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

REPORT 2 OF THE COUNCIL ON MEDICAL EDUCATION (A-18)
Update on Maintenance of Certification and Osteopathic Continuous Certification
(Resolutions 316-A-17 and 318-A-17)
(Reference Committee C)

EXECUTIVE SUMMARY

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

In 2017, the ABMS Board adopted a new name, "Continuing Board Certification," for its MOC Program (some ABMS member boards are still referring to the program as MOC). The ABMS and its 24 member boards also launched a major initiative to modernize continuing board certification. A planning committee established the "Continuing Board Certification: Vision for the Future" Commission to engage physicians, the public, and key stakeholders in a collaborative process.

This report highlights initiatives that are underway to improve MOC:

- Many ABMS member boards have taken steps to replace the MOC Part III examination with a more relevant, less onerous, and cost-efficient process for physicians. Some boards are looking at ways to innovate assessment of medical knowledge and are testing new models or have implemented alternatives to the traditional secure, high-stakes examination. The table at the end of this report summarizes the new models being implemented and/or piloted and board activities underway to improve the examination component (MOC Part III).
- The ABMS member boards have broadened the range of acceptable activities that meet the Improvement in Medical Practice (IMP) component (MOC Part IV). New activities are being implemented by the boards related to registries, systems-based practice, and practice audits.
- New studies published during the last year describe how new assessment models and IMP activities have resulted in improved quality and patient care and physician satisfaction.

Updates on the following MOC activities are also included in this report:

- AMA participation in meetings and conferences to improve the MOC process (pages 2-5)
- The ABMS Continuing Certification Directory (pages 5-6)
- Alternatives to the MOC Part III secure, high-stakes examination (pages 6-8)
- Improvement in medical practice (MOC Part IV) (pages 8-9)
- The ABMS Multi-Specialty Portfolio Program (pages 9-10)
- Emerging data and literature regarding the value of MOC (pages 10-13)
- Osteopathic Continuous Certification (pages 13-14)
- State legislation related to the use of MOC (pages 14-15)

The Council on Medical Education is committed to ensuring that continuing board certification supports physicians' ongoing learning and practice improvement and can assure the public that physicians are providing high-quality patient care. The Council continues to work with the ABMS, ABMS member boards, American Osteopathic Association, state and specialty medical societies, and key stakeholders to identify and suggest improvements to continuing certification programs. During the next year, the Council will also be actively engaged in following the work of the ABMS Commission and the development of the Commission's recommendations for the future continuing board certification process.

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

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-A-18

Subject: Update on Maintenance of Certification and Osteopathic Continuous Certification (Resolutions 316-A-17 and 318-A-17)

Presented by: Lynne M. Kirk, MD, Chair

Referred to: Reference Committee C
(Sherri S. Baker, MD, Chair)

Resolution 316-A-17, "Action Steps Regarding Maintenance of Certification," Resolves 4 and 5, introduced by Florida, Pennsylvania, Georgia, California, New York, Arizona, Texas, American College of Radiation Oncology, and American Society of Interventional Pain Physicians and referred by the American Medical Association (AMA) House of Delegates (HOD), asks the AMA to:

> 4) join with state medical associations and specialty societies in directly lobbying state medical licensing boards, hospital associations, and health care insurers to adopt policy supporting the use of satisfactory demonstration of lifelong learning with high quality CME as specified by a physician's specialty society for credentialing and bar these entities from using the ABMS sponsored MOC process using lifelong interval high stakes testing for credentialing; and
>
> 5) partner with state medical associations and specialty societies to undertake a study with the goal of establishing a program that will certify physicians as satisfying the requirements for continuation of their specialty certification by successful demonstration of lifelong learning utilizing high quality CME appropriate for that physician's medical practice as determined by their specialty society with a target start date of 2020 or before, with report back biannually to the HOD and AMA members.

Resolution 318-A-17, "Oppose Direct to Consumer Advertising of the ABMS MOC Product," introduced by Michigan and also referred by the HOD, asks the AMA to:

> 1) oppose direct-to-consumer marketing of the American Board of Medical Specialties Maintenance of Certification (MOC) product in the form of print media, social media, apps, and websites that specifically target patients and their families including but not limited to the promotion of false or misleading claims linking MOC participation with improved patient health outcomes and experiences where limited evidence exists; and
>
> 2) amend existing AMA Policy D-275.954, "Maintenance of Certification and Osteopathic Continuous Certification" by addition as follows:
> <u>36. Direct the ABMS to ensure that any publicly accessible information pertaining to maintenance of certification (MOC) available on ABMS and ABMS Member Boards' websites or via promotional materials includes only statistically validated, evidence based, data linking MOC to patient health outcomes.</u>

Policy D-275.954 (1), "Maintenance of Certification and Osteopathic Continuous Certification," asks that the AMA continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the HOD regarding the MOC and OCC processes.

BACKGROUND

Reference Committee C heard mixed testimony on Resolution 316-A-17. There was overwhelming support for the first and second resolves, which are consistent with existing HOD policy that 1) affirms that lifelong learning is a fundamental obligation of the profession, and 2) recognizes that lifelong learning for a physician is best achieved by ongoing participation in a program of high quality continuing medical education (CME) appropriate to that physician's medical practice as determined by the relevant specialty society.

However, in accordance with existing policy, the AMA has already developed model state legislation intended to prohibit hospitals, health care insurers, and state boards of medicine and osteopathic medicine from requiring participation in MOC processes as a condition of credentialing, privileging, insurance panel participation, licensure, or licensure renewal. This model bill is on file with the AMA Advocacy Resource Center, which will assist any interested state medical associations in pursuing legislation that is consistent with AMA policy. The AMA has also focused on educating state medical associations about activity around the country, as well as on the risks and benefits of legislating the use of MOC. During the testimony, it was noted that enacted and defeated state legislation related to the use of MOC is complex and its potential impact on professional self-regulation is unknown. It was therefore recommended that the fourth and fifth resolves be referred for study with a report back to the HOD on the current status of such legislation.

The reference committee also heard mixed testimony related to Resolution 318-A-17. Although the AMA opposes direct-to-consumer marketing of drugs and devices, it was noted that this resolution focuses on a different kind of communication. It was also noted that the American Board of Medical Specialties (ABMS) is making a statement to inform the public about the certification status of physicians. There is no precedent in AMA policy that supports this issue, and the AMA has no purview over how the ABMS communicates information about its certification process. It was therefore recommended that this resolution be referred for further study.

MAINTENANCE OF CERTIFICATION (MOC): AN UPDATE

The AMA Council on Medical Education and the AMA HOD have carried out extensive and sustained work in developing policy on MOC and OCC (Appendix A), including working with the ABMS and the American Osteopathic Association (AOA) to provide physician feedback to improve the MOC processes, informing our members about progress on MOC and OCC through annual reports to the House, and developing strategies to address the concerns about the MOC and OCC processes raised by physicians. The Council has prepared reports covering MOC and OCC for the past nine years.[1-9] During the last year, Council members, AMA Trustees, and AMA staff have participated in the following meetings with the ABMS and its member boards:

- ABMS Board of Directors Meeting (2/27/2018 - 3/1/2018)
- American Board of Anesthesiology/ABMS Maintenance of Certification Research Summit (9/24-25/2017)

- ABMS 2017 Conference and Forum on Organizational Quality Improvement (9/26-29/2017)
- ABMS Committee on Continuing Certification (11/15-16/2017)
- ABMS Meeting with Medical Societies to address physician concerns about MOC (12/4/2017)
- Council of Medical Specialty Societies (CMSS) National Specialties and ABMS Medical Boards Annual Dyad Meeting (12/5/2017)
- Planning Committee for the Continuing Board Certification: Vision for the Future Initiative (12/6/2017)
- Commission for the Continuing Board Certification: Vision for the Future Initiative (3/19-20/2018)
- AMA Council on Medical Education and the ABMS Jointly Sponsored Conference on Continuing Board Certification (3/26/2018)

Council on Medical Education members, AMA trustees, and AMA staff are planning additional dialogue on this topic with stakeholders throughout 2018.

"Maintenance of Certification" to be modernized and renamed "Continuing Board Certification"

In 2017, the ABMS Board adopted a new name, "Continuing Board Certification," for its MOC Program, but some member boards still refer to the program as MOC. The ABMS and its 24 member boards also launched a major initiative to modernize continuing board certification (visioninitiative.org/). A planning committee was formed to establish the "Continuing Board Certification: Vision for the Future" Commission, which includes representatives from the ABMS, Accreditation Council for Continuing Medical Education (ACCME), Accreditation Council for Graduate Medical Education (ACGME), Coalition for Physician Accountability, CMSS, and AMA Council on Medical Education, as well as public members. The Commission has been designed to engage physicians, the public, users of the credential, and other stakeholders in a collaborative process.

The planning committee identified the construct and membership of a 27-member Commission, and a member of the Council on Medical Education was selected to serve on the Commission. The planning committee also identified key questions for consideration by the Commission and will oversee a national opinion survey.

The Commission is in turn gathering information, holding hearings, addressing key questions, and making recommendations for the future continuing board certification process. During the course of its work, the Commission will generate several briefing documents for community consideration and feedback. The purposes of these documents are to present information about current and proposed practices, test concepts and ideas, and continue to engage the broader community in this process. The Commission will communicate with the broader community about the concepts and ideas and will engage in a series of discussions with stakeholders about different aspects of continuing board certification. This process is intended to facilitate the Commission's building an achievable, sustainable model. In addition, portions of the Commission meetings will be open to guests; guests will be able to hear testimony, presentations, and discussions. The Commission will also meet in closed sessions.

On March 26, 2018, the AMA Council on Medical Education, ABMS, and ABMS member boards jointly convened a conference that included additional stakeholders (i.e., specialty societies, state medical societies, ACCME, American Hospital Association, Association for Hospital Medical Education, Association of American Medical Colleges, CMSS, and the Federation of State Medical Boards) to determine how continuing certification can meet the needs of diverse stakeholders and to develop recommendations that will be sent to the Commission for their consideration on behalf

of the attendees. During the conference, several ABMS member boards shared the results of surveys to obtain feedback from physicians regarding MOC and discussed some of their recently implemented changes. In order to develop recommendations for the Commission, the conference focused on the roles of the boards and specialty and medical societies to determine how assessment, learning, and improvement in practice can be relevant, meaningful, and integrated with the way physicians practice. A white paper summarizing the conference and final recommendations is being considered by the Council at the suggestion of the attendees. The Commission is expected to release a draft report for public comment in November 2018. A final report will be sent to the ABMS in February 2019.

Report from the ABMS Committee on Continuing Certification

The Committee on Continuing Certification (3C) is charged with reviewing existing MOC programs to ensure the ABMS member boards meet the 2015 Standards for the Program for MOC, which evaluates the effectiveness of different approaches to MOC and identifies innovations to share among the boards.

In 2017, 3C reviewed the Professionalism and Professional Standing (Part I) component of the member boards' Programs for MOC, seeking to understand the boards' current processes for assessing professionalism and responding to potential lapses. Additionally, the member boards have been sharing information with 3C about pilot projects undertaken to enhance the experience and value of their MOC programs for their diplomates.

Report from the ABMS meeting with medical societies to address physician concerns about MOC

On December 4, 2017, staff from the ABMS held a meeting with members of the CMSS, the Specialty Society CEO Consortium (S2C2), state medical societies, and other stakeholders, including a member of the Council on Medical Education, to discuss the MOC programs of its member boards. The meeting focused on the critical issues and concerns physicians have raised about MOC, what the ABMS member boards are doing to resolve these concerns, and how these organizations can work together to create a future continuing board certification program that is relevant and valuable to stakeholders, board certified physicians, and the patients they serve.

State medical and specialty societies voiced their members' concerns about the complexity, relevance to practice, and the time and indirect cost burden associated with MOC programs. They also noted that physician frustration with MOC programs has led to legislative initiatives in many states that would prevent hospitals from requiring physicians to recertify. The state medical society leaders and their members expressed a desire to have ongoing input into the development of the continuing certification programs, a commitment to action and transparency from the member boards, and improved communication. In addition, they requested more consistency across the boards' continuing board certification programs in order to establish best practices across specialties that also indicate the programs' impact in improving patient care. All attendees agreed on the need to jointly develop solutions to avoid a decline in the value of board certification and the erosion of public trust in the ability of the profession to self-regulate.

The following "Statement of Shared Purpose" was agreed to by those present:

> "ABMS certifying boards and national medical specialty societies will collaborate to resolve differences in the process of on-going certification and to fulfill the principles of professional self-regulation, achieving appropriate standardization, and assuring that on-going certification is relevant to the practices of physicians without undue burden.

> "Furthermore, the boards and societies, and their organizations (ABMS and CMSS), will undertake necessary changes in a timely manner, and will commit to ongoing communication with state medical associations to solicit their input."

On December 5, 2017, leaders from the CMSS membership, ABMS, ABMS member boards, and additional guests met to discuss innovative approaches for continuous medical education. The ABMS member boards discussed 170 innovations they are working on to address continuous learning for physicians. Many of the innovations included input from various outside stakeholders and focused on greater consistency amongst the member boards. The innovations included alternatives to the high-stakes examinations with a focus on longitudinal learning for physicians in their relevant practice areas. Many of the member boards outlined current (or planned) learning modules that would be seamless for physicians, and they provided a gap analysis. There was also discussion by some member boards about reducing the exam fees and the need for the member boards to be more "customer friendly" when dealing with their diplomates. The member boards are interested in bidirectional communication going forward.

Update on new innovative CME models

The AMA and the ACCME have been collaborating on a strategy to more closely align the two organizations' requirements, simplify the system, and eliminate any barriers that would constrain innovation in educational development and the delivery of CME.[10] Both organizations want to ensure the education community has the permission to provide more CME options to physicians that integrate new technology and are adaptable to their learning style, accessible, and relevant. A proposal that was developed with various groups (including staff, volunteers, and the leadership from accredited organizations and state medical societies) about how to simplify the system to better support the evolution of CME was adopted by the AMA and ACCME and went into effect in September 2017.

The ABMS and its member boards are also collaborating with academic medical centers, specialty societies, and other continuing professional development/continuing medical education (CPD/CME) stakeholders to help board certified physicians find quality certified CME activities linked to components of the ABMS Program for MOC.

ABMS Continuing Certification Directory

The ABMS "Continuing Certification Directory," formerly called the "MOC Directory" (continuingcertification.org/) continues to offer physicians access to a comprehensive, centralized, web-based repository of CME activities that have been approved for MOC credit by ABMS member boards. During the past two years, the directory has increased its inventory and now indexes 600-plus activities from more than 60 CME providers to help diplomates from across the specialties meet MOC requirements for Lifelong Learning and Self-Assessment (Part II) and Improvement in Medical Practice (Part IV).

The following types of activities are currently included in the directory: internet enduring activities, journal CME, internet point of care, live activities, and performance improvement CME. All CME activities are qualified to award credit(s) from one or more of the CME credit systems: *AMA PRA Category 1 Credit*™, AAFP Prescribed Credit, ACOG Cognates, and AOA Category 1-A.

The directory includes a wide variety of activities addressing emerging issues such as physician well-being and safe opioid prescribing initiatives as well as a full suite of AMA STEPS Forward™ Practice Improvement Strategies. STEPS Forward offers more than 40 online modules, plus

resources, case studies, and other content around patient care, work flow process, leading change, professional well-being, technology, and finance. The ABMS has invited the CPD/CME communities to submit for inclusion in the directory any certified CME activities that support the development of high-functioning physicians. For example, the most recent call for activities (abms.org/news-events/abms-call-for-physician-well-being-cme-activities/) focuses on improving physician well-being.

The ACCME continues to collaborate with the American Board of Internal Medicine (ABIM), American Board of Anesthesiology (ABA), and American Board of Pediatrics (ABP);allows accredited CME providers to identify CME activities that also meet the MOC requirements for each of the member boards (ABIM, ABA, and ABP); and facilitates reporting of learner data from the accredited provider to the relevant member board (accme.org/news-publications/news/accreditation-council-cme-american-board-anesthesiology-and-american-board). The collaborations are designed to expand the number and diversity of accredited CME activities that meet the member boards' MOC Part II requirements. This simplifies a physician's search for approved activities (cmefinder.org/). CME providers are using the ACCME Program and Activity Reporting System (PARS) to attest that their activities comply with board requirements. The ACCME maintains a list of accredited and certified CME activities registered for ABIM MOC, ABA MOC, and ABP MOC. The ABIM currently has more than 6,200 activities that have been certified for CME credit and registered for MOC points. Many of these activities are available across specialties, while some are specialty specific. The AMA transmits JAMA Network data to the ACCME for ABIM and is considering expansion to additional boards in the future.

Elimination of the secure, high-stakes examination for assessing knowledge and cognitive skills in MOC

Twenty-one ABMS member boards (87.5%) have moved away from the secure, high-stakes exam, and more than two thirds of the boards (71%) have launched, or will soon be launching, assessment pilots that combine adult learning principles with state-of-the-art technology, enabling delivery of assessments that promote learning and are less stressful (Table). A number of them are combining the longitudinal assessment approach with CertLink™, a technology platform developed by the ABMS to support its boards in delivering more frequent, practice-relevant, and user-friendly competence assessments to physicians (abms.org/initiatives/certlink-platform-and-pilot-programs/). The platform provides the technology to enable the boards to create assessments focused on practice-relevant content; offers convenient access on desktop, tablet, or smartphone (depending on the board's program); provides immediate, focused feedback and guidance to resources for further study; and provides a personal dashboard that displays areas of strength and weakness. The member boards that are developing CertLink™ pilot programs include the American Board of Colon and Rectal Surgery (ABCRS), American Board of Dermatology (ABD), American Board of Medical Genetics and Genomics (ABMGG), American Board of Nuclear Medicine (ABNM), American Board of Otolaryngology (ABOto), American Board of Pathology(ABPath), and American Board of Physical Medicine and Rehabilitation (ABPMR).

Other ABMS member boards that have been piloting new innovative assessment approaches have received positive feedback on their pilots. For example, the ABA surveyed its physicians in December 2016 to collect their feedback on year one of the redesigned Maintenance of Certification in Anesthesiology Program® (known as MOCA 2.0®). Nearly 75 percent of the physicians who responded reported that the MOCA Minute® pilot served them well as an assessment tool. Additionally, nearly 62 percent of survey respondents rated the experience better or much better than their experience with the traditional MOCA exam. Furthermore, physicians who participated in the 2014 and 2015 MOCA Minute pilot outperformed non-participants on the

MOCA Exam, according to a study published in the November 2016 issue of *Anesthesiology*.[11] In January 2017, the ABA expanded its longitudinal assessment program to include diplomates maintaining subspecialty certificates.

In January 2017, the ABP launched a pilot of its proposed longitudinal assessment approach called Maintenance of Certification Assessment for Pediatrics (MOCA-Peds) (abp.org/mocapeds). Nearly all 5,000 diplomates—approximately 98 percent of those eligible—enrolled in the 2017 MOCA-Peds pilot. At the end of each quarter, the ABP surveyed pilot participants about their experiences. Highlights from the first two surveys showed that 92 percent of participants had a satisfactory experience with the information technology platform, and nearly 80 percent agreed or strongly agreed that the MOCA-Peds questions were relevant to general pediatrics.[12] Based on this feedback, the ABP plans to replace the 10-year secure exam with MOCA-Peds beginning in 2019.

In 2018, the ABIM began offering a new two-year assessment option to provide physicians more choice, relevance, and convenience in meeting the assessment requirement of its MOC program. These "Knowledge Check-Ins" will allow diplomates to take shorter assessments in a location of their choice. The ABIM will first pilot the Knowledge Check-In for physicians certified in internal medicine or nephrology. The shorter assessments will become available to other specialties in 2019 and 2020 as an additional option along with the traditional 10-year MOC exam.

Several member boards are considering or have integrated journal article-based core questions into their assessments. The American Board of Obstetrics and Gynecology (ABOG) launched its MOC Pilot Program (abog.org/new/abog_mocimp.aspx) in 2016; more than 2,000 physicians opted to participate. In a survey of pilot participants conducted in 2017, 93 percent of the 1,268 respondents affirmed that the journal article assignments—a core element of the pilot—are beneficial to their clinical practice. Additionally, 87 percent of respondents agreed that if the ABOG fully adopts the pilot, it will make MOC more valuable to clinical practice, and 89 percent agreed that it will make MOC more relevant to clinical practice.[13] The ABOG studied the pilot results through 2017 and will decide whether to permanently adopt the changes to its MOC program in 2018.

Preliminary analysis from the American Board of Ophthalmology's (ABO) new Quarterly Questions™ program (diplomatedigest.com/single-post/2018/02/06/Article-Based-Learning-and-Assessment-in-Quarterly-Questions), launched in 2017, has been extremely favorable, earning the support of ABO diplomates as an approach to learning and assessment. Nearly 20 percent of ABO's active diplomate population participated in the program's optional pilot year, with 94 percent reporting that the article-based questions were useful for learning new, relevant information. Eighty-five percent of participants said the information they learned while completing the activity would help them provide better care to their patients in the future, and 99 percent said they would recommend the program to a colleague.

Other member board efforts include more diplomate input into exam blueprints; modularization of exam content that allows for tailoring of assessments to reflect physicians' actual areas of practice; access during the exam to resources similar to those used at the point of care; remote proctoring to permit diplomates to be assessed at home or in the office; and performance feedback mechanisms. All boards will also provide multiple opportunities for physicians to retake the exam. These program enhancements will significantly reduce the cost diplomates incur to participate in MOC by reducing the need to take time off or travel to a testing center for the assessment; ensure that the assessment is practice relevant; emphasize the role of assessment for learning; assure opportunities for remediation of knowledge gaps; and reduce the stress associated with a high-stakes test environment.

Progress with improving MOC Part IV, Improvement in Medical Practice

The ABMS member boards have broadened the range of acceptable activities that meet the Improvement in Medical Practice (IMP) requirements, including those offered at the physician's institution and/or individual practices, in order to address physician concerns about the relevance, cost, and burden associated with fulfilling the IMP requirements. In addition to improving alignment between national value-based reporting requirements and continuing certification programs, the boards are implementing a number of activities related to registries, systems-based practice, and practice audits.

Registries

The ABMS member boards are increasingly incorporating the use of patient registries into their continuing certification process. Registries target quality concerns and provide physicians with meaningful, actionable information that helps align their MOC activities with federal and state quality incentive programs. While many member boards have been providing physicians the opportunity to earn MOC credit for participating in externally developed patient registries, some boards are designing performance improvement initiatives supported by registry data. Many of the member boards also recognize participation in registries developed by their professional societies as satisfying their IMP requirements.

- In 2017, the ABO began piloting a program that enables ophthalmologists to create customized quality improvement (QI) projects using the data supplied through the American Academy of Ophthalmology's IRIS® Registry. After numerous improvement projects were successfully completed, ABO transitioned the pilot into a permanent program in October 2017. Ophthalmologists can use the monthly reports to identify areas for improvement, set specific goals for each measure, outline the steps (changes in care delivery processes) to achieve these goals, and evaluate their success by analyzing subsequent monthly performance reports. Ophthalmologists receive MOC credit for approved, completed projects.

- The ABOto has partnered with the American Academy of Otolaryngology-Head and Neck Surgery for the past two years to develop a qualified clinical data registry, Reg-ent. This registry is able to extract data from an otolaryngologist's electronic health records (EHRs) for multiple purposes, including reporting quality measures for Merit-based Incentive Payment System (MIPS) as payment shifts to performance under the Quality Payment Program. The ABOto will be able to extract data from Reg-ent to provide feedback to board certified otolaryngologists and document improvement, thereby meeting MOC requirements without requiring data entry by the physicians.

- More than 3,000 physicians are using the American Board of Family Medicine (ABFM) PRIME Registry, which extracts patient data from the practice EHR and converts it into actionable measures that are presented in an easy to use dashboard. The PRIME Registry is a qualified clinical data registry that is approved to propose measures to the Centers for Medicare & Medicaid Services (CMS). The ABFM's PRIME Registry offers tools that simplify and automate reporting for MIPS and CMS's Comprehensive Primary Care Plus or CPC+, and enables physicians to use their measures data to create and implement a QI plan in their practice to simplify continuous certification and align it with MIPS reporting requirements. The ABFM is also developing a new tool, the Population Health & Assessment Engine, to integrate social determinants of health data with clinical data in the registry to help physicians understand the impact of social determinants on individual patients and the populations they serve and to improve intervention and care.

Interoperability between clinical data registries and EHRs continues to be a priority for specialty society registry hosts. CMSS published the *Registry Primer* to serve as background and a resource guide on clinical registry development and implementation (https://cmss.org/732-2/). CMSS member societies are also exploring a Clinical Data Registry Collaborative, which is planning a pilot project to identify and match patient-centric data elements from two or more data registries in their current hosting environment. CMSS plans to engage with the National Quality Registry Network and the National Quality Forum, which are exploring similar interoperability challenges.

Systems-based practice

The ABMS member boards are aligning MOC activities with other organizations' QI efforts to reduce redundancy and physician burden while promoting meaningful participation. Twenty-one of the boards encourage participation in organizational QI initiatives through the ABMS Multi-Specialty Portfolio Program™ (described below). Many boards encourage involvement in the development and implementation of safety systems or the investigation and resolution of organizational quality and safety problems. For physicians serving in research or executive roles, some boards have begun to give IMP credit for having manuscripts published, writing peer-reviewed reports, giving presentations, and serving in institutional roles that focus on QI (provided that an explicit Plan-Do-Study-Act [PDSA] process is used). Physicians who participate in QI projects resulting from morbidity and mortality conferences and laboratory accreditation processes resulting in the identification and resolution of quality and safety issues can also receive IMP credit from some boards.

Practice Audits

Several ABMS member boards have developed online practice assessment protocols that allow physicians to assess patient care using evidence-based quality indicators. Other initiatives include:

- Free tools to complete an IMP project, including a simplified and flexible template to document small improvements, educational videos, infographics, and enhanced web pages.
- Partnering with specialty societies to design quality and performance improvement activities for diplomates with a population-based clinical focus.
- Successful integration of patient experience and peer review into several of the boards' IMP requirements; one board has aggressively addressed the issue of cost and unnecessary procedures with an audit and feedback program.
- Integration of simulation options.
- A process for individual physicians to develop their own improvement exercises that address an issue important to them, using data from their own practices, built around the basic PDSA process.

ABMS Multi-Specialty Portfolio Program

The ABMS Multi-Specialty Portfolio Program (Portfolio Program™) offers health care organizations a way to support physician involvement in their institution's quality and performance improvement initiatives by offering credit for the IMP component of the ABMS Program for MOC (mocportfolioprogram.org). Originally designed as a service for large hospital institutions, the Portfolio Program is extending its reach to physicians whose practices are not primarily in institutions. This includes non-hospital organizations such as academic medical centers, integrated delivery systems, interstate collaboratives, specialty societies, and state medical societies. Recent

additions among the 93 current sponsors include the American College of Cardiology, American Hospital Association, and American College of Obstetricians and Gynecologists.

More than 2,600 types of QI projects have been approved by the Portfolio Program, focusing on such areas as advanced care planning, cancer screening, cardiovascular disease prevention, depression, immunizations, obesity, patient-physician communication, transitions of care, and patient-safety related topics including sepsis and central line infection reduction. Many of these projects have had a profound impact on patient care and outcomes. For example, during the past two years, Portfolio Program initiatives at the Children's Hospital of Philadelphia have been responsible for inpatient hospital days for oncology patients with fever and neutropenia decreasing by more than 35 percent, preventable readmissions for neurology patients decreasing by approximately 80 percent, and rates of urinary catheterization for febrile infants decreasing by 65 percent. Additionally, rates of pneumococcal immunization among patients with chronic kidney disease have increased by 79 percent, and the application of evidence-based practices to evaluate and manage children with attention deficit disorder and hyperactivity has increased by 50 percent. There have been nearly 19,700 instances of physicians receiving MOC IMP credit through participation in the program. Twenty ABMS member boards participate in the program.

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

The Council on Medical Education has continued to review published literature and emerging data as part of its ongoing efforts to critically review MOC and OCC issues. Although there is still frustration with the MOC process and its cost,[14] many improvements have been made to the MOC Program, such as making the process more efficient, convenient, and cost-effective, and less burdensome. In addition, important peer-reviewed studies published during the last year demonstrate the benefits of participating in a continuous certification program. These studies are summarized below.

Many of the ABMS member boards have been enhancing the MOC Part III examinations to ensure the exam is practice-relevant. A study by Gray et al. analyzed whether the ABIM MOC exams from 2010-2013 reflected practice conditions during either office visits or hospital stays for each of 186 condition categories within internal medicine. The study showed that the majority of exam questions generally reflected what occurs in practice, with 69 percent of the questions on these exams harmonizing with conditions in practice.[15] A study by Lipner et al., involving 825 physicians initially certified by the ABIM or who took the ABIM MOC exam in 2012 to 2015, compared the results of a closed book exam to an open book exam that allowed the use of electronic resources typically used at the point of care. The study showed that inclusion of an electronic resource with time constraints did not adversely affect test performance and did not change the specific skill or factor targeted by the exam.[16]

One study looked at the benefits derived from taking the MOC Part III examination. More than 2,500 emergency physicians who took the American Board of Emergency Medicine (ABEM) ConCert high-stakes examination in 2015 participated in a voluntary post-examination survey in 2015. When asked about the benefits of preparing for the exam and maintaining ABEM certification, the majority of emergency physicians (more than 90 percent) reported they either gained medical knowledge or reinforced knowledge they already had, making them better clinicians. Most of them also found career benefits to remaining ABEM certified, including greater employment choices, higher financial compensation, and higher esteem from other physicians.[17]

A number of recently published studies evaluate the effectiveness and value of IMP activities (MOC Part IV).

- A study conducted by the University of Michigan Health System Adolescent Health Initiative evaluated whether a MOC Part IV project could improve the delivery of confidential care to minor adolescent patients seen in outpatient primary care practices. This study showed that this Part IV project was an effective way to change physician practice and improve the delivery of confidential care to minor adolescents seen for wellness visits. The study also showed that another major benefit was that it served as the primary mechanism to get physicians in non-adolescent specialties engaged in improving care for adolescents. In addition, participation broadly increased participating primary care physicians' knowledge of best practices in adolescent care, which may lead to wider improvements for adolescents in the practice as a whole.[18]

- A study of pediatric gastroenterologists who participated in a MOC Part IV activity showed significant improvements in clinical care documentation and processes as well as improvements in patient outcomes for various endoscopic procedures. In addition, parents had a much greater understanding of the informed consent process. An analysis of data taken from web-based MOC QI modules also showed significant practice variation across several processes and demonstrated how the web-based MOC activities improved them.[19]

- In a study that examined whether organization-developed MOC performance improvement modules (PIMs), such as the PIMs created by the ABP, improve the quality of pediatric care, the PIMs were linked to better care for children. Pediatricians improved care for attention-deficit/hyperactivity disorder, asthma, and influenza. Hand hygiene also improved.[20]

- A study of hypertension Performance in Practice Modules completed by family physicians from July 2006 through 2013 showed that these physicians significantly improved the quality of care for patients with hypertension, including improving blood pressure control and diet and exercise counseling, after completing the activity.[21]

- A study undertaken at Nationwide Children's Hospital evaluated the effectiveness of integrating QI training within the institution by developing a course called "Quality Improvement Essentials" in 2012. The results of surveys were positive, indicating increased and maintained QI competency among staff. Approximately 40 percent of the physicians who participated in the course converted their course project to receive MOC Part IV credit.[22]

- A study by Jennings, et al., evaluated a QI project in a community emergency department (ED) aimed at decreasing the use of head computed tomography (CT) scans in children. The study showed that pediatricians who participated in the MOC activity reduced the use of unnecessary head CT scans for children with head injuries in the ED. In addition, coaching and mentoring from a regional hospital participating in the MOC Portfolio Program (Seattle Children's Hospital) had a significant effect on the successful QI effort at the community setting.[23]

- Shaw et al. described how pediatric physicians' increased participation in MOC Part IV QI activities at the Children's Hospital of Philadelphia is improving patient care (e.g., asthma management, patient flow, and cardiac arrest outcomes).[24]

Recently published articles describe improvements made to the continuing certification process.

- One article describes how the American Board of Allergy and Immunology's (ABAI) Part III continuous assessment program will replace the ABAI's 10-year high-stakes examination beginning in 2018. This process will be an open-book and web-based program that will focus on adult learning theory methods to reduce the cost and burden on diplomates.[25]

- Two articles discuss how improvements being made to the MOC process make continuing certification more meaningful and acceptable to physicians. The ABIM and ABP have worked closely with their specialty societies to increase the number of CME programs that count for MOC. In addition, the ABIM and ABP have tested and evaluated new assessment models to replace the 10-year high-stakes examinations.[26, 27]

- An article by Juul et al. highlights the development of geriatric psychiatry subspecialty certification. The article focuses on how the American Board of Psychiatry and Neurology (ABPN) is attempting to meet the need for more geriatric psychiatrists by strategically developing a flexible approach to MOC that includes options for taking combined examinations which cover their diplomates' specialty and/or subspecialty. Other ABPN MOC requirements are the same as those for recertification in general psychiatry only or in a single subspecialty.[28]

- An article by Carlos et al. provides an overview of how the American Thoracic Society developed a core curriculum focusing on adult pulmonary, critical care, and sleep medicine and pediatric pulmonary medicine that can be integrated into the MOC programs offered by the ABIM and ABP. The guiding principles outlined in this article may aid other societies that are considering launching similar initiatives to meet the needs of their members.[29]

- An article by McMillan et al. addresses the importance of focusing on behavioral and mental health in pediatric resident training and the efforts being made by the ACGME and ABP to improve this area of need. This article also identifies how MOC will be used to try to improve learning.[30]

Three articles describe quality measurement that is being used in clinical care improvement, regulation, accreditation, public reporting, surveillance, and MOC. A 2015 quality metrics (QUALMET) survey assessed the commonalities and variability of selected quality and productivity indicators, including MOC participation, currently used by 112 U.S. academic radiology departments. MOC participation was found to be varied and a requirement of employment for nearly half of the survey respondents. The study suggests that MOC is currently the best metric to evaluate whether a radiologist has up-to-date knowledge and is familiar with quality and safety practices.[31] A policy statement published by the American Academy of Pediatrics recommended that national policymakers "harmonize and align measures used in national/state reporting programs, including payment programs, such as state Medicaid and private payers, accreditation bodies, regulatory agencies, and MOC programs to reduce reporting burden on physicians."[32] An article by Price and Lang presents a QI model for the clinical practice of allergy and immunology that can be used by physicians to develop and implement practice-based QI activities that improve processes and outcomes of care for patients.[33]

Recent articles also evaluate self-regulation, professionalism, and perceptions about MOC. A review of retrospective cohort studies between MOC and clinical processes or outcomes, published from 2007 to 2016, shows that although methodological challenges remain, a rapidly growing body

of literature provides evidence that MOC is associated with better care or has been an incentive for physicians to collaborate in systematically improving patient care and outcomes.[34] A review article summarizes the challenges of teaching and assessing professionalism in radiology, how professionalism is part of MOC and the American Board of Radiology's competency assessment, and how a greater understanding of professionalism as part of competency assessment is needed.[35] A study conducted by the Seattle Children's Hospital showed that, of 123 physicians who participated in a MOC project and completed a survey, 97 percent of the survey respondents view Part IV favorably. Participation was associated with modest improvements in perceptions of QI engagement and attitude, application of QI methods, and patient care.[36]

More than 60 sessions at the ABMS annual QI Forum held during the 2017 ABMS Conference (abmsconference.com/2017/session-descriptions) focused on continuing certification, initial certification, health policy research, patient safety, and improvement in medical practice. Posters presented by Portfolio Program sponsors and other health care researchers underscored best practices and research in continuing certification and QI activities (abmsconference.com/2017/poster-session). One example highlighted a program at the University of Michigan Health System in which more than 40 QI projects are available for physician participation, including improving the rate of foot exams for adult diabetic patients, reducing the number of non-medically indicated planned deliveries, and improving the clinical management of overweight and obese pediatric patients.

Stakeholders from the fields of medical education and assessment also met to develop a collaborative research agenda and strategy to study learning and assessment throughout a physician's career during the 2017 ABA/ABMS Research Summit entitled, "Improving Health and Healthcare Systems: Defining a Research Agenda for Learning and Assessment across the Continuum of a Physician's Career" (abmsconference.com/2017/session-descriptions/).

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

OSTEOPATHIC CONTINUOUS CERTIFICATION (OCC): AN UPDATE

The American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) was organized in 1939 as the Advisory Board for Osteopathic Specialists to meet the needs resulting from the growth of specialization in the osteopathic profession. Today, 18 AOA-BOS specialty certifying boards offer osteopathic physicians the option to earn board certification in a number of specialties and subspecialties. As of December 2016, over 29,000 osteopathic physicians held active board certification through the AOA (with some of these physicians holding multiple certifications).

OCC was implemented on January 1, 2013, by all 18 specialty certifying member boards of the AOA-BOS.[37] All osteopathic physicians who hold a time-limited certificate are required to participate in the following five components of the OCC process in order to maintain osteopathic board certification:

- Component 1 - Active Licensure: physicians who are board certified by the AOA must hold a valid, active license to practice medicine in one of the 50 states, District of Columbia, or U.S. territories, and adhere to the AOA's Code of Ethics.

- Component 2 - Life Long Learning/Continuing Medical Education (CME): requires that all recertifying diplomates fulfill a minimum number of hours of CME credit during each three-year CME cycle (15 certifying boards require 120 hours; three certifying boards require 150 hours). A minimum of 50 credit hours of this requirement must be in the specialty area of certification. Self-assessment activities are also designated by each of the 18 specialty certification boards. For osteopathic physicians who hold subspecialty certification(s), a percentage of their specialty credit hours must be in their subspecialty certification area.
- Component 3 - Cognitive Assessment: requires provision of one (or more) psychometrically valid and proctored examinations that assess a physician's specialty medical knowledge as well as core competencies in the provision of health care.
- Component 4 - Practice Performance Assessment and Improvement: requires that physicians engage in continuous quality improvement through comparison of personal practice performance measured against national standards for their respective medical specialty.
- Component 5 - Continuous AOA Membership.

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

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

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

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

In July 2016, the AOA House of Delegates approved a resolution calling for the AOA to study and evaluate all components of OCC. The Task Force reported its findings and recommendations regarding the five OCC components to the BOS at its annual meeting on November 6, 2016. The Task Force's recommendations focus on making the OCC process less onerous and apply current and new evaluation processes that take advantage of the latest concepts in certification and supporting technology. The BOS drafted resolutions based on the Task Force's recommendations and submitted these to the AOA Board of Trustees for approval at its February 2017 meeting. The resolutions were approved by the AOA Board of Trustees and the individual boards are now working on implementation plans for the updated OCC components.

STATE LEGISLATION RELATED TO THE USE OF MOC

MOC is intended to be a career-long process of learning, assessment, and performance improvement that is meant to demonstrate physicians' proficiency within a chosen discipline, but is separate from and not required for state medical licensure. Many hospitals have independently made the decision to require recertification for the granting of privileges, and various quality organizations and insurers use MOC to help identify commitment to professionalism and continuous performance improvement. These requirements are within their legal rights. However, AMA policy discourages such mandates. The AMA has adopted the following related policies:

- Policy H-275.924, "Maintenance of Certification," (15) states, "The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation."

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

Some states are proposing or have enacted legislation that prohibits the use of MOC as a criterion for licensure, privileging, employment, reimbursement, and/or insurance panel participation. Nine states (Arizona, Georgia, Kentucky, Maryland, Maine, Missouri, Oklahoma, Tennessee, and Texas) have enacted laws addressing MOC requirements. With the exception of Texas, where the enacted legislation has implications for hospitals' and health plans' use of MOC, the laws passed to date prohibit the use of MOC for initial and renewal licensure decisions. At the time of filing, 18 state legislatures (Alaska, Florida, Iowa, Indiana, Maryland, Massachusetts, Michigan, Missouri, New Hampshire, New York, Ohio, Oklahoma, Rhode Island, South Carolina, Tennessee, Utah, Washington, and Wisconsin) were actively considering MOC-related legislation.

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

DIRECT-TO-CONSUMER ADVERTISING OF THE ABMS MOC PRODUCT

Society relies on members of the medical profession to establish standards for entering the profession and to assure that they are maintaining competence throughout their careers.[38] Patients expect that their physician's certification reflects ongoing education and practice improvement. Board certification makes a public statement about a physician's capabilities to provide quality care in his or her chosen specialty. Patients, families, and others have a right to know a physician's certification status, and they should also be able to access this information through multiple channels and in formats that are easily understood.

Although the AMA opposes direct-to-consumer marketing of drugs and devices, Resolution 318-A-17 focuses on a different aspect of marketing. Health professionals, both physicians and non-physicians alike, are generally allowed to advertise to the public their training, education, experience, and expertise. Twenty states have enacted legislation prohibiting deceptive or misleading advertising, communication, or other deceptive or misleading conduct concerning health professionals' skills, education, training, professional competence, or licensure.

Some physicians may advertise that they are board certified or board eligible. The AMA opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of ABMS- or AOA-BOS-board certified physicians in any medical specialty, or takes

advantage of the prestige of any medical specialty for purposes contrary to the public good and safety (H-275.926 (1), "Medical Specialty Board Certification Standards"). Similarly, the AMA's "Truth in Advertising" campaign highlights the need to improve transparency, clarity, and reliability for the patient and public. Through this campaign, the AMA developed materials including a model bill, the "Health Care Professional Transparency Act," which includes a drafting note with sample language for use by state and specialty societies that wish to pursue legislation governing advertising about physician certification status (ama-assn.org/truth-advertising). The campaign provides medical societies with tools and resources to develop and advocate for legislation to help ensure that patients are promptly and clearly informed of the training and qualifications of their health care practitioner.

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education is committed to ensuring that MOC and OCC support physicians' ongoing learning and practice improvement and serve to assure the public that physicians are providing high-quality patient care in their practice settings. The AMA will continue to advocate for a certification process that is evidence-based and relevant to clinical practice as well as cost-effective and inclusive to reduce duplication of work. During the last year, the Council has continued to monitor the development of MOC and OCC and work with the ABMS, ABMS member boards, AOA, and the state and specialty medical societies to identify and suggest improvements to the MOC and OCC programs. Since the AMA will continue to work with these organizations and key stakeholders and a council member will be closely involved in the ABMS Commission and in the development of the Commission's recommendations for the future continuing board certification process, a study with the goal of establishing a program that will certify physicians is not warranted at this time.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolutions 316-A-17 and 318-A-17 and the remainder of the report be filed.

1. That our American Medical Association (AMA) continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so. (Directive to Take Action)

2. That our AMA, through its Council on Medical Education, continue to be actively engaged in following the work of the ABMS Continuing Board Certification: Vision for the Future Commission. (Directive to Take Action)

Fiscal Note: $2,500

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

American Board of:	Current Examination Format	New Models/Innovations
Allergy and Immunology (ABAI) abai.org	Computer-based, secure exam administered at a proctored test center once a year. Diplomates must pass the exam once every 10 years.	In 2018, ABAI-Continuous Assessment Pilot Program will be implemented in place of current exam: • A 10-year program with two five-year cycles. • Diplomates take exam where and when it is convenient. • Open-book exam with a total of approximately 80 questions per year. • Mostly article-based with some core questions during each six-month cycle. Diplomates are required to answer three questions for each of ten journal articles in each cycle. The articles will be posted in January and July and remain open for six months. Articles can be printed or downloaded for review. • Questions can be answered for each article independently. Diplomate feedback on each question will be required. • Opportunity to drop the two lowest six-month cycle scores during each five-year period to allow for unexpected life events. • Ability to complete questions on PC, laptop, MAC, tablet, and smart phone formats by using the new diplomate dashboard via the existing ABAI Web Portal page.
Anesthesiology (ABA) theaba.org	1) MOCA 2.0 introduced in 2014 to provide a tool for ongoing low-stakes assessment and provide more extensive, question-specific feedback. Also provides focused content that could be reviewed periodically to refresh knowledge and document cognitive expertise. 2) Piloting MOCA Minute™—a longitudinal assessment tool that requires diplomates to answer 30 questions per calendar quarter, or 120 per year, in lieu of taking a 10-year exam. *All diplomates with time-limited certification that expired on or before Dec. 31, 2015 and diplomates whose subspecialty certificates*	Analysis of the pilot data is underway to determine whether participants accessed the links to additional resources, learned the material, and improved performance in the content knowledge areas represented in the MOCA Minute Pilot.

	expired on or before December 31, 2016, must complete the traditional MOCA® requirements before they can register for MOCA 2.0®.	
Colon and Rectal Surgery (ABCRS)[1] abcrs.org	Computer-based secure exam administered at a proctored test center once a year (in May). Diplomates must pass the exam once every 10 years.	• Exploring ways to modify the exam experience to provide a more consistent evaluation process and to replace the exam as it presently is administered. The ABCRS is developing a CertLink™-based longitudinal assessment pilot to evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam. • The first diplomates enrolled are those sitting for the ABCRS certifying exam in September 2017. These diplomates start CertLink™ MOC in the Spring of 2018. Other diplomates will be able to enroll shortly thereafter.
Dermatology (ABD)[1] abderm.org	• Computer-based secure modular exam administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years. • Test preparation material available six months before the exam at no cost. The material includes diagnoses from which the general dermatology clinical images will be drawn and questions that will be used to generate the subspecialty modular exams. • Examinees are required to take the general dermatology module, consisting of 100 clinical images to assess diagnostic skills, and can then choose among 50-item subspecialty modules.	• The ABD successfully completed trials employing remote proctoring technology to monitor exam administration in the diplomates' homes or offices. • The ABD is developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam.
Emergency Medicine (ABEM) abem.org	ABEM's ConCert™, computer-based, secure exam administered at a proctored test center once a year. Diplomates must pass the exam once every 10 years.	The ABEM is monitoring recent efforts within the ABMS board community that have focused on pilots that assess knowledge, judgment, and skills using longitudinal assessments rather than an every-10-year exam. The alternative assessment method would have to show that its learning and assessment advantage is better than the current ABEM exam.
Family Medicine (ABFM) theabfm.org	• Computer-based secure exam administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years. • Improving relevance of recertification	Changes to the ABFM exam are not being considered at this time.

	exam by using national study of care content in family medicine practices. • Providing feedback to residents and practicing physicians about the "anatomy" of the exam and their particular knowledge gaps. Effort has resulted in significant improvement in passing rates and improved feedback regarding relevance.	
Internal Medicine (ABIM) abim.org	• Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. • Introduced grace period for physicians to retry assessments for additional study and preparation if initially unsuccessful.	In 2018,the ABIM plans to offer two assessment options: 1) Certified physicians (Internal Medicine and Nephrology with more specialties to roll out in 2019 and 2020) will be eligible to take the Knowledge Check-In, a new two-year open-book (access to *UpToDate*®) assessment with immediate performance feedback. Assessments can be taken at the physician's home or office, or at a computer testing facility instead of taking the long-form exam every 10 years at a testing facility. Those who meet a performance standard on shorter assessments will not need to take the 10-year exam again to remain certified. 2) Diplomates can also choose to take a long-form assessment given every 10 years. This option is the same as the current 10-year exam, but it will include open-book access (to *UpToDate*®) that physicians requested. *ABIM is also working with specialty societies to explore the development of collaborative pathways through which physicians can maintain board certification.*
Medical Genetics and Genomics[1] (ABMGG) abmgg.org	Computer-based secure exam administered at a proctored test center once a year (August). Diplomates must pass the exam once every 10 years.	Developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam.
Neurological Surgery (ABNS) abns.org	• The 10-year secure exam can be taken from any computer, i.e., in the diplomate's office or home. Access to reference materials is not restricted; it is an open book exam. • On applying to take the exam, a diplomate must assign a person to be his or her proctor. Prior to the exam, that	In 2018, an adaptive MOC cognitive learning tool will be available: • The tool will consist of updated knowledge that has evolved since the diplomate's last certification, and the tool will be shorter, relevant, and more focused than the prior exam.

	individual will participate in an on-line training session and "certify" the exam computers.	• The open book knowledge-based exam will provide updated evidence-based core neurological surgery knowledge in a web-based format. • The web-based learning tool can be mastered in the diplomates' home or office anytime 24/7. • Immediate feedback to each question and references with links and/or articles will be provided.
Nuclear Medicine[1] (ABNM) abnm.org	Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.	Developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam.
Obstetrics and Gynecology (ABOG) abog.org	The secure, external assessment is offered in the last year of each ABOG diplomate's six-year cycle in a modular test format, and they are allowed to choose two selections that are the most relevant to their current practice.	Studying the results of a pilot program launched in 2016 and 2017 to integrate the self-assessment and external assessment MOC requirements which allowed diplomates to continuously demonstrate their knowledge of the specialty. The pilot allowed diplomates to earn an exemption from the current computer-based exam in the sixth year of the program if they reach a threshold of performance during the first five years of the self-assessment program.
Ophthalmology (ABO) abop.org	• Quarterly Questions™ replacing DOCK (high-stakes, 10-year) exam with longitudinal assessment program. • Will deliver 50 questions (40 knowledge based and 10 article based) remotely at home or office through computer, tablet or mobile apps. The questions should not require preparation in advance, but a content outline for the multiple choice questions will be available. Users will receive instant feedback and recommendations for resources related to gaps in knowledge. • Key ophthalmic journal articles with questions focused on the application of this information to patient care are provided. The journal portion will require reading five articles from a list of 30 options.	In 2019, Quarterly Questions™ will replace the DOCK Examination for all diplomates.
Orthopaedic Surgery (ABOS) abos.org	• Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. The optional oral exam is given in Chicago in July. • Diplomates without subspecialty certifications are allowed to take	Piloting a virtual practice evaluation to evaluate diplomates on their own cases without requiring travel. Diplomates must submit medical records on 12 selected cases similar to an oral exam with the exam performed in a virtual platform.

	practice-profiled exams in orthopaedic sports medicine and surgery of the hand. • General orthopaedic questions were eliminated from the practice-profiled exams so diplomates are only tested in areas relevant to their practice. • Detailed blueprints are being produced for all exams to provide additional information for candidates to prepare for and complete the exams. • Eight different practice-profiled exams offered to allow assessment in the diplomate's practice area.	
Otolaryngology[1] (ABOto) aboto.org	Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	Developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam.
Pathology[1] (ABPath) abpath.org	• Computer-based secure modular exam administered at the ABP Exam Center in Tampa, Florida twice a year (March and August). • Remote computer exams can be taken anytime 24/7 that the physician chooses during the assigned two-week period (spring and fall) from their home or office. • Physicians are allowed to choose from more than 90 modules, covering numerous practice areas for a practice-relevant assessment. *Diplomates must pass the exam once every 10 years.*	Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.[1]
Pediatrics (ABP) abp.org	1) Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. 2) Piloting Maintenance of Certification Assessment for Pediatrics (MOCA-Peds), a new testing platform with shorter and more frequent assessments that include: • A series of questions released through mobile devices or a web browser at regular intervals. • Twenty multiple choice questions that are available quarterly and may be answered anytime during the quarter. • Immediate feedback and references. • Resources (i.e., internet, books) that can be used when taking the exam. • Allows for questions to be tailored to the pediatrician's practice profile.	In 2019, MOCA-Peds will roll out to all certified pediatricians in subsequent years. Those who wish to continue taking the exam once every five years in a secure testing facility will still be able to do so.

	• Physicians will provide feedback on individual questions so the exam can be continuously improved.	
Physical Medicine and Rehabilitation (ABPMR)[1] abpmr.org	• Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. • Releasing MOC 100, a set of free practice questions pulled directly from the ABPMR exam question banks to help physicians prepare for the exam. • Working with the specialty society to produce clinical updates that integrate with the longitudinal assessment tool.	Developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam.
Plastic Surgery (ABPS) abplasticsurgery.org	• Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years. • Modular exam to ensure relevance to practice. • Offers an MOC Study Guide with multiple choice question items derived from the same sources used for the exam.	Piloting online delivery of MOC exam in place of centralized in-person testing center to reduce costs and time away from practice. Diplomates will be given immediate feedback on answers and offered an opportunity to respond again. If successful, this pilot may replace the high-stakes exam.
Preventive Medicine (ABPM) theabpm.org	In-person, pencil-and-paper, secure exam administered at secure test facility. MOC exams follow the same content outline as the initial certification exam (without the core portion). *In 2016, new multispecialty subspecialty of Addiction Medicine was established.* In 2017, Addiction Medicine subspecialty certification exam was administered to diplomates of any of the 24 ABMS member boards who meet the eligibility requirements.	Changes to the ABPM exam are not being considered at this time.
Psychiatry and Neurology (ABPN) abpn.com	• Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. • Developing MOC exams with committees of clinically active diplomates to ensure relevance to practice. • Enabling diplomates with multiple certificates to take all of their MOC exams at once and for a reduced fee. • Grace period so that diplomates can retake the exam.	Implementing a Part III pilot program to allow physicians who read lifelong learning articles and demonstrate learning by high performance on the questions accompanying the article, to earn exemption from the 10-year MOC high-stakes exam.
Radiology (ABR) theabr.org	Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	Developing a pilot that may replace the current 10-year traditional exam, with an Online Longitudinal Assessment (OLA) model that will be piloted and include modern and more relevant adult learning concepts to provide psychometrically valid sampling of the

		diplomate's knowledge. • Diplomates will create a practice profile of the subspecialty areas that most closely fit what they do in practice, as they do now for the modular exams. • Diplomates will receive weekly emails with links to questions relevant to their registered practice profile. • Questions may be answered singly or, for a reasonable time, in small batches, in a limited amount of time. • Diplomates will learn immediately whether they answered correctly or not and will be presented with the question's rationale, a critique of the answers, and brief educational material. • Those who answer questions incorrectly will receive future questions on the same topic to gauge whether they have learned the material.
Surgery (ABS) absurgery.org	• Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. • Transparent exam content, with outlines, available on the ABS website and regularly updated. • Coordinating with the American College of Surgeons and other organizations to ensure available study materials align with exam content.	In 2018, the ABS will begin offering shorter, more frequent, open-book, modular, lower-stakes assessments required every two years in place of the high-stakes exam. The new assessment is being introduced for general surgery, with other ABS specialties launching over the next few years. For 2018, diplomates will select from four practice-related areas: general surgery, abdomen, alimentary tract, or breast. More areas are planned for the future based on feedback from diplomates and surgical societies. Diplomates will take the assessment through their own computer at a time and place of their choosing within the assessment window, be provided with immediate feedback, and have two opportunities to answer a question correctly.
Thoracic Surgery (ABTS) abts.org	• Remote, secure, computer-based exams can be taken any time 24/7 that the physician chooses during the assigned two-month period (September-October) from their home or office. Diplomates must pass the exam once every 10 years. • Modular exam, based on specialty, and presented in a self-assessment format with critiques and resources made available to diplomates.	The ABTS developed a web-based self-assessment tool (SESATS) that includes all exam material, instant access to questions, critiques, abstracts and references.

Urology (ABU) abu.org	• Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years. • Clinical management emphasized on the exam. Questions are derived from the American Urological Association (AUA) Self-Assessment Study Program booklets from the past five years, AUA Guidelines, and AUA Updates. • Diplomates required to take the 40-question core module on general urology, and choose one of four 35-question content specific modules. • ABU provides increased feedback to reinforce areas of knowledge deficiency.	.

*The information in this table is sourced from ABMS Member Board websites and is current as of March 27, 2018.

[1]Seven ABMS member boards are utilizing CertLink™, an ABMS web-based platform that leverages smart mobile technology to support the design, delivery, and evaluation of longitudinal assessment pilots, some of which launched in 2017. More information is available at: abms.org/news-events/american-board-of-medical-specialties-announces-development-of-new-web-based-platform/ (accessed 1-8-18).

APPENDIX

CURRENT AMA POLICIES RELATED TO MOC AND OCC

H-275.924, "Maintenance of Certification"
AMA Principles on Maintenance of Certification (MOC)
1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit™, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. MOC should be used as a tool for continuous improvement.
15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. MOC activities and measurement should be relevant to clinical practice.
19. The MOC process should be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in MOC.
27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.
(CME Rep. 16, A-09 Reaffirmed: CME Rep. 11, A-12 Reaffirmed: CME Rep. 10, A-12 Reaffirmed in lieu of Res. 313, A-12 Reaffirmed: CME Rep. 4, A-13 Reaffirmed in lieu of Res. 919, I-13 Appended: Sub. Res. 920, I-14 Reaffirmed: CME Rep. 2, A-15 Appended: Res. 314, A-15 Modified: CME Rep. 2, I-15 Reaffirmation A-16 Reaffirmed: Res. 309, A-16 Modified: Res. 307, I-16 Reaffirmed: BOT Rep. 05, I-16 Appended: Res. 319, A-17 Reaffirmed in lieu of: Res. 322, A-17 Modified: Res. 953, I-17)

D-275.954, “Maintenance of Certification and Osteopathic Continuous Certification”
Our AMA will:
1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.

3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations.
10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements.

20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
34. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.
35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for MOC Part IV.
(CME Rep. 2, I-15 Appended: Res. 911, I-15 Appended: Res. 309, A-16 Appended: CME Rep. 02, A-16 Appended: Res. 307, I-16 Appended: Res. 310, I-16 Modified: CME Rep. 02, A-17 Reaffirmed: Res. 316, A-17 Reaffirmed in lieu of: Res. 322, A-17)

H-275.926, “Medical Specialty Board Certification Standards”
Our AMA:
1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic

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

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