HOD ACTION: Council on Medical Education Report 6 adopted as amended in lieu of Resolution 316 and the remainder of the report filed.

REPORT 6 OF THE COUNCIL ON MEDICAL EDUCATION (A-14)
Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure
(Reference Committee C)

EXECUTIVE SUMMARY

To address American Medical Association (AMA) Policy D-275.960 (2) (6), "An Update on Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC), and Maintenance of Licensure (MOL)," this report builds on previous Council reports to the House of Delegates (HOD) on this topic and provides an update on the implementation of MOC and OCC, and the framework for MOL. In June 2013, the AMA HOD called for a stronger evidence base to support the reported value of MOC. The value of MOC is evidenced by ongoing public interest in seeking out board-certified physicians and by the expanding number of hospitals and other health care organizations that make participation in MOC a key qualification for medical staff privileges. The American Board of Medical Specialties (ABMS) developed a library of peer-reviewed references and study annotations that it cites as the basis for MOC.

Although there is evidence to support the need for a periodic examination to assure the public about the knowledge and clinical skills of physicians, there is disagreement among physicians about the relevance of a closed book exam to current clinical practice. The AMA is working with the ABMS to explore alternatives to the secure, high-stakes examination for assessing knowledge and cognitive skills in MOC. In February the ABMS held the first in its series of educational forums planned for 2014 to assist the ABMS Member Boards in leveraging external assessments. In addition, the ABMS and the AMA will sponsor a meeting in June 2014 that will bring subject matter experts in physician assessment together with representatives from the Council, AMA sections, and the ABMS Member Board community to further discuss practice-relevant and innovative MOC Part III activities.

The AMA supports ongoing ABMS Member Boards' efforts to allow other physician educational and quality improvement activities, i.e., self-directed practice improvement modules, simulations, and interactive workshops, to count for MOC and has encouraged the ABMS Member Boards to enhance the consistency of such programs across all boards. The AMA has encouraged the ABMS to provide full transparency related to the finances associated with MOC. The ABMS cites the Updated Standards that focus on sharing of resources and of opportunities for innovation, and on developing added efficiencies to control costs for physicians and the ABMS Member Boards. The ABMS is assessing the time and administrative burdens associated with participation.

In 2015, the ABMS Member Board Program for MOC review process will be launched to allow the ABMS to collect information on ABMS Member Boards' policies regarding multiple certifications. The ABMS has begun to conceptualize several online toolkits highlighting existing educational and assessment resources. Utilization of the toolkits may further facilitate the fulfillment of MOC requirements by physicians certified by multiple Member Boards.

As an initial step to address concerns raised by the HOD that called for an independent entity to study the impact that MOC and MOL requirements may have on the physician workforce, physicians' practice costs, patient outcomes, patient safety, and patient access, the AMA contacted the Cecil G. Sheps Center for Health Services Research. The AMA was advised that data are currently not available to study the effect of MOC and MOL on the retention of physicians in the workforce. Developing a study to answer the question of whether some physicians choose retirement over maintaining certification would require a fairly complex research effort.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6-A-14

Subject: Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure

Presented by: Jeffrey P. Gold, MD, Chair

Referred to: Reference Committee C (Kesavan Kutty, MD, Chair)

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1 Policy D-275.960 (2) (6), "An Update on Maintenance of Certification, Osteopathic Continuous
2 Certification, and Maintenance of Licensure," calls on our American Medical Association (AMA)
3 to:
4
5 - Continue to monitor the evolution of maintenance of certification (MOC), osteopathic
6 continuous certification (OCC), and maintenance of licensure (MOL), continue its active
7 engagement in the discussions regarding their implementation, and report back to the
8 House of Delegates (HOD) on these issues.
9
10 - Solicit an independent entity to commission and pay for a study to evaluate the impact that
11 MOL and MOC requirements have on physicians' practices, including but not limited to:
12 physician workforce, physicians' practice costs, patient outcomes, patient safety, and
13 patient access. Such a study will look at the examination processes of the American Board
14 of Medical Specialties (ABMS), the American Osteopathic Association (AOA), and the
15 Federation of State Medical Boards (FSMB). Such a study is to be presented to the AMA
16 HOD, for deliberation and consideration before any entity, agency, board or governmental
17 body requires physicians to sit for MOL licensure examinations. Progress report is to be
18 presented at Annual 2014; complete report by Annual 2015.
19
20 BACKGROUND
21
22 The AMA has extensive policy on MOC and OCC as well as policy to support the principles of
23 MOL (Appendix A). This update builds on information provided in five previous Council reports
24 to the HOD on this topic (Council on Medical Education Reports: 4-A-13,[1] 10-A-12,[2] 11-A-12,[3] 3-
25 A-10,[4] and 16-A-09[5]) and addresses the policy above by providing updates on:
26
27 1. Progress on the implementation of MOC, OCC, and the policies and framework for MOL.
28 2. The reported value of MOC.
29 3. AMA efforts to explore with the ABMS alternatives to the mandatory secure, high-stakes
30 examination for MOC.
31 4. Efforts to ensure that the ABMS specialty boards provide full transparency.
32 5. AMA efforts to work with ABMS and specialty boards to lessen the burden for physicians
33 who have multiple board certifications.

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6. Streamlining educational and quality improvement efforts as related to MOC, OCC and MOL.
7. Tools and services that facilitate the physician's ability to meet MOC requirements.
8. The independent study to evaluate the impact that MOL and MOC requirements have on the physician workforce, physicians' practice costs, patient outcomes, patient safety and patient access.

As part of the effort of the Council on Medical Education to monitor the implementation of MOC, OCC, and MOL, Council members—along with the Board of Trustees and AMA staff—have participated in meetings that include the Special Committee on Maintenance of Licensure, Maintenance of Licensure Implementation Group, ABMS Continuing Certification Committee, MOL Workgroup on Non-clinical Physicians, Joint Working Group on MOC-CME, Workshops on ABMS MOC, and CEO Advisory Council conference calls. This report reflects an update based, in part, on these interactions.

MAINTENANCE OF CERTIFICATION (MOC): AN UPDATE

ABMS Updated Standards for Programs for MOC: An Overview

The ABMS Board of Directors approved the Updated Standards for the ABMS Program for MOC on January 15, 2014 (see Appendix B).[6] The Standards were developed over two years, with input from physician leaders, practicing physicians and the public. AMA representatives, including the Council on Medical Education, provided comments to the ABMS during a two-month public comment period. The ABMS reported receiving over 625 comments. These Standards, which are being implemented during 2014, will take effect in 2015.

The focus of the Updated Standards is to 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 encouraged by ABMS to accept distinctions in learning and assessment appropriate for the specialty and to provide feedback to physicians on their examination performance. Physician feedback will be solicited related to the MOC evaluation process and how team-based learning and improvement relate to MOC. Patricia Turner, MD, FACS, of the Council on Medical Education, has been appointed to the new ABMS Committee on Continuing Certification. Dr. Turner will be able to communicate between the AMA and ABMS as these Standards are implemented as well as relate updates on ABMS Member Boards' MOC Programs.

In February 2014, the ABMS conducted an MOC Implementation Workshop for its member boards about the Standards. This and future workshops will focus on external and innovative methods of assessment, learning and practice improvement—incorporating existing feedback from secure, high-stakes examinations—to modify performance improvement and CME activities and to enhance the practice relevancy of MOC Part III activities.

MOC: Evidence of a Public Mandate

Rapid expansion in scientific knowledge, changes in disease management, and the ongoing development of procedures and technologies make continuous learning and improvement a professional necessity and a patient safety issue. Consumer groups such as AARP have adopted policies, based on their consumer survey results and research, and they encourage their members to seek out board-certified physicians.[7] The ABMS reports that patients and family members routinely

check their physicians' certification status by using the free ABMS search mechanism at CertificationMatters.org. In 2012, more than 1.5 million ABMS searches were conducted, though the breakdown as to who searched the site is not available.

The number of hospitals and other health care organizations, e.g., The Joint Commission, and Centers for Medicare and Medicaid Services (CMS), that include board certification and participation in MOC as a key qualification for medical staff privileges continues to expand.[8] Freed et al. reported that a larger proportion of hospitals (80% vs. 67%) require pediatricians and pediatric subspecialists to be board certified, comparing 2010 and 2005 data.[9] Hospitals may also be influenced by regulatory agencies, such as the CMS MOC Program Incentive, which provides physicians with an additional incentive payment beyond the Physician Quality Reporting System (PQRS) incentive when MOC program incentive requirements have been met.[10]

To better align the activities of practicing physicians with the requirements of MOC, the ABMS has delineated opportunities for ABMS Member Board-certified physicians to have MOC activities satisfy other national, state, and private-sector quality improvement and reporting activities. For example, to reduce the data collection burden on physicians, the MOC Part IV programs of nine ABMS member boards, including the American Boards of Allergy and Immunology, Dermatology, Emergency Medicine, Internal Medicine, Nuclear Medicine, Neurological Surgery, Radiology, Obstetrics and Gynecology, and Ophthalmology, align with the PQRS quality initiative.

Value of MOC: ABMS Data

While no certification process guarantees performance or positive outcomes, evidence shows that physicians who keep current provide better quality care and show improved outcomes.[11] Initial certification only documents that the physician has completed the required educational program(s), been evaluated by knowledgeable educators, and passed a secure, high-stakes examination that assesses medical knowledge. In a recent study to examine the relationship between participation in MOC and the clinical knowledge of family physicians as they moved further away from residency training, O'Neill et al. concluded that "conscientious participation in the rigorous and structured processes required to maintain certification results in continued improvement in clinical knowledge over time."[12]

In July 2013, the ABMS created their *MOC Myths and Facts* card deck and an interactive online library of peer-reviewed references and annotations related to initial board certification and MOC (evidencelibrary.abms.org). The site lists more than 200 study annotations focusing on best practices in CME and the ABMS Program for MOC Part II, Lifelong Learning and Self-Assessment. The ABMS and the Member Boards cite these studies as the basis for their decisions about the initial certification process and MOC.

Self-assessment and Lifelong Learning: MOC Part II

Lifelong learning and self-assessment, integral parts of MOC, OCC and MOL, were reviewed in the December 2013 supplement of the *Journal of Continuing Education in the Health Professions* (*JCEHP*) available at abms.org/JCEHP_Supplement/JCEHP_v33_iS1_final.pdf. The supplement includes articles and editorials examining the ABMS MOC process. Hawkins et al. reviewed the theoretical rationale and empiric data regarding the MOC program and concluded that there was evidence to support the current structure and elements of the MOC program.[13] Other articles noted opportunities for program improvement and further study as well as the efforts in countries other than the United States to incorporate MOC-like, career-long learning and assessment programs into their systems of professional regulation.

At the February 2014 ABMS Member Boards' Meeting, a half-day session focused on the need to better link cross-specialty education and assessment to create MOC activities that more truly reflect patient-centered care. The meeting sought to foster greater collaboration between CME providers, such as specialty societies and academic health centers, and the ABMS Member Boards. The ABMS plans to convene CME providers and representatives of the ABMS Members Boards to discuss gaps in educational programming and opportunities for sharing.

Mandatory Secure, High-stakes Examination: MOC Part III

In the *JCEHP* article referenced above, Hawkins et al. also recommend that a periodic assessment of physician knowledge is needed to assure the public about the knowledge and cognitive skills of physicians, although the manner and format of knowledge assessment may evolve as MOC develops into a more mature improvement framework.[13] All ABMS Member Boards set the standards for passing secure, high-stakes examinations, based on accepted, standard-setting methodologies geared to achieve relevant, valid and reliable assessment based on psychometrics.[14,15] There is disagreement, however, among physicians about the relevance of a closed book secure exam to current clinical practice. A recent American Board of Anesthesiology (ABA) survey reported that one in three anesthesiologists preferred not to take a secure, high stakes examination as part of MOC, citing concern that the ABA Cognitive Examination covered topics that were not relevant to their current practice.[16] A December 2013 survey conducted by the Young Physicians Section (AMA-YPS), in conjunction with the ABMS, reported that more than half of the respondents (63%) agreed that the secure exam as part of MOC should be modified to make it more practice relevant. Integrating decision support or other point of care support to reflect what physicians use in daily practice (i.e., Internet access, online access to journal articles, PubMed, etc.) would make MOC Part III (the secure, high-stakes exam) more practice relevant.

Modifications to MOC Part III: Current ABMS Efforts

While the ABMS continues to engage in discussions about alternatives to a secure examination that would allow ABMS Member Boards to assess medical knowledge in a manner more relevant to practice, the Updated Standards emphasize the need to assess physician judgment and skills. Part III of the Updated Standards (Assessment of Knowledge, Judgment, and Skills - Purposes and Anticipated Outcomes) states that Part III (an objective external assessment) should be linked to Part II, continuous learning and self-assessment.[6]

To continue the discussion about practice-relevant and innovative MOC Part III activities, the ABMS and the AMA will sponsor a meeting in June 2014 that will bring subject matter experts in physician assessment together with representatives from the Council on Medical Education, AMA sections, and ABMS Member Boards.

MOC Part IV: Streamlining Efforts

The latest principles in adult learning are incorporated into MOC activities such as self-directed practice improvement modules (PIMs), simulations and interactive workshops. Most of the ABMS Member Boards permit these approaches in their performance improvement activities.

The December 2013 AMA-YPS survey, conducted in conjunction with the ABMS, showed that a variety of activities are used to satisfy Part IV of the MOC process, with the most common being PIMs (63%). Other popular activities that physicians engage in to satisfy Part IV of MOC include chart audit (41%), patient surveys (30%), and quality-improvement activities (group-based, 25%;

board defined, 22%; and self-defined, 20%). More than half of the respondents (55%) indicated that allowing CME activities required for licensure or privileging to count for MOC could have the most impact on streamlining the MOC process.

Financial considerations related to MOC: ABMS and Member Board Transparency

The ABMS reports that the average annual amount a diplomate pays to one's ABMS Member Board is approximately $270 for the past year. The ABMS cites the Updated Standards that focus on sharing of resources and of opportunities for innovation, and on developing added efficiencies to control costs for physicians and the ABMS Member Boards. In addition to direct costs, the ABMS is assessing time and administrative burden associated with participation.[6]

Multiple Board Certificates: Issues for Physicians

Diplomates certified by multiple ABMS Member Boards may have inconsistent and confusing experiences when interacting with two or more boards. As of February 2014, less than four percent of all diplomates were certified by more than one ABMS Member Board. The Council on Medical Education supports efforts by the ABMS to streamline MOC for diplomates with certification by multiple boards. In 2015, the ABMS Member Board Program for MOC review process will be launched. This review process will allow the ABMS to collect additional information on boards' policies pertaining to multiple certifications. Notable policies will be shared among the boards to facilitate the adoption of appropriate practices.

ABMS: Additional Proposed Programs

The ABMS Academic Programs and Services staff has begun to conceptualize several online toolkits highlighting existing educational and assessment resources categorized by the six ABMS/Accreditation Council for Graduate Medical Education (ACGME) core competencies. For example, the ABMS plans to work with the AMA Physician Practice Sustainability Program to identify existing AMA resources to be included in the systems-based practice toolkit. Utilization of the toolkits may further facilitate the fulfillment of MOC requirements by physicians certified by multiple Member Boards.

In April 2014, the ABMS National Policy Forum focused on medical specialty workforce development, specifically looking at opportunities to better link graduate medical training, practice, and certification to respond to a changing delivery system. The program included presentations by the Macy Foundation, the Program on Health Workforce Research and Policy (University of North Carolina), and other subject matter experts in health workforce analysis.

OSTEOPATHIC CONTINUOUS CERTIFICATE (OCC): AN UPDATE

Each of the 18 specialty certifying member boards of the American Osteopathic Association's Bureau of Osteopathic Specialists (AOA-BOS) 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/Continuing Medical Education (CME): requires that all recertifying diplomates fulfill a minimum of 120 hours of CME credit during each three-year CME cycle (some certifying boards have higher requirements). Of these 120 plus CME credit hours, a minimum of 50 credit hours must be in the specialty area of certification. Self-assessment activities will be designated by each of the 18 specialty certification boards. If an osteopathic physician holds a Certificate of Added Qualifications (CAQ), a percentage of their specialty credit hours must be in their CAQ 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 his or her medical specialty. The Standards Review Committee of the AOA-BOS has specific criteria for each Component 4 activity.

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

The AOA has developed policies for clinically inactive diplomates as well as for diplomates whose scope of practice is limited within their area of certification (limited scope physicians). For dually boarded (AOA/ABMS) diplomates, each board is developing mechanisms to partially accept ABMS MOC Part IV activities for the AOA Component 4 requirements; an osteopathic activity will still be required.

The AOA is encouraging all physicians to participate in OCC, because the FSMB recommends to state medical boards the acceptance of OCC for MOL requirements. After four AOA boards were awarded conditional approval of their OCC processes for the MOC Program incentive offered by CMS for the 2012 reporting year, the AOA applied to CMS on behalf of all AOA specialty boards for the 2013 reporting year, and all AOA board certification specialties and subspecialties were approved for the CMS MOC program incentive.[10] CMS does not require physicians to report on quality measures.

MAINTENANCE OF LICENSURE (MOL): AN UPDATE

Pilot Projects

The FSMB is engaging in a series of pilot projects to advance understanding of the process, structure and resources necessary to develop an effective and comprehensive MOL system. Nine state medical boards are participating in pilot projects: Osteopathic Medical Board of California, Colorado Medical Board, Delaware Board of Medical Practice, Iowa Board of Medicine,

Massachusetts Board of Registration in Medicine, Mississippi State Board of Medical Licensure, Oregon Medical Board, Virginia Board of Medicine and Wisconsin Medical Examining Board.

The first pilot project, a State Readiness Inventory survey, was distributed to participating pilot state medical boards in October 2012. The pilot consisted of an electronic survey designed to facilitate discussion of implementation of MOL and to identify issues state boards need to consider and possibly resolve to ensure successful implementation of MOL.

The second pilot, a survey to collect opinions from licensed physicians about the details and benefits of the CME activities in which they are currently participating, was conducted with practicing physicians in Colorado in fall 2013. Staff from the FSMB, National Board of Medical Examiners (NBME), and ABMS worked together with the Colorado Medical and Osteopathic Societies and the Colorado Medical Board to develop and disseminate the survey. The survey was administered from March 20 to July 10, 2013 via an online questionnaire and was made available to Colorado physicians by announcements on licensure renewal materials and several direct emails. Of the approximately 19,000 licensed physicians in Colorado, 3,084 completed the questionnaire.

Among respondents, the vast majority of whom were board certified, the most commonly reported methods for improving the quality of medical practice were conference attendance, reading the medical literature, and in-person and online CME programs. The primary reasons that most respondents participated in CME/continuing professional development (CPD) in the last two years were to improve overall knowledge and patient care. Respondents found all CME/CPD delivery methods to be useful for improving quality of medical practice and indicated that all methods provided insight into strengths and opportunities for improvement.

The survey was also distributed in Virginia through the Medical Society of Virginia and will be launched in other MOL pilot states in 2014. The FSMB will seek opportunities to formally publish the results of the survey after additional data is gathered. Additional pilot projects will be undertaken over the course of the year.

MOL Task Force on CPD Activities

FSMB Chair Jon Thomas, MD, convened the MOL Task Force on CPD Activities in 2013 to develop recommendations regarding tools and activities that could meet a state’s requirements for MOL. Members of the Task Force include state medical board representatives, CME experts in the community and other stakeholders. The Task Force presented an informational report to the FSMB House of Delegates at its April 2014 meeting. The report addressed issues such as models for compliance, standards, and criteria for CPD activities, and recommendations for state medical boards, the FSMB and other stakeholders.

Currently, the guiding principles for MOL, adopted by the FSMB, also recognize the value of active engagement in meeting MOC and OCC requirements. MOC and OCC are not intended to become mandatory requirements for medical licensure but should be recognized as meeting some or all of a state’s requirements for MOL to avoid unnecessary duplication of work.[17] AMA Policy H-275.923, “Maintenance of Certification/Maintenance of Licensure,” opposes mandatory board certification.

Additional information about MOL is available at fsmb.org/mol.html.

STUDY BY AN INDEPENDENT ENTITY ON MOC, OCC, AND MOL: CURRENT STATUS

Most of the data about the value, validity and benefits of MOC has been assembled by the ABMS and its Member Boards. These entities cannot be considered independent of the MOC process or unbiased in their assessment. The HOD therefore requested that the AMA "solicit an independent entity to commission and pay for a study to evaluate the impact…" of MOC, MOL and OCC on a number of issues (Policy D-275.960[6]).

As an initial step in exploring the feasibility of such a study, the AMA contacted the Cecil G. Sheps Center for Health Services Research (The University of North Carolina at Chapel Hill). The Sheps Center's Program on Health Workforce Research and Policy is one of four new national Health Workforce Centers focused on addressing the question of what health care workforce is needed to ensure access to high quality, efficient health care for the US population. The impact of MOC/OCC/MOL on physician workforce was one of the areas the study was to address. The Center is supported through a cooperative agreement with the Health Resources and Services Administration and managed by the Bureau of Health Professions' National Center for Health Workforce Analysis. As such, the Center would be considered an independent entity.

The AMA was advised that data are currently not available to study the effect of MOC and MOL on the retention of physicians in the workforce. Developing a study to answer the question of whether some physicians choose retirement over maintaining certification would require a fairly complex study design. Given the rapid pace of health system change currently underway, a multivariate analysis would be required to isolate the effect that MOC and MOL have relative to other factors that also affect physician retention in the workforce, including meaningful use requirements, electronic health records, accountable care organizations (ACOs), economic conditions, etc. A longitudinal study would be needed that also adjusted for physician age, specialty, certification cohort, gender, and years since graduation. Further, the study would need to adjust for geographic factors including rural versus urban/suburban practices.

In an effort to look at physician workforce from a different perspective, the American Academy of Family Physicians' Robert Graham Center conducted a study to investigate the characteristics of differential participation in MOC by family physicians. The study reported that after completing the transition of all family physicians into MOC in 2010, participation appears to be higher than previously, and large numbers of family physicians are participating in MOC and meeting the requirements in a timely fashion. The study also showed that physicians who have not participated in MOC for family physicians tend to be practicing in underserved areas or caring for underserved populations where health care providers and technological resources are generally limited.[18,19,20] This raises questions about the impact of MOC participation related to workforce, physician maldistribution, and the potentiation of health care disparities.

Another issue that impacts physician workforce is physician re-entry. Representatives from the Federation of State Physician Health Programs met with the ABMS Member Boards community in February 2014 during an ABMS-sponsored workshop. The discussion focused on improving awareness of and communication between the Member Boards and the state-based physician health programs in order to facilitate the exchange of appropriate information to assist in certification and re-entry decisions of physicians participating in physician health programs.

SUMMARY AND RECOMMENDATIONS

Literature citing the decline of physician knowledge, skills and performance over time, and the perceived need to reassure the public about a physician's ongoing competence, form the basis for programs such as MOC, OCC, and MOL, which will measure and monitor physician competencies over time. These programs continue to be developed and refined, and the Council on Medical Education has ongoing and active dialogue with the organizations responsible for these programs.

The Council on Medical Education recommends that the following recommendations be adopted, and that the remainder of the report be filed.

1. That our American Medical Association Council on Medical Education continue to review published literature and emerging data as part of the Council's ongoing efforts to critically review maintenance of certification (MOC), osteopathic continuous certification (OCC), and maintenance of licensure (MOL) issues. (Directive to Take Action)

2. That our AMA continue to explore with independent entities the feasibility of conducting a study to evaluate the impact that MOC requirements and the principles of MOL have on physicians' practices, including, but not limited to physician workforce, physicians' practice costs, patient outcomes, patient safety, and patient access. (Directive to Take Action)

3. That our AMA work with the American Board of Medical Specialties (ABMS) and the ABMS Member Boards to collect data on why physicians choose to maintain or discontinue their board certification. (Directive to Take Action)

4. That our AMA work with the ABMS and the Federation of State Medical Boards to study whether MOC and the principles of MOL are important factors in a physician's decision to retire and have a direct impact on the US physician workforce. (Directive to Take Action)

5. That our AMA oppose mandatory MOC as a condition of medical licensure, and encourage physicians to strive constantly to improve their care of patients by the means they find most effective. (New HOD Policy)

Fiscal Note: $5,000.

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APPENDIX A

AMA Policies on MOC, OCC, and MOL (updated 2-14-2014)

D-275.960, "An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure"
1. Our AMA will encourage the American Board of Medical Specialties (ABMS) and the specialty certification boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients as an alternative to high stakes closed book examinations. 2. Our AMA will continue to monitor the evolution of Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC), and Maintenance of Licensure (MOL), continue its active engagement in discussions regarding their implementation, and report back to the House of Delegates on these issues. 3. Our AMA will (a) work with the ABMS and ABMS specialty boards to continue to examine the evidence supporting the value of specialty board certification and MOC and to determine the continued need for the mandatory high-stakes examination; and (b) work with the ABMS to explore alternatives to the mandatory high-stakes examination. 4. Our AMA encourages the ABMS to ensure that all ABMS specialty boards provide full transparency related to the costs of preparing, administering, scoring, and reporting MOC and certifying/recertifying examinations and ensure that MOC and certifying/recertifying examinations do not result in significant financial gain to the ABMS specialty boards. 5. Our AMA will work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, in particular to ensure that MOC is specifically relevant to the physician's current practice. 6. Our AMA will solicit an independent entity to commission and pay for a study to evaluate the impact that MOL and MOC requirements have on physicians' practices, including but not limited to: physician workforce, physicians' practice costs, patient outcomes, patient safety and patient access. Such study will look at the examination processes of the ABMS, the American Osteopathic Association, and the Federation of State Medical Boards. Such study is to be presented to the AMA HOD, for deliberation and consideration before any entity, agency, board or governmental body requires physicians to sit for MOL licensure examinations. Progress report is to be presented at Annual 2014; complete report by Annual 2015. 7. Our AMA: (a) supports ongoing ABMS specialty board efforts to allow other physician educational and quality improvement activities to count for MOC; (b) supports specialty 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) encourages the ABMS specialty boards to enhance the consistency of such programs across all boards; and (d) will work with specialty societies and specialty boards to develop tools and services that facilitate the physician's ability to meet MOC requirements. (CME Rep. 10, A-12; Modified: CME Rep. 4, A-13)

H-275.920, "Impact of Maintenance of Certification, Osteopathic Continuous Certification, Maintenance of Licensure on the Physician Workforce"
1. Our AMA encourages the Federation of State Medical Boards to continue to work with state licensing boards to accept physician participation in maintenance of certification (MOC) and osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and that MOC or OCC not be the only pathway to MOL for physicians. 2. Our AMA encourages the American Board of Medical Specialties to use data from maintenance of certification to track whether physicians are maintaining certification and share this data with the AMA. (CME Rep. 11, A-12)

H-275.923, "Maintenance of Certification / Maintenance of Licensure"
Our AMA will: 1. Continue to work with the Federation of State Medical Boards (FSMB) to establish and assess maintenance of licensure (MOL) principles with the AMA to assess the impact

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

H-275.924, "Maintenance of Certification"
AMA Principles on Maintenance of Certification (MOC): 1.Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content. 2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation. 3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by each board for MOC. 4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones). 5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permit physicians to complete modules with temporal flexibility, compatible with their practice responsibilities. 6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey would not be appropriate nor effective survey tools to assess physician competence in many specialties. 7. Careful consideration should be given to the

importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research, and teaching responsibilities. 8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation. 9. The AMA affirms the current language regarding continuing medical education (CME): "By 2011, each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part 2. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA Physician's Recognition Award (PRA) Category 1, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and or American Osteopathic Association Category 1A)." 10. MOC is an essential but not sufficient component to promote patient-care safety and quality. Health care is a team effort and changes to MOC should not create an unrealistic expectation that failures in patient safety are primarily failures of individual physicians. (CME Rep. 16, A-09; 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)

D-275.971, "American Board of Medical Specialties - Standardization of Maintenance of Certification Requirements"
1. Our AMA will work with the American Board of Medical Specialties to streamline Maintenance of Certification (MOC) to reduce the cost, inconvenience, and the disruption of practice due to MOC requirements for all of their member boards, including subspecialty requirements. 2. Our AMA will actively work to enforce existing policies to reduce current costs and effort required for the maintenance of certification and to work to control future charges and expenses. (Sub. Res. 313, A-06; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Appended: Res. 319, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed in lieu of Res. 919, I-13)

D-275.969, "Specialty Board Certification and Recertification"
1. Our AMA will continue to monitor the progress by the ABMS and its member boards on implementation of Maintenance of Certification (MOC) and encourage ABMS to report its research findings on the issues surrounding certification, recertification and MOC on a periodic basis. 2. An update report will be prepared for the AMA House of Delegates no later than 2010. 3. Our AMA will encourage dialogue between the ABMS and its respective specialty societies to work on development, implementation, and monitoring of MOC that meets the needs of practicing physicians and improves patient care. 4. Our AMA will exercise its full influence to protect physicians from undue burden and expense in the Maintenance of Certification process. (CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 919, I-13)

H-275.978, "Medical Licensure"
The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent; (2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure; (3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends; (4) will continue to provide information to licensing boards

and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice; (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public; (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94); (7) urges licensing boards to maintain strict confidentiality of reported information; (8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board; (9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician; (10) urges all physicians to participate in continuing medical education as a professional obligation; (11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine; (12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient; (13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review; (14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation; (15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public; (16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses; (17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses; (18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination; (19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education; (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement; (21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and (22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license. (CME Rep. A, A-87; Modified: Sunset Report, I-97; Reaffirmation A-04; Reaffirmed: CME Rep. 3, A-10; Reaffirmation I-10; Reaffirmed: CME Rep. 6, A-12; Appended: Res. 305, A-13)

D-300.978, "Continuing Medical Education Credit for Maintenance of Certification / Osteopathic Continuous Certification Activities"

1. Our AMA will petition both the American Board of Medical Specialties (ABMS) and the American Osteopathic Association (AOA) to strongly encourage each of its specialty boards to

offer certified Continuing Medical Education (CME) credit for required Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC) activities dealing with practice performance assessment and life long learning. 2. Our AMA encourages all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty boards' MOC and associated processes. (Res. 329, A-11)

H-275.926, "Maintaining Medical Specialty Board Certification Standard"
1. Our AMA opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of 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. Our AMA will communicate its concerns about the misleading use of the term "board certification" by the National Board of Public Health Examiners and others to the specialty and service societies in the federation, the Association of Schools of Public Health, the American Board of Medical Specialties, the Accreditation Council for Graduate Medical Education, the National Board of Medical Examiners, and the Institute of Medicine. 3. Our AMA will continue to work with other medical organizations to educate the profession and the public about the 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. (Res. 318, A-07; Reaffirmation A-11)

D-275.987, "Internal Medicine Board Certification Report - Interim Report"
Our AMA shall: (1) support the ACP/ASIM in its efforts to work with the American Board of Internal Medicine (ABIM) to improve the Maintenance of Certification (MOC) program; (2) encourage specialty societies to work with their respective ABMS member board to develop, implement and evaluate the Maintenance of Certification (MOC) program; (3) continue to assist physicians in practice performance improvement; (4) continue to monitor the progress by the American Board of Internal Medicine and the other member boards of the American Board of Medical Specialties (ABMS) on implementing the Maintenance of Certification (MOC) program; (5) encourage the ABMS to include practicing physicians and physicians with time limited board certificates to assist in designing and evaluating the Maintenance of Certification (MOC) process for each of the ABMS member boards; and (6) shall study the ethical implications of the Maintenance of Certification (MOC) program including the patient assessment component vis-à-vis the doctor-patient relationship and the ethical implications of the peer review component vis-à-vis the practice environment. (CMS Rep. 7, A-02; Reaffirmed: CME Rep. 9, A-05; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09)

H-275.944, "Board Certification and Discrimination"
(1) 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, the AMA oppose 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. (2) Our AMA reaffirms and communicates its policy of opposition to discrimination against member physicians based solely on lack of American Board of Medical Specialties or equivalent American Osteopathic Board certification. (3) Our AMA continues to advocate for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not. (Sub. Res. 701, I-95; Appended: Res. 314, I-98; Appended: Sub. Res. 301, I-99; Reaffirmed: Sub. Res. 722, A-00; Reaffirmed: CME Rep. 7, A-07)

H-405.975, "Recertification Exam for the American Board of Medical Specialties"
Our AMA actively encourages those specialty boards that issue time limited certificates to include young physicians with such certificates in the decision-making process for any design of plans for recertification. (Res. 303, A-92; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09)

H-275.950, "Board Certification"
Our AMA (1) reaffirms its opposition to the use of board certification as a requirement for licensure or reimbursement; and (2) seeks an amendment to the new Medicaid rules that would delete the use of board certification as a requirement for reimbursement and would address the exclusion of internal medicine, emergency medicine, and other specialties. (Res. 143, A-92; ; Reaffirmed by Res. 108, A-98; Reaffirmation A-00; Reaffirmed: CME Rep. 16, A-09)

H-295.995, "Recommendations for Future Directions for Medical Education"
Our AMA supports the following recommendations relating to the future directions for medical education: (1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty. (2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable. (3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals. (4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students. (5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician. (6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling. (7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication. (8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose. (9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions. (10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs. (11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine. (12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components

of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted. (13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student. (14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students. (15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged. (16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice. (17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education. (18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school. (19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines. (20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education. (21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs. (22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care. (23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be

clearly understood by the profession and the public. (24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates. (25) Specialty boards should consider having members of the public participate in appropriate board activities. (26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities. (27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education. (28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued. (29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported. (30) U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various jurisdictions, prerequisites for entry into graduate medical education programs, and other factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME. (31) Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine. (32) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital. (33) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems. (34) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels. (35) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education. (36) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance. (37) Our AMA encourages the

accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance. (CME Rep. B, A-82; Amended: CLRPD Rep. A, I-92; Res. 331, I-95; Reaffirmed by Res. 322, A-97; Reaffirmation I-03; Modified: CME Rep. 7, A-05; Modified: CME Rep. 2, I-05; Appended: CME Rep. 5, A-11; Reaffirmed: CME Rep. 3, A-11)

H-405.973, "Board Certification"
It is the policy of the AMA (1) to continue to work with other medical organizations to educate the profession and the public about the board certification process; and (2) that, when the occasion arises that equivalency of board certification must be determined, the Essentials for Approval of Examining Boards in Medical Specialties be utilized for that determination. (CME Rep. D, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09)

D-275.977, "Update on the American Board of Medical Specialties Program on Maintenance of Certification (MOC)"
Our AMA will: (1) continue to monitor the progress of Maintenance of Certification (MOC) and its ultimate impact on the practice community; (2) encourage the Physician Consortium for Performance Improvement, the American Board of Medical Specialties (ABMS), and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC; (3) encourage the ABMS Maintenance of Certification Task Force to develop and adopt recommendations for re-entry into clinical practice and entry into Step IV of MOC for diplomates not involved in direct patient care; and (4) request that the ABMS restrain from dividing every aspect of their specialist physician practice into numerous added qualification exams and that, whenever possible, alternate methods be sought to ensure adequate qualifications and make the process less onerous for physicians. (CME Rep. 9, A-05; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Appended: Res. 314, A-11)

H-275.932, "Internal Medicine Board Certification Report--Interim Report"
Our AMA opposes the use of recertification or Maintenance of Certification (MOC) as a condition of employment, licensure or reimbursement. (CME Rep. 7, A-02; Reaffirmed: CME Rep. 2, A-12)

H-275.919, "American Board of Medical Specialties Board Member Enrollment in Maintenance of Certification"
Our AMA will recommend to the American Board of Medical Specialties that all physician members of those boards governing the Maintenance of Certification (MOC) process be required to participate in the MOC process. (Res. 310, A-12)

H-405.970, "Specialty Board Certification Fee Requirements"
The AMA strongly encourages member boards of the American Board of Medical Specialties 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. 303, A-93; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 16, A-09)

H-405.974, "Specialty Recertification Examinations"
Our AMA (1) encourages the American Board of Medical Specialties and its member boards to continue efforts to improve the validity and reliability of procedures for the evaluation of candidates for certification; and (2) believes that the holder of a certificate without time limits should not be required to seek recertification. (CME Rep. E, A-92; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12)

H-275.996, "Physician Competence"
Our AMA: (1) urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence; (2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure; and (3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base. (CME Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 302, A-10)

D-275.999, "Board Certification and Discrimination"
Our AMA will collect information from members discriminated against solely because of lack of American Board of Medical Specialties or equivalent American Osteopathic Board certification (Res. 314, I-98; Reaffirmed: CME Report 2, A-08)

H-310.929, "Principles for Graduate Medical Education"
Our AMA urges the Accreditation Council for Graduate Medical Education to incorporate these principles in the revised "Institutional Requirements" of the Essentials of Accredited Residencies of Graduate Medical Education, if they are not already present. (1) PURPOSE OF GRADUATE MEDICAL EDUCATION. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty. (2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education. (3) EDUATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school. (4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine. (5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits. (6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the Essentials for Accredited Residencies in Graduate Medical Education, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the

program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members. (7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education. (8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences. (9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty. (10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty. (11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues. (12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. (13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS. (14) GRADUATE MEDICAL EDUCATION IN

THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty. (15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution. (CME Rep. 9, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 14, A-09)

D-275.995, "Licensure and Credentialing Issues"
Our AMA will: (1) support recognition of the Federation of State Medical Boards' (FSMB) Credentials Verification Service by all licensing jurisdictions; (2) work jointly with the FSMB to take measures to encourage increased standardization of credentials requirements, and improved portability by increased use of reciprocal relationships among all licensing jurisdictions; (3) communicate, either directly by letter or through its publications, to all hospitals and licensure boards that the Joint Commission on Accreditation of Healthcare Organizations encourages recognition of both the Educational Commission for Foreign Medical Graduates' Certification Verification Service and the AMA's Masterfile as primary source verification of medical school credential; and (4) encourage the National Commission on Quality Assurance (NCQA) and all other organizations to accept the Federation of State Medical Boards' Credentials Verification Service, the Educational Commission for Foreign Medical Graduates' Certification Verification Service, and the AMA Masterfile as primary source verification of credentials. (Res. 303, I-00; Reaffirmation A-04)

Standards for the ABMS Program for Maintenance of Certification (MOC)

For Implementation in January 2015

Approved by the Board of Directors
of the American Board of Medical Specialties (ABMS)
January 15, 2014

Preface

The ABMS Program for Maintenance of Certification (Program for MOC) serves the patients, families, and communities of the United States (the Public) and improves patient care by establishing high standards for ongoing learning, practice improvement, and assessment activities of diplomates who have achieved initial certification from one or more of the 24 ABMS Member Boards. The Program for MOC, developed in accordance with the standards included in this document, is integral to the ABMS' mission to maintain and improve the quality of medical care by assisting the ABMS Member Boards in their development and use of professional and educational standards for the certification of physician specialists in the United States and internationally. This document presents the standards and annotations for the ABMS Program for MOC. Standards are requirements for each ABMS Member Board's Program for MOC; it is expected that each Member Board will meet these requirements in a manner consistent with the letter and spirit of the standards and consistent with the specifics of the relevant specialty. Annotations do not outline additional requirements; however, the annotations provide additional detail, offer potential pathways to meet the requirements, and emphasize important aspects of the standards.

The Program for MOC incorporates the six ABMS/ACGME Core Competencies of Practice-based Learning & Improvement; Patient Care & Procedural Skills; Systems-based Practice; Medical Knowledge; Interpersonal & Communication Skills; and Professionalism. The Program for MOC has an integrated four-part framework that addresses 1) Professional Standing and Professionalism; 2) Lifelong Learning and Self-Assessment; 3) Assessment of Knowledge, Skills, and Judgment; and 4) Improvement in Medical Practice. The standards for ABMS Programs for MOC are common across the ABMS Member Boards while permitting relevant distinctions in programs among the specialties.

Initial board certification by one or more ABMS Member Boards demonstrates that a diplomate has 1) completed an extended period of rigorous training in, and assessment of, the knowledge, skills, and professionalism required to practice in a particular specialty or subspecialty, usually via an ACGME residency program; and 2) passed additional evaluations of knowledge, skills, and professionalism. For all ABMS Member Boards, this assessment includes a secure, comprehensive examination of knowledge; other commonly used evaluations include oral examinations and simulation exercises as well as reviews of patient cases, operative records, and patient outcomes.

Consistent with rapid changes in medicine and societal expectations, the ABMS Member Boards gradually adopted the concept of time-limited board certification. In 2000, the ABMS Member Boards Community adopted the Program for MOC through which diplomates maintain continuing certification. In 2009, ABMS and its Member Boards approved MOC standards that formalized program elements and timelines for ongoing MOC implementation among the Member Boards.

In 2012 and 2013, the ABMS and the Member Boards reviewed the Program for MOC and developed the standards outlined in this document. The program review and standards development process included gaining input from multiple constituencies such as the Public; diplomates; specialty societies; ABMS Board of Directors; ABMS Member Boards; Associate Member organizations[1]; multiple ABMS Committees, including the Committee on Certification, Subcertification, and Maintenance of Certification (COCERT), Committee on Oversight and Monitoring of Maintenance of Certification

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[1] The Accreditation Council for Continuing Medical Education, Accreditation Council for Graduate Medical Education, American Hospital Association, American Medical Association, Association of American Medical Colleges, Council of Medical Specialty Societies, Education Commission for Foreign Medical Graduates, Federation of State Medical Boards, and National Board of Medical Examiners.

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(COMMOC), Maintenance of Certification Committee (MOC), Ethics and Professionalism Committee (EPCOM), and Health and Public Policy Committee (HPPC); and the ABMS Staff, among other stakeholders.

Because the Program for MOC has transformed certification from an early career event to an ongoing program of continuing learning and assessment, it can help diplomates remain current in an increasingly complex practice environment. Furthermore, the program improves patient care through practice improvement activities. MOC requirements align with other quality improvement, educational, and regulatory activities in which diplomates engage. Thus, these standards outline a relevant and meaningful mechanism for continuing professional development for diplomates while helping support the social compact between the Public and the profession.

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General Standards

Purposes and Anticipated Outcomes

The General Standards of the Program for MOC provide the broad structure for ABMS Member Boards' Programs for MOC. These standards contribute to improved patient care through the development of rigorous and relevant Programs for MOC that continuously improve and assess the knowledge, skills, and professionalism of diplomates who care for the patients, families, and communities of the United States. The standards are intended to improve diplomates' professional satisfaction by providing a relevant, user-friendly, and meaningful process of ongoing professional development and assessment that is aligned with other professional expectations and requirements and is recognized broadly as a mark of quality medical practice.

GS-1. Each ABMS Member Board's Program for MOC will incorporate all six ABMS/ACGME Core Competencies: Practice-Based Learning & Improvement; Patient Care & Procedural Skills; Systems-based Practice; Medical Knowledge; Interpersonal & Communication Skills; and Professionalism.

Annotation

The Six Core Competencies, adopted by ABMS and ACGME in 1999, are recognized as integral to quality patient care. The following are brief descriptions of the competencies.

The competency Practice-based Learning & Improvement refers to the diplomate's ability to investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve the diplomate's own practice of medicine, the collaborative practice of medicine, or both.

The competency Patient Care & Procedural Skills refers to the diplomate's use of clinical skills and ability to provide care and promote health in an appropriate manner that incorporates evidence-based medical practice, demonstrates good clinical judgment, and fosters patient-centered decision-making.

The competency Systems-based Practice refers to the diplomate's awareness of, and responsibility to, population health and systems of health care. The diplomate should be able to use system resources responsibly in providing patient care (e.g., good resource stewardship, coordination of care).

The competency Medical Knowledge refers to the diplomate's demonstration of knowledge about established and evolving biomedical, clinical, and cognate sciences, as well as the application of these sciences in patient care.

The competency Interpersonal & Communication Skills refers to the diplomate's demonstration of skills that result in effective information exchange and partnering with patients, their families, and professional associates (e.g., fostering a therapeutic relationship that is ethically sound, using effective listening skills with nonverbal and verbal communication; being mindful of health literacy; and working effectively in a team both as a team member and as a team leader).

The competency Professionalism refers to the diplomate's demonstration of a commitment to carrying out professional responsibilities, adhering to ethical principles, applying the skills and values to deliver compassionate, patient-centered care, demonstrating humanism, being sensitive to diverse patient

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populations and workforce, and practicing wellness and self-care.

ABMS Member Boards should integrate learning and assessment of the six competencies throughout their Programs for MOC in a manner that best serves the needs of patients cared for by diplomates and that is relevant to the practice of their respective specialties and to the specific type of practice of a diplomate. As appropriate, the four component parts of a Program for MOC should harmonize with each other. Multiple methods of assessment, learning, and improvement can be utilized effectively within a Program for MOC.

GS-2. Each ABMS Member Board will work to enhance the value of its Program for MOC and the experience of diplomates engaged in its Program including taking actions to increase the Program's quality, relevance, and meaningfulness and with sensitivity to the time, administrative burden, and costs (monetary and other) associated with participation.

Annotation

The ABMS Member Boards serve the Public through developing and implementing a rigorous and relevant Program for MOC; the Program for MOC also serves the Profession. ABMS Member Boards should be sensitive to diplomates' complex and diverse practice environments, regulatory requirements, learning needs, and other responsibilities in their program design and implementation.

GS-3. Each ABMS Member Board will engage in continual quality monitoring and improvement of its Program for MOC and will participate in the ABMS' Program for MOC Review Process.

Annotation

Over time, this quality monitoring should incorporate opportunities for review of activities and materials produced and accepted for MOC credit, examination quality and administration, customer service, relationship between the Program for MOC and health outcomes, and other relevant factors. ABMS Member Boards may adopt multiple approaches to quality monitoring and continuous improvement; diplomate and Public feedback must be incorporated into each ABMS Member Board's overall approach.

The ABMS Program for MOC Review Process will incorporate a continuous quality improvement mechanism and a periodic in-depth review of each ABMS Member Board's Program for MOC and for MOC Programs sponsored by multiple ABMS Member Boards. The ABMS Review Process will involve the ABMS Member Boards, the Public, and diplomates, among others.

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Part I Standards – Professionalism and Professional Standing

Purposes and Anticipated Outcomes

Part I of the Program for MOC focuses on Professionalism and Professional Standing of ABMS Member Board diplomates. These standards contribute to better patient care and improved medical practice by helping to assure the Public that diplomates exhibit professionalism in their medical practice, including acting in the patients' best interests; behaving professionally with patients, families, and colleagues across the health professions; taking appropriate self-care; and representing their board certification and Maintenance of Certification status in a professional manner. These standards also contribute to improved access to quality health care for patients by facilitating re-entry to certification and medical practice for former diplomates of ABMS Member Boards.

PPS-1. Each ABMS Member Board will identify and convey that Board's professionalism expectations to its diplomates and will incorporate professionalism learning and assessment activities into its Program for MOC.

Annotation

ABMS Member Boards will identify professionalism expectations for all diplomates. An ABMS Member Board's professionalism expectations may be articulated in documents developed or adopted by the Member Board (examples include, but are not limited to, the ABMS Medical Professionalism definition, the AMA Code of Medical Ethics, the AOA Code of Ethics, the American Board of Internal Medicine Foundation [ABIMF] Charter on Physician Professionalism, and the American College of Surgeons Code of Professional Conduct).

As with all of the six ABMS/ACGME competencies, ABMS Member Boards should incorporate professionalism into multiple parts of their Programs for MOC.

PPS-2. Each ABMS Member Board will establish and maintain a process that provides former diplomates an opportunity to regain board certification.

Annotation

A process to regain Board Certification should be extended to former diplomates who have voluntarily or involuntarily lost board certification unless the Member Board determines that compelling circumstances preclude a former diplomate's participation. A Member Board may develop different requirements on the basis of the reasons for loss of Board Certification. Engagement in a process to regain Board Certification does not guarantee that a former diplomate will ultimately regain certification and should not be linked with descriptors like 'board eligible'.

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PPS-3. Each ABMS Member Board will have a process in place to consider the circumstances of an action taken against a diplomate's license by a State Medical Board or other determination of unprofessional conduct by an appropriate authority and to respond appropriately.

Annotation

A valid and unrestricted license to practice medicine is an indication that the State Medical Boards have not identified a lack of professionalism or another issue sufficient to justify an action against a diplomate's license. Hence, this may be an appropriate screening indicator. ABMS Member Boards may, but generally do not, act as the "first investigator" of complaints about a diplomate. In some cases of action taken against a diplomate's medical license by a State Medical Board, the suspension or termination of board certification is appropriate. In other cases, the action taken against a diplomate's medical license by a State Medical Board does not preclude continued board certification. ABMS Member Boards will appropriately balance their primary obligation to the Public with the simultaneous obligation of fairness and due process to the diplomate.

ABMS Member Boards with non-physician diplomates will establish appropriate mechanisms to address actions taken against the professional licenses of these diplomates.

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Part II – Lifelong Learning and Self-Assessment

Purposes and Anticipated Outcomes

Part II of the Program for MOC focuses on Lifelong Learning and Self-Assessment (LLS) of diplomates. These standards contribute to better patient care by requiring ongoing diplomate participation in high quality, unbiased learning and self-assessment activities that are relevant to the diplomate's specialty and areas of practice within the specialty. Additional anticipated outcomes are that Part II activities are relevant, easy-to-use, cost-effective, and meaningful for diplomates.

LLS-1. Each ABMS Member Board will establish requirements for LLS and document that diplomates are meeting the learning and self-assessment requirements. ABMS Member Boards' requirements should address currently relevant medical knowledge and other competencies in the specialty and ongoing advances relevant to the applicable specialty, and should include a requirement that LLS activities be free of commercial bias and control of a commercial interest. ABMS Member Boards should work to ensure that diplomates have access to tools for identifying and learning about advances relevant to the specialty and for identifying professional practice gaps in the specialty and in their own clinical practices. ABMS Member Boards should document that LLS activities are of high quality.

Annotation

Each ABMS Member Board will establish LLS requirements for its Program for MOC and determine which activities meet the Board's requirements. LLS activities should substantially link to the diplomate's own practice activities and to professional practice gaps identified within the specialty or by the diplomate. Ideally, LLS requirements should emphasize learning based on self-assessment. These requirements should incorporate but not be limited to engagement in CME activities that are accredited (ACCME, AAFP, or AOA) or certified for credit (e.g., AMA Physician's Recognition Award [PRA] Category I, American Academy of Family Physicians [AAFP] Prescribed Credit, American Congress of Obstetricians and Gynecologists [ACOG] Cognates, or AOA Category IA). As a general example, no fewer than 25 CME credits (33% of which incorporate guided self-assessment) should be required annually.

To be considered "free of commercial bias and control of a commercial interest," LLS activities should conform, at a minimum, to ACCME Standards for Commercial Support. Other documents, including the Council of Medical Specialty Societies Code for Interaction with Companies, may be of assistance.

ABMS Member Boards should advocate for the development of learning and self-assessment activities across all six competencies, particularly those competencies (e.g., professionalism, practice-based learning & improvement, systems-based practice) for which there is a relative shortage of available learning

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resources. To the degree practical, ABMS Member Boards should support the use of specialty-specific, individualized learning and assessment plans for diplomates.

Each ABMS Member Board may work with specialty societies, other Boards and other organizations to develop LLS materials; adopt materials prepared by others; develop materials themselves; or otherwise make materials available. If a learning or self-assessment activity is not accredited by the ACCME, the AAFP, or the AOA, the ABMS Member Board must establish an internal process for quality evaluation of materials. ABMS Member Boards will publish and be transparent about their criteria for granting MOC credit for learning and self-assessment materials developed by other organizations.

LLS-2. Each ABMS Member Board will integrate Patient Safety principles into its Program for MOC requirements.

Annotation

The topic of Patient Safety should be substantially reflected throughout a Program for MOC across diplomates' careers. Patient Safety is highlighted in these standards for a number of reasons, including (1) the science underlying Patient Safety is still relatively new knowledge for many physicians, particularly those who completed graduate medical education programs before 2002; (2) studies have demonstrated the value of such knowledge in addressing the substantial mortality and morbidity associated with preventable errors in the health care system; and (3) the issue incorporates all six ABMS/ACGME Core Competencies and team activities.

ABMS Member Boards should work to ensure that diplomates have adequate knowledge of safety science and principles. Diplomates should successfully complete a Board-approved foundational patient safety course or equivalent learning experience prior to, or early in, the diplomate's participation in the Program for MOC. As patient safety courses and equivalent experiences are increasingly incorporated into graduate medical education training, Member Boards may accept such experiences as the foundational experience. After completion of a foundational patient safety course or equivalent learning experience, MOC patient safety activities should focus on those topics/activities identified as most relevant to the specialty and to gaps identified in the specialty.

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Part III – Assessment of Knowledge, Judgment, and Skills

Purposes and Anticipated Outcomes

Part III of the Program for MOC focuses on the Assessment of Knowledge, Judgment, and Skills of the diplomates. Part III should build upon and link to the continuous learning and self-assessment requirements of Part II of the Program for MOC. These standards contribute to better patient care by incorporating an external objective assessment of the diplomate. Engagement in external assessment provides an assurance that the diplomate has maintained the necessary commitment to lifelong learning and seeks to remain current in the core subject matter of the specialty. Furthermore, assessment can drive learning both through preparing for the examination and through targeted learning in response to examination results. These standards are specific to the examinations for maintaining certification.

KJS-1. ABMS board certification requires ongoing examination of diplomates' knowledge of core content, judgment, and skills in the specialty no less often than every 10 years.

Examinations should be constructed in a manner that incorporates educational standards for test development, reliability, validity, administration, scoring, and reporting. Examinations will be conducted in a manner that ensures that (1) the identified test-taker is, in fact, the person who is taking the test; (2) materials (and any other assistance in any form) used during the examination are limited to materials (and any other assistance in any form) provided or approved by the ABMS Member Board; and 3) actual test content and information about the test content are not shared by examinees, examiners, or anyone else associated with the examination, unless specifically approved by the Member Board.

Annotation

The examination should demonstrate that the diplomate has the necessary core knowledge of the specialty. The examination will focus on core clinical information and advances within the specialty. An ABMS Member Board may link the examination within the Program for MOC with a diplomate's specific practice areas within the specialty through modular components or similar elements.

Professionalism in constructing, administering, and scoring the examination is critical. The examination process should balance sensitivity to the needs of examinees with the importance of the intent and security of the examination.

ABMS Member Boards are exploring new methods of evaluating diplomate knowledge, judgment, and skills; alternatives to traditional testing; and mechanisms for linking examination content to specific practice elements. These explorations are encouraged and may affect test development and administration,

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including formats, testing venues, and other aspects of the assessment process. These explorations will be consistent within the KJS-1 standard criteria, unless prior approval is obtained from the ABMS' Committee on Continuing Certification (CCC). In their review, the members of the CCC will consider elements such as methods of test development, reliability, examination validity, and scoring.

KJS-2. To assist diplomates in developing individualized LLS programs, the ABMS Member Board will provide feedback to the diplomate about performance on secure examinations.

Annotation

ABMS Member Boards should provide information about diplomates' performance on these examinations to the diplomates. This information should be provided in a manner that informs the diplomate of strengths and weaknesses, while also respecting the security requirements of the examination.

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Part IV – Improvement in Medical Practice

Purposes and Anticipated Outcomes

Part IV of the Program for MOC focuses on Improvement in Medical Practice (IMP) by the diplomates. These standards contribute to improved patient care through ongoing assessment and improvement in the quality of care provided by diplomates in their individual practices and/or in the larger hospital, health system, or community setting in which the diplomates practice medicine. Ongoing assessment and practice improvement may include activities that result in improved patient or population health outcomes, improved access to health care, improved patient experience (including patient satisfaction), and/or increased value in the health care system.

IMP-1. Each ABMS Member Board will incorporate practice assessment and improvement activities into its Program for MOC requirements throughout diplomates' careers. Each ABMS Member Board's Program for MOC will incorporate ways in which diplomates may engage in specialty-relevant, performance-in-practice assessment followed by improvement activities when practice gaps are identified.

Annotation

The ideal outcome of this standard is the ongoing engagement of diplomates in assessment and improvement activities relevant to improving patient outcomes, the patient care experience, and the value of the health care experience in the diplomate's practice and/or within the broader system in which the diplomate practices. Recognizing this goal, the ABMS Member Board should create appropriate expectations for engagement of diplomates in these activities.

Each ABMS Member Board will identify a variety of ways in which practice assessment and improvement activities can be completed; these may include the use of registries, patient logs, patient surveys, peer surveys, practice improvement modules, performance improvement CME activities, etc. To the degree possible, the use of recognized performance measures should be incorporated into these activities.

Each ABMS Member Board may work with specialty societies, other Boards and other organizations to develop IMP methods and materials, adopt methods and materials prepared by others; develop these methods and materials themselves; or otherwise make these methods and materials available. The methods and materials offered should foster ongoing improvements in the care of patients by the physician and the health care system in which the physician practices medicine. An ABMS Member Board's Program for MOC performance-in-practice requirements should encourage and enable diplomates to address the more difficult issues within their practices.

ABMS Member Boards should work to ensure that diplomates have adequate knowledge of quality improvement science and practice.

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IMP-2. Each ABMS Member Board should encourage diplomate involvement in performance improvement activities within the context of the health care team and system of practice, and in alignment with other care-related quality improvement programs.

Annotation

Diplomates work across the medical specialties, as part of multi-professional health care teams, and within complex health care systems. Substantive diplomate engagement in organizational or health care system quality initiatives is encouraged and should be recognized for MOC credit.

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