a study method used by a substantial majority (97.8 percent) of emergency physicians who prepared for the examination by using written materials specifically designed for test taking was associated with the highest performance.[12] This association with preparation and the examination demonstrated the significance of the MOC Part III component as an important incentive to maintain current medical knowledge and skills over time.[12]

Three studies show that meaningful practice improvement activities undertaken as part of MOC result in improved quality care measures:

- An evaluation of the effectiveness of the American Board of Ophthalmology's (ABO) practice improvement modules (PIMs) on processes such as primary open-angle glaucoma, surgical management of cataracts, age-related macular degeneration, etc., showed that after completing the PIMs, performance improved on 80 percent of individual process measures and 38.9 percent of individual outcome measures.[13] This retrospective analysis demonstrated that improvements in technology and data collection methods—for example, standardized documentation and the use of electronic health records—may contribute significantly to meaningful QI efforts.
- A study showed how participation in MOC Part IV by primary care pediatricians was associated with a significant increase in captured opportunities for improved vaccination coverage. In addition, results were achieved at a relatively modest cost and with high pediatrician satisfaction. This study demonstrated that MOC-required QI projects may have the benefits of engaging physicians in projects that they may not otherwise participate in, and allowing physicians to be involved in the project from inception to completion.[14]
- A practice quality improvement project in thoracic imaging was undertaken to reduce the effective radiation dose of routine chest CT imaging in a busy clinical practice. In addition to demonstrating a significant reduction in the effective radiation dose of thoracic CT scans, this project had a direct benefit for patients.[15]

Two studies examined MOC and quality reporting requirements:

- One study comparing changes in quality measures from the ABFM Performance in Practice Modules (PPMs), Physician Quality Reporting System (PQRS), and a combined PQRS/PPM for diabetes showed that combining PQRS and PPM resulted in improvement in the outcomes quality of care measures. This study showed that practice assessment combined with feedback improves care and that further aligning MOC with quality reporting may be beneficial.[16]
- A second retrospective study involving 30,614 radiologists enrolled in Medicare's Physician Compare Initiative showed that participation in the MOC program is an additional incentive because of PQRS requirements.[17] Radiologists performed highly in the MOC program specialty-specific metrics.[17]

To address physicians' concerns about MOC and other required data reporting requirements, the ABFM launched the development of its primary care registry (PRIME) to support physician capacity for quality assessment, improvement, data-reporting requirements, and population management. The ABFM has also pledged to move away from the recertification examination for most diplomates once the registry is reliably providing benchmark quality data and the breadth and scope of physician practice can be assessed.[18]

The literature also shows that, despite recent criticism about the value of MOC as well as negative perceptions with the current MOC Program,[19,20] recent changes to MOC performance in practice modules (PPM) are resulting in increased physician satisfaction and practice changes:

- A study was conducted to understand how ABFM diplomates viewed their PPM participation, and their resulting experience with QI. In the study, which involved 29,755 diplomates who completed PPMs in topics such as diabetes, hypertension, and asthma, 78.7 percent of the respondents indicated that they would change patient care, and 90.2 percent indicated that they would continue QI activities after completing the PPM.[21]
- A separate survey study showed that recent efforts by the American Academy of Pediatrics and the American Board of Pediatrics (ABP) to develop learning modules that integrate QI methods and projects have resulted in high participation rates in QI activities.[22]

Two retrospective studies, including one of rural general surgeons who participated in the American Board of Surgery (ABS) MOC program, and a second involving recertifying pediatric surgeons who perform complex cases, reinforced the need for continuous learning to maintain surgical skills and promote optimal patient outcomes.[23,24] Two studies regarding the practice considerations and needs of aging physicians showed how the ongoing MOC process contributes to maintaining clinical knowledge and skills, which research suggests declines with increasing years in medical practice.[25,26,27]

To determine if patient experience is associated with MOC status, a project to review Marshfield (Wisconsin) Clinic physicians was undertaken. During the study, randomly selected patients seen by Marshfield Clinic physicians completed a patient experience survey that did not indicate whether the physician was participating in MOC. The analysis was based on information that was combined from the Clinic's patient experience database and MOC database. Although the analysis did not demonstrate significant differences, the findings did show that physicians participating in MOC had patients reporting they were more likely to recommend them to others; they were more confident in their skills as physicians; and they felt they received more information about medications compared to patients of physicians who were not participating in MOC.[28]

Twenty-eight improvement efforts from organizations including the Mayo Clinic, Boston Medical Center, Carolinas Healthcare System, Johns Hopkins All Children's Hospital, and many others were presented during the 2016 Forum on Organizational Quality Improvement (QI Forum), hosted by the ABMS in conjunction with the ABMS Multi-Specialty Portfolio Program™. Posters presented by Portfolio Program sponsors and other health care researchers that highlight best practices and research in organizational QI and MOC activities are available at: www.abms.org/initiatives/delivering-organizational-quality-improvement/forum-on-organizational-quality-improvement/2016-qi-forum-posters/. The QI Forum also featured speakers from organizations such as the Agency for Healthcare Research and Quality, Institute for Healthcare Improvement, AMA, and University of Leicester in the United Kingdom who discussed the emerging role of public policy on QI and research and the ABMS Program for MOC.

To accommodate and organize the growing body of literature regarding improvements in practice related to MOC, the ABMS Continuing Certification Reference Center™ replaced its Evidence Library™ in 2016 (http://ccrc.abms.org/). The latter was revised to accommodate the broad and continually growing variety of literature and internet resources relevant to the board certification community. While the format of the publicly accessible, web-based resource remains the same, new indexing and filtering options have been added that further divide the literature by study types and certification topics. Several hundred articles have been reviewed by ABMS staff and physician volunteers/consultants for inclusion in the Center.[29]

The Council on Medical Education is committed to monitoring emerging data and the literature to identify improvements to the MOC program, especially those that improve physician satisfaction with MOC as well as those that enable physicians to keep pace with advances in clinical practice, technology, and assessment.

ABMS MOC Directory

In 2015, the ABMS, in collaboration with the Association of American Medical Colleges, developed the MOC Directory (http://mededportal.org/abmsmoc/continuingeducation/) to assist physicians by reducing the time required to find practice-relevant MOC activities acceptable to the ABMS member boards. The MOC Directory offers diplomates easy access to a comprehensive, centralized repository of approved MOC activities across medical specialties and subspecialties. A

number of AMA continuing medical education (CME) activities are listed on the Directory as being eligible for Lifelong Learning and Self-Assessment (MOC Part II).

In addition, the Accreditation Council for Continuing Medical Education (ACCME) also announced collaborations with the American Board of Anesthesiology (ABA) and ABP, similar to its collaboration with the American Board of Internal Medicine (ABIM) in 2015 that allows accredited CME providers to identify CME activities that also meet the MOC requirements for each of the member boards (ABIM, ABP, and ABA) and facilitates reporting of learner data from the accredited provider to the relevant member board (http://accme.org/news-publications/news/accreditation-council-cme-american-board-anesthesiology-and-american-board). The collaborations are designed to expand the number and diversity of accredited CME activities that meet the member boards' MOC requirements for MOC Part II. They also will simplify the search for approved activities by physicians. CME providers that choose to participate will use the ACCME Program and Activity Reporting System (PARS) to attest that their activities comply with board requirements. The ACCME maintains a list of accredited and certified CME activities registered for ABIM MOC, ABA MOC, and ABP MOC. The ABIM currently has more than 6,200 activities that have been certified for CME credit and registered for MOC points. Many of these activities are available across specialties, while some are specialty specific. The AMA currently transmits JAMA Network data to the ACCME for ABIM, and is considering expansion to additional boards in the future.

Alternatives to the secure, high-stakes examination for assessing knowledge and cognitive skills in MOC

The Council continues to work with the ABMS and its member boards to address AMA member concerns about the MOC Part III examination. About half of the ABMS member boards have taken steps to make the examination more constructive and less onerous for physicians.[30] The boards are addressing issues of convenience, relevance, and cost, and many are moving toward longitudinal low-stakes assessment to reduce the anxiety and burden of the 10-year examination. Concurrent with these efforts, some member boards are also looking at ways to innovate assessment of medical knowledge, and some are testing or have already implemented alternatives to the traditional secure, high-stakes examination (Table 1). New initiatives include incorporating more physician input into examination blueprints as well as experimenting with the use of modular examinations that allow physicians to focus on specific areas of assessment based on their actual areas of practice. Several boards are also allowing access to resources for the examination similar to those used at the point of care. Some boards have adopted or are considering the adoption of remote proctoring of examinations, which alleviates the need for examinees to travel to testing centers and minimizes time spent away from work. Other boards, i.e., ABIM, American Board of Neurological Surgery (ABNS), ABP, and American Board of Radiology (ABR), are testing mechanisms that provide immediate feedback and references. (Table 1).[30]

Seven of the member boards will be utilizing CertLink™, a web-based platform that leverages smart mobile technology to support the design, delivery, and evaluation of assessment pilots. Other pilot projects will resemble the ABA's MOCA Minute™, which encourages anesthesiologists to frequently assess and improve their specialty knowledge by answering 30 questions per quarter related to clinical practice. Pilot projects underway at several boards will integrate assessments based on curated articles focusing on important new evidence in the discipline, in addition to, or in lieu of, more traditional test questions. In addition, some boards are participating in an ABMS-led MOC Assessment Initiative to understand how emerging adult learning theories and technologies can be integrated into the MOC framework and to explore how more frequent, smaller-bite,

longitudinal formative assessments can be used to make summative decisions regarding specialty certification.

Some of these assessment formats highlight the use of spaced repetition, a technique that promotes learning and retention by exposing examinees to the same or similar content over time to test and stimulate recall. This testing technique has been shown to improve knowledge retention over traditional approaches. In addition, physicians are provided with immediate feedback about their performance and offered a dashboard that displays areas of strength and weakness, which can encourage learning targeted to identified knowledge and practice gaps. In some cases, physicians will have the option of tailoring the assessment content based on the nature of their actual practices. The ABMS and its member boards are also reviewing how information regarding aggregate longitudinal assessment performance can be used by CME providers to develop activities for physicians that address their knowledge gaps.

Some of the boards, i.e., the ABIM, are allowing for greater flexibility in the scheduling of the assessment during the year. It should also be noted that some of the boards have reduced the price of the examination. For example, the American Board of Allergy and Immunology (ABAI) reduced the MOC examination fee by 50 percent, the American Board of Plastic Surgery (ABPS) reduced the MOC examination fee by 10 percent, and the American Board of Otolaryngology (ABOto) has eliminated the examination fee and includes a portion of the fee in its new MOC annual fee.

Update on Improvement in Medical Practice

Recognizing the many changes being adopted by the member boards to their Improvement in Medical Practice (IMP) requirements, in late 2015 the Executive Committee of the ABMS Board of Directors (BOD) convened the Task Force on Improvement in Medical Practice to review the purpose and increase the value of the Improvement in Medical Practice (IMP) component of MOC. The Task Force consulted extensively with multiple stakeholders, including hospitals, health plans, consumers, specialty societies, and quality measurement and improvement experts. The Task Force also met separately with the AMA Council on Medical Education to obtain its input. The Task Force explored core issues identified by key stakeholders, including the relationship between individual and system improvement and the need for alignment with other professional assessment and improvement activities. In developing its recommendations, the Task Force sought to strike a balance of two goals: consistency in what the Boards are expected to achieve and flexibility in how they achieve it. The Task Force presented its final report and recommendations to the ABMS BOD at its October 2016 meeting.

The ABMS Committee on Continuing Certification also conducted a comprehensive review of the IMP MOC Program component (MOC Part IV) in 2016. In its report, the Committee noted that the ABMS member boards have broadened the range of acceptable activities that meet the IMP requirements in order to address physician concerns about the relevance, cost, and burden associated with fulfilling the IMP requirements. The report also highlighted a number of activities being implemented by the boards related to registries, systems-based practice, and practice audits.

<u>Registries</u>

Many of the member boards recognize participation in registries developed by their professional societies as satisfying their IMP requirements; the American Board of Family Medicine (ABFM) has its own registry. The ABFM, with funding from the Agency for Healthcare Research and Quality, obtains data from electronic health records (EHRs) without cumbersome data entry and provides feedback to participating clinicians on a variety of measures. The American Board of

Orthopaedic Surgery (ABOS) pilot tested collecting patient-reported outcome data to track patient functional outcomes, and is planning to release it to younger physicians this year.

Systems-based practice

The member boards are aligning MOC activities with other organizations' quality improvement (QI) efforts to reduce redundancy and physician burden while promoting meaningful participation. Twenty-one of the boards encourage participation in organizational QI initiatives through the ABMS Multi-Specialty Portfolio Program™ (described below). Many boards encourage involvement in the development and implementation of safety systems or the investigation and resolution of organizational quality and safety problems. Some boards encourage assessment and training in teamwork, for example, through Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) training programs.[31] Six boards accept physician activities related to hospital-based Ongoing and Focused Professional Practice Evaluation conducted under The Joint Commission standards. For physicians serving in research or executive roles, some boards have begun to give IMP credit for having manuscripts published, writing peer-reviewed reports, giving presentations, and serving in institutional roles that focus on QI (provided that an explicit Plan-Do-Study-Act process is used). Physicians who participate in QI projects resulting from morbidity and mortality conferences and laboratory accreditation processes resulting in the identification and resolution of quality and safety issues can also receive IMP credit from some boards.

Practice Audits

Several member boards have developed online practice assessment protocols that allow physicians to assess patient care using evidence-based quality indicators. The American Board of Ophthalmology (ABO) is working with the American Academy of Ophthalmology (AAO) to integrate data from the AAO's Intelligent Research in Sight (IRIS) registry, which is populated with data extracted directly from electronic health records (EHRs). Other initiatives include:

- Successful integration of patient experience and peer review into several of the boards' IMP requirements; one board has aggressively addressed the issue of cost and unnecessary procedures with an audit and feedback program.
- Integration of simulation options.
- Substantial efforts to educate physicians about QI theory and practice; one board has set up standard templates to guide the QI process, while another has built step-by-step instructions into some of its modules. Both of these interventions have received positive feedback from physicians.
- A process for individual physicians to develop their own improvement exercises that address an issue important to them, using data from their own practices, built around the basic PDSA (Plan-Do-Study-Act) process.

To continue the discussion about practice-relevant and innovative IMP activities, the ABMS and the AMA will cosponsor a meeting in June 2017 that will bring together representatives from the Council on Medical Education, AMA sections, and ABMS member boards.

ABMS Multi-Specialty Portfolio Program

The Portfolio Program (www.mocportfolioprogram.org) continues to offer health care organizations opportunities to support and encourage physician involvement in internal QI projects and team-based initiatives while providing MOC Part IV credit to physicians actively participating

in the program. Many of these MOC activities also satisfy other national, state, and private-sector QI and reporting activities. The Portfolio Program eases the burden on physicians by reducing duplication of QI projects, with no additional costs to physicians who participate in the program. More than 1,800 types of QI projects have been approved by the Portfolio Program in areas such as prevention and screening, improvements in disease-specific care processes, patient-physician communication, patient safety, harm reduction, and interdisciplinary team-based care. The number of organizations participating in the program continues to grow. Currently, there are more than 80 portfolio sponsors, and additional organizations are exploring the opportunity to join. In 2016, the American Heart Association-The Guideline Advantage™ program, Boston Medical Center, Dartmouth-Hitchcock, Johns Hopkins Medicine, Oregon Health & Science University, Sharp Healthcare, Texas Children's Hospital, University of Arkansas for Medical Sciences, University of Kansas School of Medicine, and Vanderbilt University Medical Center became portfolio sponsors. The AMA is approved as a portfolio sponsor and is developing some CME activities to be eligible for MOC Part IV. The program has engaged more than 9,300 physicians in practice improvement initiatives at hospitals and health systems across the country (many showing improvement in care outcomes). Twenty-one ABMS member boards participate in the program. Sponsoring relationships with medical societies and two specialty societies have also been developed to provide more support for physicians with practices that are not primarily hospital-based.

ALTERNATIVE PATHWAYS TO BOARD RECERTIFICATION

Policy D-275.954 (28), "Maintenance of Certification and Osteopathic Continuous Certification," asked that the 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. As a first step, the Council provided background information about recertification programs in CME Report 2-A-16, "Update on Maintenance of Certification and Osteopathic Continuous Certification."[1]

In its report, the Council noted that wide-scale use of long-standing traditional recertification programs, such as the ABMS MOC, are reflected in training and delivery systems, and based on core competencies developed and adopted by the ABMS and the Accreditation Council for Graduate Medical Education (ACGME). The MOC program was designed to provide a comprehensive approach to physician life-long learning, self-assessment, and practice improvement, and strives to identify those physicians capable of delivering high-quality specialized medical care.[32]

Newer alternative pathways to specialty board recertification, such as the National Board of Physicians and Surgeons (NBPAS), have been formed to address physician concerns about the rigorous MOC process.[20] There are ongoing concerns about the administrative burdens, the value of the program, the relevance and cost of the examination, and the time it takes physicians away from patient care. Although there is variability among specialties, participation in the MOC program may require passing a secured, high-stakes examination every 10 years. The NBPAS does not require an external assessment or practice improvement.

Many hospitals have independently made the decision to require board recertification for staff privileges. Their leadership recognizes that diagnostic and treatment knowledge changes rapidly, and that 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. Although newer recertification programs, such as the NBPAS, are gaining

acceptance by some hospitals, many hospitals still rely on the traditional MOC and OCC programs.[20, 33]

The American Gastroenterological Association (AGA) addressed physician dissatisfaction with the current MOC process by convening a Task Force to identify their vision of the ideal pathway for recertification of gastroenterologists. After the Task Force conducted a scholarly review of educational theory and literature and considered current health care environmental and technology factors, they recommended that MOC be replaced with individual pathways that would integrate self-assessment activities, allowing physicians to achieve a high level of competency in one or more areas while maintaining a more modest level of competency in other areas. The individualized self-assessment activities would provide constant feedback and opportunities for learning and remove the secure high-stakes examination required every 10 years. The proposal is based on a broad agreement on competencies established by educational leaders from five gastroenterology societies. This alternative pathway, called "The Gastroenterologist: Accountable Professionalism in Practice (G-APP)" would allow physicians to receive credit for activities they already do in practice, research, or teaching. The AGA has communicated this proposal to the ABIM and acts as an intermediary between AGA members and the ABIM, since gastroenterology is a subspecialty of internal medicine.[34]

The American College of Cardiology (ACC) has also continued to work with ABIM to produce meaningful changes to the MOC process. Alternative options, including initiating a new recertification process, have been investigated and remain an option, depending on the outcomes of current MOC modification efforts, but they are not currently felt to be the ideal pathway. The ACC believes that over the past year, the ABIM has made substantial changes to its MOC process in response to concerns raised by physicians and specialty organizations including ACC. The ACC is also seeking further improvements to the ABIM's shorter, more focused assessment planned for 2018, adoption of an open-book format for those diplomates choosing the 10-year exam option, elimination of practice improvement (Part IV) activities as a requirement for MOC (which are important but will soon be required of all providers by federal law), and ongoing research to test the outcome of MOC activities on the actual improvement in patient care (to provide an evidence-base for the value of MOC). Additional improvements, such as allowing the ACC and qualified entities to put forth standards-based processes that would be certified by the ABIM as well as enabling diplomates to receive credit for activities in which they lead and participate on behalf of hospitals, health care systems, payers, and state medical boards, are also being sought by the ACC. The ACC was approved as a Portfolio Program Sponsor through the ABMS Multi-Specialty Portfolio Approval Program™. Additionally, the ACC continues to work with ABIM and other internal medicine stakeholder groups to find solutions that best allow clinicians to maintain and demonstrate competence as it relates to patient outcomes, quality care, and cost-effectiveness.[35]

The American College of Physicians, ACC, and American Society of Clinical Oncology are also working with the ABIM to explore piloting a "Society Maintenance Pathway" option. If the pilots go forward and are successful, they may be expanded to more internal medicine subspecialty groups. These pathways would be in addition to any pathways offered by the ABIM, such as the 10-year secure examination, or the two or five-year approaches that ABIM may develop.[36]

As noted above, the AMA actively participates in the ongoing development of MOC, and meets regularly with the ABMS and its member boards. Due to Council efforts with the ABMS and its member boards, many changes are occurring to improve the MOC process. Many of the member boards have taken steps to improve the MOC Part III high-stakes examination. The ABMS Portfolio Program is also providing 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. The AMA supports the development of Performance Improvement CME (PICME) activities that are consistent with the requirements of the AMA Physician's Recognition Award (AMA PRA) Credit system, one of the three major credit systems that comprise the foundation for CME in the United States, 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 participation in CME. In addition, the AMA has adopted extensive policy on MOC, including the AMA Principles of MOC (Policy H-275.924), to continue to improve the process for physicians who choose to participate in the MOC program.

The AMA does not have the same relationship with other recertification programs, and is not directly involved in the processes being developed by other organizations such as the NBPAS. Although alternative pathways to board recertification appear to be less rigorous than the traditional MOC and OCC processes, as outlined in CME Report 2-A-16,[1] establishing criteria and constructing a tool to evaluate if alternative methods for board recertification are equivalent to established pathways would require substantial resources and may not be necessary at this time if the ABMS member boards continue to improve their processes for physicians.

AMA POLICY RELATED TO DISCRIMINATION DUE TO NONPARTICIPATION IN MOC

AMA policy related to MOC supports the intent of this program (see Appendix). MOC is a career-long process of learning, assessment, and performance improvement that is meant to demonstrate proficiency within a chosen discipline, but is separate and not required for licensure, employment, or reimbursement.

The following policies support the first resolve in Resolution 315-A-16, "Maintenance of Certification (MOC) and Licensure (MOL) vs. Board Certification, CME and Life-Long Commitment to Learning," introduced by the Tennessee Delegation.

- AMA Policy H-275.924 (15), amended at the 2016 Interim Meeting, currently states, "The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation."

- In addition, Policy D-275.954 (34) states that the AMA, "through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure."

- Policy H-275.926 (3) also states that the AMA "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."

The AMA Council on Legislation has developed, and the AMA Board of Trustees approved, model state legislation intended to prohibit state boards of medicine and osteopathic medicine from requiring physicians to maintain certification for licensure or license renewal; prohibit hospitals from denying staff privileges or admitting privileges to a physician solely based on the physician's lack of participation in MOC or OCC; and prohibit insurers from denying reimbursement to a physician, or preventing a physician from participating in the insurer's network, based solely on the physician's lack of participation in MOC or OCC. The model bill is on file with the AMA Advocacy Resource Center, which will assist any interested state medical association in pursuing such legislation or any other legislation consistent with AMA policy.

In April 2017, the American College of Obstetricians and Gynecologists (ACOG) and the American Board of Obstetrics and Gynecology (ABOG) issued a joint statement, "Political Interference in Physician Maintenance of Skills Threatens Women's Health Care" (http://www.acog.org/-/media/Departments/State-Legislative-Activities/2017ACOG-ABOGJntStmntCertification.pdf?dmc=1&ts=20170413T1546120618). The statement urges state lawmakers not to interfere with successful self-regulation and to realize that each medical specialty has its own experience with its MOC program.

The AMA is in the process of fully analyzing the regulations of a final rule released by the Centers for Medicare & Medicaid Services (CMS), on October 14, 2016, that details the final regulations for implementation of the Medicare Access and CHIP Reauthorization Act (MACRA), the historic Medicare reform law that replaced the Sustainable Growth Rate (SGR) formula last year (www.ama-assn.org/sites/default/files/media-browser/public/physicians/macra/macra-qpp-summary.pdf). It will be important for the Council on Medical Education to collaborate with the Council on Legislation and/or the Council on Medical Service to determine the MOC alignment with legislative activities and quality, patient safety and value qualifiers—such as the Quality Payment Program (QPP) created by MACRA—that will reward physicians for delivering coordinated care with better outcomes.

Currently, MOC is meant to demonstrate proficiency within a chosen discipline, but is not required for state medical licensure. In addition, many hospitals have independently made the decision to require recertification for the granting of privileges, and various quality organizations and insurers use MOC to help identify commitment to professionalism and continuous performance improvement. These requirements are within their legal rights. However, some states are considering or have enacted legislation that prohibits the use of MOC as a criterion for privileging, employment, and reimbursement. Additional data will be needed to determine if an action plan should be developed to protect physicians when MOC is used as a requirement for licensure, credentialing, reimbursement, network participation or employment (Resolution 315-A-16, resolve 2). To date, the Council has not accumulated data on instances where this has occurred. However, when data become available, the Council will determine if these cases fit into a pattern and will advise the HOD on how to proceed.

OSTEOPATHIC CONTINUOUS CERTIFICATION (OCC): AN UPDATE

The American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) (http://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. As of November 2016, over 28,000 osteopathic physicians held active board certification through the AOA (with some of these physicians holding multiple certifications).

OCC was implemented on January 1, 2013 by all of the 18 specialty certifying member boards of the AOA-BOS. 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 - Active Licensure: physicians who are board certified by the AOA must hold a valid, active license to practice medicine in one of the 50 states, and adhere to the AOA's Code of Ethics.
- Component 2 - Life Long Learning/Continuing Medical Education (CME): requires that all recertifying Diplomates fulfill a minimum number of hours of CME credit during each three-year CME cycle (15 certifying boards require 120 hours; three certifying boards require 150 hours). A minimum of 50 credit hours of this requirement must be in the specialty area of certification. Self-assessment activities are also designated by each of the 18 specialty certification boards. For osteopathic physicians who hold 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 their respective 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/Pages/default.aspx.

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).

In April 2016, the AOA empaneled a Certifying Board Services Task Force charged with the following tasks:

1. Improve customer experience through user-friendly processes.
2. Continuously increase quality and enhance standards of high-stakes examinations.
3. Simplify and align the OCC process across all specialties.
4. Serve as a focus group on technological enhancements.

The Task Force reported its findings and recommendations regarding the five OCC components to the BOS at its annual meeting on November 6, 2016. The Task Force's recommendations focus on making the OCC process less onerous, and apply current and new evaluation processes that take advantage of the latest concepts in certification and supporting technology. The BOS has drafted resolutions based on the Task Force's recommendations, which were submitted to the AOA Board of Trustees for approval at its February 2017 meeting.

RECERTIFICATION AND ASSESSMENT PROCESSES FOR OTHER HEALTH CARE PROFESSIONS

The Council also monitors the assessment models used for recertification of other health care professionals. Recent changes to the recertification requirements for nurses and physician assistants (PAs) are highlighted below.

Nurses

The American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association, recertifies and recognizes individual nurses in specialty practice areas. There are over 200 nursing specialties and subspecialties. Although nurses are not required to participate in a formal maintenance of certification program, their certification generally must be renewed every five years through completion of 75 continuing education hours in the clinical nurse specialist (CNS) or nurse practitioner (NP) certification held. An assessment is required only if the nurse's certification has expired (www.nursecredentialing.org/Certification/CertificationRenewal).

Physician assistants

The National Commission on Certification of Physician Assistants (NCCPA) recertifies PAs. State requirements to maintain PA certification differ. Some states require CME and/or the Physician Assistant National Recertification Examination (PANRE), which is administered by NCCPA (www.nccpa.net/CertificationProcess). Twenty-seven states currently require PAs to pass PANRE in order to maintain certification.

In 2014, PANRE was transitioned from a six-year to a 10-year cycle. More recently, there has been concern that the PANRE examination is considered by many to be outdated and too broad in scope (70% of PAs specialize in practice). The American Academy of Physician Assistants (AAPA) is opposed to the PANRE, and has been advocating for the creation of a new PA certifying body, which may not be accepted by the state medical boards. Many PAs are calling to eliminate the PANRE entirely. In response, NCCPA has proposed a new assessment model, composed of a core medical knowledge examination administered during a 10-year cycle through periodic take-home examinations. Specialty-related knowledge would be assessed through a secure, proctored, timed exam during the final years of the 10-year cycle. Ten to twelve specialty examinations may initially be offered.

As other health care professions such as nurses or PAs contemplate or implement MOC programs, it would be important for physicians to clarify the purpose and standards of ABMS MOC or AOA OCC as they may be relevant considerations about scope of practice.

SUMMARY AND RECOMMENDATIONS

The public 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.[36] Patients expect that their physician's certification reflects ongoing education and practice improvement and that they are competent and provide high-quality care.[23] Patients also expect that physicians are periodically examined to assure that they are up to date in knowledge and practice. Contemporary methods of self-regulation, such as MOC, clinical performance measurement, and CME requirements, were created by the profession in part due to increasing recognition that sole reliance on individual physicians reporting colleagues' performance, even if it were 100 percent reliable, still would not be enough to meet shared obligations for quality assurance and patient safety.[37] The

limitations of a more formal peer review process, which is often used in the context of hospital staff privileging procedures, relate to significant variability across institutions in their oversight mechanisms, methods used, performance criteria and standards, resource requirements, and perceptions of quality.[38,39]

The Council on Medical Education is committed to ensuring that MOC and OCC support physicians' ongoing learning and practice improvement as well as to assuring 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. During the last year, the 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. During the next year, the Council will also engage in cross council collaborations with the Council on Legislation and/or Council on Medical Service to review MOC alignment with legislative activities and quality, patient safety, and value qualifiers, such as the Quality Payment Program (QPP) created by the Medicare Access and CHIP Reauthorization Act (MACRA).

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 315-A-16, and the remainder of the report be filed.

1. That our American Medical Association (AMA) advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for MOC Part IV. (Directive to Take Action)

2. That our AMA rescind Policy D-275.954 (28), "Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC)," since that has been accomplished through this report. (Rescind HOD Policy)

Fiscal Note: $2,500

TABLE. IMPROVEMENTS TO THE AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS) PART III, SECURE, HIGH-STAKES EXAMINATION*

The American Board of:	Current Examination Format	New Models/Innovations
Allergy and Immunology (ABAI) www.abai.org	Computer-based, secure exam administered at a proctored test center once a year. Diplomates must pass the exam once every 10 years.	In 2018, ABAI-Continuous Assessment Pilot Program will be implemented in place of current exam: • A 10-year program with two 5-year cycles. • Diplomates take exam where and when it is convenient. • Diplomates required to answer three questions for each of ten journal articles in each cycle. The articles will be posted in January and July and remain open for 6 months. Articles can be printed or downloaded for review. • Questions can be answered for each article independently. Diplomate feedback on each question will be required. • "Open-book" with a total of approximately 80 questions per year. • Mostly article-based with some core questions during each 6-month cycle. • Opportunity to drop the two lowest 6-month cycle scores during each 5-year period to allow for unexpected life events. • Ability to complete questions on PC, laptop, MAC, tablet, and smart phone formats by using the new diplomate dashboard via the existing ABAI Web Portal page. • The exam fee reduced by 50% to $1300.
Anesthesiology www.theaba.org	• Traditional Maintenance of Certification in Anesthesiology Program (MOCA): Computer-based, secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. • MOCA 2.0 introduced in 2014 to provide a tool for ongoing low-stakes assessment and provide more extensive, question-specific feedback. Also provides focused content that could be reviewed	• Currently piloting a free web application known as MOCA Minute™—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. • 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.

	periodically to refresh knowledge and document cognitive expertise. *All diplomates with time-limited certification that expired on or before Dec. 31, 2015 must complete the traditional MOCA® requirements before they can register for MOCA 2.0®.*	
Colon and Rectal Surgery[1] www.abcrs.org	Computer-based secure exam administered at a proctored test center once a year (in May). Diplomates must pass the exam once every 10 years.	• ABCRS is exploring ways to modify the exam experience to provide a more consistent evaluation process and to replace the exam as it presently is administered. • Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.[1]
Dermatology (ABD)[1] www.abderm.org	• Computer-based secure modular exam administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years. • ABD makes test preparation material available 6 months before the exam. The material includes diagnoses from which the general dermatology clinical images will be drawn and questions that will be used to generate the subspecialty modular exams. • Examinees are required to take the general dermatology module, consisting of 100 clinical images designed to assess diagnostic skills, and can then choose among 50-item subspecialty modules.	• ABD successfully completed trials employing remote proctoring technology to monitor exam administration in the diplomates' homes or offices. • Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.[1]
Emergency Medicine (ABEM) www.abem.org	ABEM's ConCert™, computer-based, secure exam administered at a proctored test center once a year. Diplomates must pass the exam once every 10 years.	ABEM is monitoring recent efforts within the ABMS board community that have focused on pilots that assess knowledge, judgment, and skills using longitudinal assessments rather than an every-10-year exam. The alternative assessment method would have to show that its learning and assessment advantage is better than the current ABEM exam.

Family Medicine www.theabfm.org	Computer-based secure exam administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years.	Changes to the ABFM exam are not being considered at this time.
Internal Medicine (ABIM) www.abim.org	Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	In 2018, ABIM plans to offer two assessment options: 1) Certified physicians will be eligible to take shorter more frequent assessments with continuous learning, feedback, and improvement. Assessments can be taken on their home or office computer instead of taking the long-form exam every 10 years at a testing facility. Diplomates who perform well on the shorter exam can test out of the current assessment taken every 10 years. Those who meet a performance standard on shorter assessments will not need to take the 10-year exam again to remain certified. 2) Diplomates can also choose to take a long-form assessment given every 10 years. This option is the same as the current 10-year exam, but it will include some new features that physicians requested. • New fidelity features may include 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. • New web-based, geographic score report presents more clearly performance results for a given examinee, to highlight areas of strength and weakness for specific exam questions that were missed. • Some exams allow the examinee to select the best of two or best of three options instead of being limited to a single option response. • ABIM is researching and developing the use of external or web resources during the exam, 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.
Medical Genetics and Genomics[1] www.abmgg.org	Computer-based secure exam administered at a proctored test center once a year (August). Diplomates must pass the exam once every 10 years.	• Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.[1]
Neurological Surgery (ABNS) www.abns.org	The 10-year secure exam can be taken from any computer, i.e., in diplomate's office or home. Access to reference materials is not restricted; it is an open book test. On applying to take the examination, a diplomate must assign a person to be his or her proctor. Prior to the exam, that individual will participate in an on-line training session and "certify" the exam computers.	In 2017, an adaptive MOC cognitive learning tool will be piloted: • The tool will consist of updated knowledge that has evolved since the diplomate's last certification and the tool will be far shorter, relevant, and more focused than the prior MOC exam. • The ABNS will use the platform designed by the same company which delivers millions of American Heart Association exams, such as Basic Life Support, so the format will be familiar and easy to use. • The exam will provide updated "evidence based" core neurological surgery knowledge in a web-based format. • The web-based learning tool can be mastered in the diplomates' home, or office, anytime 24/7. • Immediate feedback to each question will be provided to the diplomate. References with links and/or articles will be provided.
Nuclear Medicine[1] www.abnm.org	Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.	• Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.[1]
Obstetrics and Gynecology (ABOG) www.abog.org	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.	In 2016, ABOG launched a pilot program to integrate the self-assessment and external assessment MOC requirements to allow diplomates to continuously demonstrate their knowledge of the specialty. The pilot allows diplomates to earn an exemption from the current computer-based exam in the sixth year of the program if they reach a threshold of performance during the first 5 years of the self-assessment program.

Ophthalmology (ABO) www.abop.org	Diplomates must successfully pass the Demonstration of Ophthalmic Cognitive Knowledge (DOCK) exam, a computer-based secure modular exam administered at a proctored test center once a year (September). Diplomates must pass the exam once every 10 years.	In 2017, a Quarterly Question Pilot Program will evaluate shorter, more frequent assessments. 1) Will deliver 40 multiple-choice questions (MCQs) on fundamental knowledge needed in the everyday practice of ophthalmology through computer, tablet or mobile apps. The MCQs should not require preparation in advance, but a content outline for the MCQs will be available. Users will see instant feedback and receive recommendations for resources related to gaps in knowledge. 2) Key ophthalmic journal articles with questions focused on the application of this information to patient care will be provided. The journal portion will require reading five articles from a list of 15 options. The articles will be available at the beginning of 2017 and the 10 article-based questions will be delivered in Q4 (October). *Based on the performance of the pilots, these programs may replace the DOCK Exam.*
Orthopaedic Surgery (ABOS) www.abos.org	Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. The optional oral exam is given in Chicago in July.	Changes to the ABOS exam are not being considered at this time.
Otolaryngology[1] www.aboto.org	Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	• Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.[1]
Pathology[1] www.abpath.org	• Computer-based secure modular exam administered at the ABP Exam Center in Tampa, Florida twice a year (March and August). • Remote computer exams can be taken any time 24/7 that the registrant chooses during the assigned 2-week period (spring and fall) from their home or office. *Diplomates must pass the exam once every 10 years.*	• New modules were added to make the exam more relevant to a diplomate's practice. • Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.[1]

Pediatrics www.abp.org	Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	In 2017, launching (pilot) Maintenance of Certification Assessment for Pediatrics (MOCA-Peds), a new testing platform with shorter and more frequent assessments. • A series of questions will be released through mobile devices or a web browser at regular intervals. • Twenty MCQs will be available every 2 months and may be answered anytime during the quarter. • Provides immediate feedback and references. • Allows for questions to be tailored to the pediatrician's practice profile. • Participants will provide feedback on individual questions so that the exam can be continuously improved.
Physical Medicine and Rehabilitation[1] www.abpmr.org	Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.[1]
Plastic Surgery www.abplasticsurgery.org	Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.	• Eliminated the 6-month case log requirement for the exam application. • Reduced the exam fee by 10%. • Offers an MOC Study Guide with more than 2,300 MCQ items derived from the same sources used for the exam.
Preventive Medicine (ABPM) www.theabpm.org	In-person, pencil-and-paper, secure exam administered at secure test facility. MOC exams follow the same content outline as the initial certification exam (without the core portion). *In 2016, new multispecialty subspecialty of Addiction Medicine was established.*	Changes to the ABPM exam are not being considered at this time. *In 2017, Addiction Medicine subspecialty certification exam to be administered to diplomates of any of the 24 ABMS member boards who meet the eligibility requirements.*
Psychiatry and Neurology (ABPN) www.abpn.com	Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	Changes to the ABPN exam are not being considered at this time.
Radiology (ABR) www.theabr.org	Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	ABR is developing a pilot that may replace the current 10-year traditional exam, with an online continuous assessment process. The online longitudinal assessment model that will be piloted incorporates modern and more relevant adult learning concepts to provide psychometrically valid sampling of diplomate knowledge.

		• Diplomates will create a practice profile of the subspecialty areas that most closely fit what they do in practice, as they do now for the modular exams. • Diplomates will receive weekly emails with links to questions relevant to their registered practice profile. • Questions may be answered singly or, for a reasonable time, in small batches, in a limited amount of time. • Diplomates will learn immediately whether they answered correctly or not and will be presented with the question's rationale, a critique of the answers, and brief educational material. • Feedback will assist diplomates by guiding their CME (MOC Part II). • Those who answer questions incorrectly will receive future questions on the same topic to gauge whether they have learned the material.
Surgery (ABS) www.absurgery.org	Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	ABS soliciting feedback from diplomates.
Thoracic Surgery (ABTS) www.abts.org	Remote, secure, computer exams can be taken any time 24/7 that the registrant chooses during the assigned 2-month period (September-October) from their home or office. Diplomates will be allowed to enter the online program 10 times for a total of 15 hours. Modular exam, based on specialty, and presented in a self-assessment format with critiques and resources made available to diplomates.	ABTS developed a web-based assessment available for immediate access upon purchase. The latest version (SESATS XI) includes all exam materials, instant access to questions, critiques, abstracts and references, plus hundreds of digital images and movies.
Urology www.abu.org	Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.	In 2017, a modular MOC exam will be reinstituted. • Diplomates will be required to take the 40 question core module on general urology, and choose one of four 35 question content modules.

*The information in this table is sourced from ABMS Member Board websites and is current as of February 15, 2017.

1. Seven ABMS member boards are utilizing CertLink™, an ABMS web-based platform that leverages smart mobile technology to support the design, delivery, and evaluation of longitudinal assessment pilots, some of which will launch in 2017. More information is available at: http://www.abms.org/news-events/american-board-of-medical-specialties-announces-development-of-new-web-based-platform/

APPENDIX

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 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 CreditTM, 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, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
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 Reaffirmation A-16 Reaffirmed: Res. 309, A-16 Modified: Res. 307, I-16 Reaffirmed: BOT Rep. 05, I-16)

D-275.954, Maintenance of Certification and Osteopathic Continuous Certification

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.

28. Examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification; and 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.
29. Ask the ABMS to encourage its member boards to review their maintenance of certification 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 maintenance of certification activities relevant to their practice.
30. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
31. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
32. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
33. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
34. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
35. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.
(CME Rep. 2, I-15 Appended: Res. 911, I-15 Appended: Res. 309, A-16 Appended: CME Rep. 02, A-16 Appended: Res. 307, I-16 Appended: Res. 310, I-16)

H-275.926, Medical Specialty Board Certification Standards

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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