HOD ACTION: Council on Medical Education Report 3 adopted as amended and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-A-10

Subject: Specialty Board Certification and Maintenance of Licensure

Presented by: Susan Rudd Bailey, MD, Chair

Referred to: Reference Committee C
(Floyd A. Buras, Jr., MD, Chair)

In response to Council on Medical Education Report 7-A-07, "Specialty Board Certification and Recertification" studied the issues surrounding certification and recertification by medical specialty boards. These issues included, but were not limited to, the varying methods and criteria used by specialty boards for recertification, their appropriateness as measures of competence, and third party payers' requirement of board certification as a condition of participation in their networks.

Council on Medical Education Report 16-A-09, "Maintenance of Certification/Maintenance of Licensure" summarized the background and organizations involved in producing the current proposals for Maintenance of Certification (MOC), Maintenance of Licensure (MOL), and the *Guide to Good Medical Practice – USA*. The report discussed competence, credentialing, and licensing, and contained a series of recommendations, including adoption of ten principles, regarding MOC and additional assessment modalities relating to physician competence. Continued support and promotion of the American Medical Association (AMA) Physician's Recognition Award (PRA) credit system was also recommended in this report.

Policy D-450.969, "Improve the Recertification Process," (AMA Policy Database) directs our AMA to review and report back on the evolving data on the relationship between recertification and improving patient outcomes.

This report builds on the information provided in the previous reports by providing:

1. An update on the progress that has been made in developing MOC and MOL, and the implications for medical education; and
2. An update on the evolving data on the relationship between recertification and improving patient outcomes.

BACKGROUND

The American Board of Medical Specialties (ABMS) addressed physician competency by adopting the six competency areas proposed by the Accreditation Council for Graduate Medical Education (ACGME) and by instituting a framework for MOC for each of its 24 member boards. The Federation of State Medical Board (FSMB) has developed strategies for the MOL.

MAINTENANCE OF CERTIFICATION (MOC)

In 2000, the 24 member boards of the ABMS agreed to evolve their recertification programs to one of continuous professional development – ABMS Maintenance of Certification® (ABMS MOC®). ABMS MOC requires physicians to provide evidence of lifelong learning and competency in a specialty and/or subspecialty. Measurement of the competencies happens in a variety of ways, some of which vary according to the specialty. In 2006, all member boards received approval of their ABMS MOC program plans, and the boards are in the process of implementation.

While the ABMS guides the MOC process, ABMS' 24 member boards set the criteria and curriculum for each specialty. The four-part MOC process includes:

- Part I-Professional Standing
  Physicians must hold a valid, unrestricted medical license in at least one state or jurisdiction in the United States, its territories, or Canada.

- Part II-Lifelong Learning and Self-Assessment
  Physicians must participate in educational and self-assessment programs that meet specialty-specific standards that are set by their member board.

- Part III-Cognitive Expertise
  Physicians must demonstrate, through formalized examination, that they have the fundamental, practice-related and practice environment-related knowledge to provide quality care in their specialty.

- Part IV-Practice Performance Assessment
  Physicians must be evaluated in their clinical practice according to specialty-specific standards for patient care. They are asked to demonstrate that they can assess the quality of care they provide compared to peers and national benchmarks and then apply the best evidence or consensus recommendations to improve that care using follow-up assessments.[1]

RECERTIFICATION AND IMPROVING PATIENT OUTCOMES

The ABMS plans to identify appropriate metrics and promote research to demonstrate how MOC improves physician performance and patient outcomes, and use this information to improve the MOC programs of the member boards. Individual specialty boards, e.g., the American Board of Internal Medicine (ABIM), are also conducting research to assess the relationship between performance in MOC and outcomes, processes, and systems of care and the relevance of MOC for key stakeholders, including physicians, health plans, and health care system managers. Although no national mandates have been developed, the ABIM has developed Web-based quality improvement tools to assist diplomates to report practice performance to health plans, insurance companies, and hospitals.

By 2012, all 24 member boards of the ABMS will have programs in place that require physicians to demonstrate competence periodically in order to maintain their board certification. The American Osteopathic Association Bureau of Osteopathic Specialists will also have periodic certification requirements in place for its 18 specialty boards by 2012.[2]

MAINTENANCE OF LICENSURE (MOL)

In July 2009, members of the MOL Impact Taskforce (comprised of members and staff of 13 state medical boards) continued to analyze the impact MOL policy would have on state medical boards. The Taskforce focused on: strategies to mitigate possible unintended consequences that may result from implementing MOL policies; options for dealing with licensed physicians who are pursuing careers in nonclinical settings (e.g., administration), such as different types of licenses; and how states would address physicians who choose not to or are unable to comply with MOL requirements.[3]

In August 2009, the FSMB convened an Advisory Group on Continued Competence of Licensed Physicians to review the FSMB's current and previous work on MOL. The group issued an opinion to the FSMB Board of Directors concerning the MOL initiative and more specifically, whether the framework proposed in the report of the Special Committee on Maintenance of Licensure for use by state medical boards in assuring the continued competence of licensed physicians is feasible, reasonable, consistent with the guiding principles adopted by the FSMB's House of Delegates in May 2008, and suitable for use by state medical boards in assuring the continued competence of licensed physicians.[3]

In December 2009, the Advisory Group disseminated a summary report on the FSMB's MOL initiative to state medical and osteopathic boards and other stakeholder organizations, including the AMA, for comment. A survey of state medical boards was also conducted to obtain their level of discussion/dialogue about MOL and their ability to implement MOL requirements, either through statutory authority or reinterpretation of existing continuing medical education (CME) language. The FSMB's desired outcomes from these activities include:

- "A brief, compelling, clear statement about the future direction of the MOL initiative.
- A continued, strong leadership role for the FSMB in medical licensure and regulation.
- Momentum for the FSMB to take the next steps and move the MOL agenda forward.
- A simple, unified process that should not compromise patient care nor create barriers to physician practice.
- Very specific recommendations regarding strategies and time lines for implementation, if possible."

In its report, the Advisory Group also presented a modified version of the original framework proposed in the Draft Report on MOL, February 2008 (Attachment A), interrelated components of professional development program and activities (Attachment B), and the following modified recommendations:

- "Licensees should be expected to provide documented evidence of compliance with the state medical board's MOL requirements. State medical boards should provide guidance to licensees as to the types of evidence deemed acceptable and not acceptable for purposes of meeting MOL requirements.

- Physicians not in active clinical practice who wish to maintain an active license should be expected to comply with all MOL requirements adopted by the state medical board.

- Physicians whose licenses are inactive or have lapsed should be expected to meet MOL requirements upon reentering active clinical practice.

- State medical boards should require licensees to report information about their practice as part of the license renewal process. Such information may include: area of current practice, type of practice (to include location, supervisory responsibilities), status (e.g., full-time, part-time, number of hours worked per week), whether they are actively seeing patients, specialty board certification or recertification status, and what activities they are engaged in if they are not engaged in clinical practice (e.g., research, administration, non-medical work, retired, etc.). Licensees should keep the board apprised of their practice status by reporting any subsequent changes to the board within a specified timeframe as determined by the board.

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

- The FSMB and its member state medical boards should work with other stakeholder organizations to develop research aimed at assessing the impact of MOL programs on physician practice and patient care.

- Assessment tools used to meet MOL requirements should be: valid, reliable, and feasible; credible with the public and the profession; and provide adequate feedback to the licensee to facilitate practice improvement.

- Individual learning plans should address any identified needs and should include educational and improvement activities that are shown to improve performance and include plans to assess the impact of the educational and improvement activities on each physician's practice.

- MOL is separate and distinct from MOC and Osteopathic Continuous Certification (OCC). However, state medical boards at their discretion may determine that participation in MOC and OCC represents substantial compliance with MOL requirements. Physicians who are not participating in the maintenance of certification/continuous certification processes may meet MOL requirements by providing evidence of participation in available MOC or OCC activities or by participating in other approved MOL requirements."

AMA PRINCIPLES OF MAINTENANCE OF LICENSURE

The AMA has robust policies related to medical licensure. A review of all AMA policies related to licensure was conducted to validate that the policies are consistent with the AMA Principles of MOL.

AMA policy supports the underlying principles of MOL which are consistent with the direction that the practice of medicine is evolving. The recommendations of the Advisory Group contain options for doctors to meet MOL requirements that can also be used to meet other purposes and will provide an opportunity to monitor outcomes and produce useful data. The AMA will await the final document of the FSMB with great interest and hopes that the MOL program will be carefully coordinated as much as possible between the states.

THE AMA PHYSICIAN'S RECOGNITION AWARD CREDIT SYSTEM

CME will predictably be a major component of the MOC/MOL model. The AMA PRA is awarded to recognize physicians who demonstrate their commitment to staying current with advances in medicine. The credit system derived to support this award, which includes AMA PRA Category 1

Credit™ and AMA PRA Category 2 Credit™, has evolved as the "common currency" for physicians of any specialty in the United States to meet CME requirements for multiple credentialing purposes.

The American Academy of Family Physicians (AAFP) awards "Prescribed" or "Elective" credit to family physicians for approved CME activities. The American Osteopathic Association (AOA) allows its accredited organizations to award Osteopathic CME credits, 1-A, 1-B, 2-A, and 2-B, to physicians. These systems are dedicated to serving the specific needs of their constituent physicians and are recognized by many of the state licensing boards and credentialing agencies that also recognize AMA PRA credits. There is strong communication and cooperation among the AMA, AOA, and AAFP, and their CME rules are similar in many ways.

The AMA Council on Medical Education establishes requirements and approves learning formats for educational activities to be certified for AMA PRA Category 1 Credit™. The AMA's core requirements, which are based on sound well-recognized adult education principles, have remained in place for the past 30 years. However, the AMA PRA credit system has evolved over time, particularly through the approval of additional certified learning formats to reflect physicians' needs, the changing practice environment, and new technologies. The two most recent examples include performance improvement continuing medical education (PI CME) and Internet Point of Care.

Research in the field of CME has increased over the years. One major area of interest has been determining the impact of CME on knowledge, skills, professional performance, and patient outcomes. Studies have shown that CME has a positive impact in all of these areas. Furthermore, studies confirm that CME, which is ongoing, interactive, contextually relevant, and based on needs assessment, can foster those improvements.[4, 5]

One large review of eighty-one trials concluded that educational meetings, alone or combined with other interventions, can improve professional practice and the achievement of treatment goals by patients.[6] Physician's Evidence-Based Educational Guidelines were published in 2009 to provide evidence-based recommendations that can be used by CME providers, planners, and faculty to develop educational activities in order to achieve the desired goals of improving knowledge, skills, attitudes, behavior, and patient outcomes.[7]

The ABMS MOC® standards, Part II and Part IV, relate directly to certified CME activities. Currently, the AMA PRA Category 1 Practice Improvement credits meet these criteria, provided all stages are completed.[8]

DISCUSSION

In 2008, 80% (667,232) of the approximately 834,546 active practicing physicians (not including resident physicians) were certified by one of the 24 member boards of the ABMS. Of the total certified, 66.4% were initial certifications, 24.6% were recertifications, and 9.0% had both.[9, 10] For some physicians, participation in the MOC would fulfill requirements for MOL and would avoid unnecessary duplication of work. However, approximately 20% of physicians are not specialty board certified and would not be eligible for MOC. Furthermore, physicians may not wish to participate in MOC because they currently hold an ABMS lifetime certificate or due to the expense and time involved. In those instances, a parallel process should be available.

MOC Part I (hold a valid, unrestricted medical license) is already covered by the licensing board process. Initial licensure is a threshold event that includes standardized and proven assessments of

knowledge and a wealth of individualized and first-hand assessments of performance throughout undergraduate and graduate medical education. For the foreseeable future, initial licensure will be conducted according to existing national norms. The state medical boards have the latitude to examine a wide range of physician behaviors and to hold providers accountable for competence and professionalism. They can independently investigate physician behaviors and inappropriate conduct using experienced investigators. They also have the ability, as single entities, to assess sanctions in a consistent manner.[11]

The value of certified CME activities in the continued professional development of physicians has been demonstrated by the research, supported by the participation of physicians in certified CME activities, and recognized by multiple stakeholders interested in the improvement and quality of patient care such as The Joint Commission, specialty societies, certifying boards, and the state medical boards.

The AMA PRA, as well as the AAFP and AOA credit systems, fulfills Parts II and IV of MOC. These established credit systems facilitate the current re-licensing process by providing evidence that a physician has maintained a commitment to study, apply, advance scientific knowledge, and maintain a commitment to medical education through participation in appropriate CME activities. Furthermore, these activities are accepted by 49 states/territories that require certified CME credits for renewal of medical licenses.

SUMMARY AND RECOMMENDATIONS

The Federation of State Medical Boards and the licensing boards are moving towards a process of maintenance of licensure that mirrors the American Board of Medical Specialties maintenance of certification process. Current CME credit systems should be considered in the re-licensure process to avoid duplication of work as physicians meet multiple requirements for licensure and board certification.

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 (AMA) continue to support the AMA Principles of Maintenance of Certification (MOC) (Directive to Take Action);

2. That our AMA Reaffirm AMA Policies H-275.978 and H-275.923 that support the ongoing evaluation of Licensure (Reaffirm HOD Policy); and

3. That our AMA monitor Maintenance of Licensure (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. (Directive to Take Action)

Fiscal Note: Less than $5,000 of staff time.

REFERENCES

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8. Recognizing physicians' participation in educational activities. American Medical Association. *http://www.ama-assn.org/ama1/pub/upload/mm/455/ama_pra_system.pdf* (accessed 2-9-2010)

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Attachment A

ADVISORY GROUP OPINION ABOUT REQUIREMENTS FOR DEMONSTRATING COMPETENCE FOR PHYSICIAN LICENSE RENEWAL

The Advisory Group gave careful consideration to the "Framework for Maintenance of Licensure" as recommended in the *Draft Report on Maintenance of Licensure*, February, 2008, and believes that, as modified below, the framework is feasible, reasonable, consistent with the guiding principles adopted by FSMB's House of Delegates in May 2008 and suitable for use by state medical boards in assuring the continued competence of licensed physicians.

The Advisory Group suggests the following modifications to the framework with the intent of providing greater clarity, simplicity and options to the state medical boards. *The modified framework is indicated below in italics and illustrated on the next page.* Supplemental document G includes the original framework as proposed in the Draft Report on Maintenance of Licensure, February, 2008.

As a condition of license renewal, physicians should provide evidence of participating in a program of professional development and lifelong learning that is based on the general competencies model:

medical knowledge
patient care
interpersonal and communication skills
practice based learning
professionalism
systems based practice

The following requirements reflect the three major components of what is known about effective lifelong learning in medicine.

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

2. Assessment of Knowledge and Skills (What do I need to know?)
Physicians must demonstrate the knowledge, skills and abilities necessary to provide safe, effective patient care within the framework of the six general competencies as they apply to their individual practice.

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

As a condition of license renewal, physicians should provide evidence of participating in a program of professional development and lifelong learning that is based on the general competencies model:

medical knowledge
patient care
interpersonal and communication skills
practice based learning
professionalism
systems based practice

Attachment B

COMPONENTS OF PROFESSIONAL DEVELOPMENT PROGRAMS AND ACTIVITIES

Professional development programs and activities should include the following interrelated components:

GOALS	STRATEGY (HOW)	OPTIONS /EXAMPLES
1. Reflective Self Assessment (What Improvements Do I Need to Make?) Physicians must participate in an ongoing process of reflective self-evaluation, self-assessment and practice assessment, with subsequent successful completion of tailored educational or improvement activities.	Self assessment incorporates external measures of knowledge and skills or performance benchmarks.	Assessment tools could include: • Self-review tests such as - MOC and Osteopathic Continuous Certification (OCC) - Home study courses or web-based materials - Medical professional society/organization or institution-based simulation • Others approved by the state medical board Professional development activities could include: • Review of literature in the physician's current practice area • CME in the physician's current practice area that enhances patient care, performance in practice and or patient outcomes.
2. Assessment of Knowledge and Skills (What Do I Need to Know?) Physicians must demonstrate the knowledge, skills and abilities necessary to provide safe, effective patient care within the framework of the six competencies as they apply to their individual practice.	Assessments of knowledge and skills should be structured, valid, practice relevant, and should produce data to identify learning opportunities.	Examples of assessments addressing one or more of the competencies include but are not limited to: • Practice relevant multiple choice exams, e.g., MOC/OCC exams, National Board of Medical Examiners (NBME) shelf exams • Standardized patients • Computer-based clinical case simulations • Patient and peer surveys • Mentored or proctored observation of procedures • Performance improvement CME • Other performance improvement projects such as the Surgical Care Improvement Project (SCIP), American Medical Institute (AMI), Institute for Healthcare Improvement (IHI), Healthcare Effectiveness Data and Information Set (HEDIS) • Procedural hospital privileging • Others approved by SMBs

GOALS	STRATEGY (HOW)	OPTIONS /EXAMPLES
3. Performance in Practice (How am I Doing?) Physicians must demonstrate accountability for performance in their practice.	Physicians should use a variety of methods that incorporate reference data to assess their performance in practice and guide improvement. 3rd party attestation of participation will satisfy this component.	Assessment tools could include but are not limited to: • 360-degree/multi-source evaluations (self evaluation, peer assessment and patient surveys). • Patient reviews, such as satisfaction surveys • Collection and analysis of practice data such as medical records, claims review, chart review and audit, case review and submission of a case log • Registries • American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BS) Clinical Assessment Program • An approved American Board of Medical Specialties (ABMS) MOC Part IV Practice Improvement activity • Medical professional society/organization clinical assessment/practice improvement programs • Peer review • Centers for Medicare and Medicaid Services (CMS) and other similar institutional based measures • Other performance improvement projects such as the Surgical Care Improvement Project (SCIP), American Medical Institute (AMI), Institute for Healthcare Improvement (IHI), Healthcare Effectiveness Data and Information Set (HEDIS) • Other tools approved by the state medical board

AMA Policies

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; and (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. (CME Rep. A, A-87; Modified: Sunset Report, I-97; Reaffirmation A-04)

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 (Appendix A); 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. (CME Rep. 16, A-09)