

**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-19)

Update on Maintenance of Certification and Osteopathic Continuous Certification

(Resolution 316-A-18)

(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 and Osteopathic Continuous Certification,” 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), ABMS member boards, and key stakeholders to improve the continuing board certification process.

In December 2018, the Council provided comments to strengthen the draft recommendations of the Continuing Board Certification: Vision for the Future Commission, established by the ABMS. In February 2019, the Commission completed its final report, which includes 14 recommendations intended to modernize continuing board certification so that it is meaningful, contemporary, and a relevant professional development activity for diplomates who are striving to be up-to-date in their specialty. The ABMS and ABMS member boards, in collaboration with professional organizations and other stakeholders, will prioritize these recommendations and develop the strategies and infrastructure to implement them. A summary of the recommendations is provided in this report.

This report also highlights initiatives that are underway to improve MOC:

- Twenty-three ABMS member boards have moved away from the secure, high-stakes exam, and more than three-fourths of the boards have completed, or will soon be launching, assessment pilots that combine adult learning principles with state-of-the-art technology, enabling delivery of assessments that are a more relevant, less onerous, and cost-efficient process for physicians. Appendix F in this report summarizes these new models.
- 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, to address physician concerns about the relevance, cost, and burden associated with fulfilling the IMP requirements. Appendix F includes a summary of these initiatives.
- 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 activities are also included in this report:

- AMA participation in meetings and conferences to improve the MOC process (pages 4-5)
- New innovative continuing medical education models (pages 5-6)
- Alternatives to the secure, high-stakes examination (Part III) (pages 6-7)
- Improvement in medical practice (Part IV) (pages 7-8)
- The ABMS Multi-Specialty Portfolio Program (page 8)
- Emerging data and literature regarding the value of MOC (pages 8-12)
- Osteopathic Continuous Certification (pages 12-13)

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 will continue to identify and suggest improvements to continuing certification programs.

**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-19

Subject: Update on Maintenance of Certification and Osteopathic Continuous Certification (Resolution 316-A-18)

Presented by: Carol Berkowitz, MD, Chair

Referred to: Reference Committee C  
(Nicole Riddle, MD, Chair)

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1 Resolution 316-A-18, “End Part IV IMP Requirement for ABMS,” introduced by Michigan and  
2 referred by the American Medical Association (AMA) House of Delegates (HOD), asks the AMA  
3 to call for an end to the mandatory American Board of Medical Specialties “Part 4 Improvement in  
4 Medical Practice” maintenance of certification requirement.

5  
6 Policy D-275.954 (39), “Maintenance of Certification and Osteopathic Continuous Certification,”  
7 asks the AMA to continue studying the certifying bodies that compete with the American Board of  
8 Medical Specialties and provide an update in the Council on Medical Education’s annual report on  
9 maintenance of certification at A-19.

10  
11 Policy D-275.954 (1), “Maintenance of Certification and Osteopathic Continuous Certification,”  
12 asks that the AMA continue to monitor the evolution of Maintenance of Certification (MOC) and  
13 Osteopathic Continuous Certification (OCC), continue its active engagement in discussions  
14 regarding their implementation, encourage specialty boards to investigate and/or establish  
15 alternative approaches for MOC, and prepare a yearly report to the HOD regarding the MOC and  
16 OCC processes.

17  
18 **BACKGROUND**

19  
20 During the 2018 Annual Meeting, testimony before Reference Committee C was mixed regarding  
21 Resolution 316-A-18. Testimony noted the lack of relevance, burden, and cost of the Maintenance  
22 of Certification (MOC) Part IV process in addition to the other requirements physicians are  
23 required to fulfill for meaningful use, the Medicare Access and CHIP Reauthorization Act  
24 (MACRA), etc. However, it was also noted that the broadening range of acceptable activities that  
25 meet the Improvement in Medical Practice (MOC Part IV) component has made this activity  
26 acceptable for other national value-based reporting requirements and continuing certification  
27 programs. It was further noted that the boards are implementing a number of activities related to  
28 registries, systems-based practice, and practice audits to show improvement in practice. The ABMS  
29 Multi-Specialty Portfolio Program™ offers health care organizations a way to support physician  
30 involvement in their institution’s quality and performance improvement initiatives by offering  
31 credit for the Improvement in Medical Practice component of the ABMS Program for MOC. Due  
32 to the Council on Medical Education’s ongoing work with the ABMS and the ABMS member  
33 boards to improve this process, the HOD referred this item for further study as part of this annual  
34 report.

1 CONTINUING BOARD CERTIFICATION: VISION FOR THE FUTURE COMMISSION

2  
3 In early 2018, the Continuing Board Certification: Vision for the Future Commission was  
4 established by the ABMS and charged with reviewing continuing certification within the current  
5 context of the medical profession. The Commission was also asked to address key issues currently  
6 facing the ABMS member boards and diplomates. The Commission was composed of 27  
7 individuals who represented diverse stakeholders including practicing physicians; health care  
8 leadership; academic medicine; group medical practices; state and national medical associations;  
9 ABMS Board executives; specialty societies; and health advocate groups who represented patients,  
10 families, and the public at large.

11  
12 In March 2018, shortly after the Commission was established, the Council on Medical Education  
13 co-convened a conference with the ABMS, ABMS member boards, and key stakeholders to discuss  
14 how continuing board certification can meet the needs of diverse stakeholders, including  
15 physicians, hospitals, patients, and the public, and to develop recommendations for the  
16 Commission. Meeting attendees explored approaches for maximizing assessment, learning, and  
17 improvement. The meeting also highlighted the importance of addressing physicians' needs and  
18 expectations while at the same time recognizing the value of continuous maintenance and  
19 improvement of competence. While no effort was made to develop consensus on any specific issue,  
20 the discussion reflected a broad range of attitudes and opinions, and nine emergent themes about  
21 continuing certification were identified that suggested the process should be affirmative,  
22 affordable, aligned, appropriately managed, collaborative, innovative, meaningful, patient-focused,  
23 and supportive.

24  
25 Throughout 2018, the Commission conducted a national survey, heard public testimony from  
26 diplomates and key stakeholders, and held Commission meetings to review the information  
27 collected and presented. The Commission used this knowledge base to establish a conceptual  
28 framework and guiding principles that were then used to draft its report and recommendations. The  
29 recommendations highlighted the need for any assessment framework to identify gaps in  
30 knowledge and skills that are relevant to the physician's practice in order to foster lifelong learning  
31 and assist physicians in remaining current with new knowledge and advances in medicine. In its  
32 recommendations, the Commission emphasized that improving practice and quality of care is an  
33 important goal of the continuing certification process, which means assessing practice data and  
34 gaps in quality of care. The Commission recommended new program models for continuing board  
35 certification that are responsive to the needs of those who rely on the system, and that are relevant,  
36 meaningful, and of value to those who hold the credential. A number of recommendations relate to  
37 the process of creating a better system of continuing certification and to the ways that continuing  
38 certification status is used by health systems and payers. The Commission stressed the importance  
39 of collaboration with professional organizations in the redesign of MOC and noted that any  
40 framework for continuing certification must be assessed by independent research to integrate  
41 continuous quality improvement (QI) into the continuing board certification process. The  
42 Commission's draft report and recommendations were widely circulated for comments.

43  
44 In December 2018, the Council on Medical Education reviewed the Commission's draft report and  
45 recommendations and provided comments back to the Commission. The Council praised the  
46 Commission for producing a thorough report and for acknowledging long-standing physician  
47 frustrations, such as the concern that the benefits of the continuing certification process  
48 traditionally have not been worth the time or financial investment required for participation. At the  
49 same time, however, the Council strongly objected to some of the draft recommendations and other  
50 portions of the report (Appendix A).

1 On February 12, 2019, the Commission released its final report, which included a total of 14  
2 recommendations (<https://visioninitiative.org/commission/final-report/>). Of these, the Commission  
3 emphasized that some must be implemented by the ABMS and its member boards in the short term  
4 (one to two years) or within an intermediate time frame (e.g., less than five years). The  
5 Commission also noted that one recommendation is foundational and three are aspirational.

6  
7 Most of the Council's concerns were addressed in the final report (Appendix B). For example, the  
8 final recommendations included stronger language regarding the secure, high-stakes examination  
9 and the acceptance of quality data already being reported by individual physicians. The final  
10 recommendations also note that the ABMS must demonstrate the value, meaning, and purpose of  
11 continuing certification, but that it should not be the only criterion used for credentialing and  
12 privileging decisions. In addition, detailed financial transparency regarding fiscal responsibility  
13 toward diplomates was addressed. As suggested by the Council, the final recommendations also  
14 emphasize the need for a more consistent process and requirements for continuing certification  
15 among the ABMS member boards.

16  
17 On March 12, 2019, after reviewing the final recommendations of the Commission, the ABMS  
18 Board of Directors announced that all 24 member boards had accepted the Commission's  
19 recommendations. To support implementation, the ABMS Board of Directors also announced the  
20 establishment of the Achieving the Vision for Continuing Board Certification Oversight Committee  
21 ([https://www.abms.org/media/194984/abms-announces-plan-to-implement-recommendations-  
22 from-the-continuing-board-certification-vision-for-the-future-commission.pdf](https://www.abms.org/media/194984/abms-announces-plan-to-implement-recommendations-from-the-continuing-board-certification-vision-for-the-future-commission.pdf)). This committee  
23 will seek guidance from the ABMS' new Stakeholder Council and various stakeholders in the  
24 continuing certification process throughout the implementation phase. Possible implementation  
25 actions include: considering how the standards for continuing certification should be revised to  
26 reflect a more integrated framework, additional flexible approaches to knowledge assessment,  
27 feedback requirements from boards to diplomates, consistency in requirements and core processes,  
28 defining categories of consequential decisions, pathways for lifetime certificate holders to engage  
29 with continuing certification, consistency regarding professional standing, and providing a "wide  
30 door" for QI/performance improvement activities that satisfy continuing certification requirements.  
31 Organizational standards such as governance composition and financial transparency will also be  
32 reviewed.

33  
34 The ABMS has attained the agreement of all member boards to commit to longitudinal or other  
35 formative assessment strategies and to offer alternatives to the highly secure, point-in-time  
36 examinations of knowledge. Other implementation actions may include developing and defining  
37 best practices for diplomate engagement; developing policies regarding diplomates with multiple  
38 certificates; allocating funds and/or allowing access to data to support external research; displaying  
39 diplomate participation on public websites; and communicating and educating hospitals, health  
40 systems, payers, and other health care organizations about the appropriate use of the continuing  
41 board certification certificate. The ABMS will involve external stakeholders and form additional  
42 task forces to address remediation pathways, assessment of professionalism, QI and advancing  
43 practice, and data and information sharing. A meeting of the ABMS/Council of Medical Specialty  
44 Societies joint board leadership will also be established to ensure full specialty society engagement  
45 in building the road map defined by the Commission report, especially with regard to the role of  
46 continuing certification in advancing clinical practice.

1 The Commission's final recommendations align with HOD policies and directives (Appendix C).  
2 Thus, it will be important for the Council on Medical Education to continue to work with the  
3 ABMS, ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to  
4 pursue opportunities to implement the Commission's recommendations and to ensure that the  
5 continuing certification process is meaningful and relevant for physicians and patients.

#### 6 7 MAINTENANCE OF CERTIFICATION (MOC): AN UPDATE 8

9 The AMA Council on Medical Education and the HOD have carried out extensive and sustained  
10 work in developing policy on MOC and OCC (Appendix D), including working with the ABMS  
11 and the AOA to provide physician feedback to improve the MOC and OCC processes, informing  
12 our members about progress on MOC and OCC through annual reports to the HOD, and  
13 developing strategies to address the concerns about the MOC and OCC processes raised by  
14 physicians. The Council has prepared reports covering MOC and OCC for the past ten years.<sup>1-10</sup>  
15 During the last year, Council members, AMA trustees, and AMA staff have participated in the  
16 following meetings with the ABMS and its member boards:

- 17
- 18 • ABMS Committee on Continuing Certification
- 19 • ABMS Forum on Organizational Quality Improvement
- 20 • ABMS 2018 Conference
- 21 • Maintenance of Certification Summit
- 22 • ABMS Board of Directors Meeting
- 23 • AMA Council on Medical Education/ABMS/ABMS member boards joint meeting to explore  
24 approaches for maximizing assessment, learning, and improvement
- 25

#### 26 *ABMS Committee on Continuing Certification to Refocus the Direction of MOC* 27

28 The ABMS Committee on Continuing Certification (3C) is charged with reviewing existing MOC  
29 programs to ensure that the ABMS member boards meet the 2015 Standards for the Program for  
30 MOC, which evaluate the effectiveness of different approaches to MOC and identify innovations to  
31 share among the boards. During 2018, the 3C approved substantive changes that have been  
32 implemented and announced new active pilot programs (Appendix E). In April and November, the  
33 3C also met with content experts who research physician competence and administer assessment  
34 programs to discuss the future development of continuing professional development programs as  
35 well as security considerations, performance standards, and psychometric characteristics with  
36 longitudinal assessment programs.

#### 37 38 *ABMS Stakeholder Council* 39

40 In 2018, the ABMS established a new Stakeholder Council to serve as an advisory body  
41 representing the interests of volunteer physicians, patients, and the public. The Council's  
42 fundamental role is to ensure that the ABMS Board of Directors makes decisions grounded in an  
43 understanding of the perspectives, concerns, and interests of multiple constituents and stakeholders  
44 who may be impacted by the work of ABMS. The Stakeholder Council is composed of five  
45 representatives from among ABMS associate members, six public members, two at-large member  
46 board executives or directors/trustees, one member from the greater credentialing community, and  
47 ten practicing physicians.

1 *ABMS Accountability and Resolution Committee*

2

3 In 2018, the ABMS also established the Accountability and Resolution Committee (ARC). The  
4 ARC serves as a subcommittee of the ABMS Board of Directors and addresses and makes  
5 recommendations to resolve complaints and problems related to noncompliance by the boards, both  
6 organizational and individual, that have not been resolved through other mechanisms.

7

8 *Update on Membership of Young Physicians Serving on ABMS and ABMS Member Boards*

9

10 The ABMS is working with its member boards to encourage early-career physicians to participate  
11 in ABMS work by promoting opportunities for engagement to young physicians, reducing travel  
12 obligations with online/remote engagement opportunities, choosing easily accessible locations for  
13 in-person meetings, and integrating opportunities for engagement into established annual meetings  
14 whenever possible.

15

16 The boards recognize that early-career physicians have demands on their time, and that committing  
17 to participation on ABMS and/or ABMS member board leadership boards or committees may not  
18 be feasible. However, it is common for early-career physicians to begin their involvement with the  
19 member boards by serving as volunteer test item writers. The ABMS and the member boards  
20 recruit and encourage early-career physicians to participate, solicit nominations from medical  
21 societies for opportunities including the newly formed Stakeholder Council, promote volunteer  
22 opportunities on diplomate dashboards and websites, and promote volunteer opportunities through  
23 social media platforms. The member boards also encourage early-career physicians to participate in  
24 focus groups and to contribute to standard setting and practice analysis groups. Further, the ABMS  
25 and some member boards have Visiting Scholars Programs that encourage early-career physicians  
26 to get involved through scholarly work in the member boards community.

27

28 *Update on New Innovative Continuing Medical Education (CME) Models*

29

30 The ABMS Continuing Certification Directory™ ([https://www.abms.org/initiatives/abms-  
31 continuing-certification-directory/](https://www.abms.org/initiatives/abms-continuing-certification-directory/)) continues to offer physicians access to a comprehensive,  
32 centralized, web-based repository of CME activities that have been approved for MOC credit by  
33 ABMS member boards. During the past year, the directory has increased its inventory and now  
34 indexes 700-plus activities from more than 60 CME providers to help diplomates from across the  
35 specialties meet MOC requirements for Lifelong Learning and Self-Assessment (Part II) and  
36 Improvement in Medical Practice (Part IV).

37

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

42

43 The member boards also employ technology to personalize assessments that promote greater self-  
44 awareness and support participation in CME. For example, the American Board of Anesthesiology  
45 (ABA) is now able to link assessment results from its MOCA Minute® program with CME  
46 opportunities. More than half (53 percent) of MOCA Minute® questions can be linked to at least  
47 one CME activity, and more than 110 accredited CME providers have been able to link a combined  
48 total of 3,261 activities to the MOCA content outline.<sup>11</sup>

1 *Elimination of the Secure, High-stakes Examination for Assessing Knowledge and Cognitive Skills*  
2 *in MOC*

3  
4 Twenty-three ABMS member boards (95.8 percent) have moved away from the secure, high-stakes  
5 exam, and more than three-fourths of the boards (75 percent) have completed, or will soon be  
6 launching, assessment pilots that combine adult learning principles with state-of-the-art  
7 technology, enabling delivery of assessments that promote learning and are less stressful  
8 (Appendix F).

9  
10 Three member boards will be converting their pilot programs into permanent options in 2019. The  
11 ABA, American Board of Obstetrics and Gynecology (ABOG), and American Board of Pediatrics  
12 (ABP) will offer innovative alternatives to the traditional examinations, which may offer both time  
13 and cost savings to physicians certified by these boards by reducing or eliminating the need for  
14 study courses, travel to exam centers, and time away from practice. Overall, the programs allow  
15 physicians to assess their knowledge, fill knowledge gaps, and demonstrate their proficiency. The  
16 programs engage physicians in answering 80 to 120 questions per year; allow for the development  
17 of practice-relevant content; offer convenient access on computer, tablet, or smartphone; and  
18 provide immediate feedback and guidance to resources for further study.

19  
20 Seven ABMS member boards engaged in the longitudinal assessment approach with CertLink™—  
21 the American Board of Colon and Rectal Surgery (ABCRS), American Board of Dermatology  
22 (ABD), American Board of Medical Genetics and Genomics (ABMGG), American Board of  
23 Nuclear Medicine (ABNM), American Board of Otolaryngology-Head and Neck Surgery  
24 (ABOHNS), American Board of Pathology (ABPath), and American Board of Physical Medicine  
25 and Rehabilitation (ABPMR)—have launched their pilots. CertLink™ is a technology platform  
26 developed by the ABMS to support the boards in delivering more frequent, practice-relevant, and  
27 user-friendly competence assessments to physicians ([https://www.abms.org/initiatives/certlink-  
28 platform-and-pilot-programs/](https://www.abms.org/initiatives/certlink-platform-and-pilot-programs/)). The platform provides technology to enable boards to create  
29 assessments focused on practice-relevant content; offers convenient access on desktop or mobile  
30 device (depending on each board's program); provides immediate, focused feedback and guidance  
31 to resources for further study; and provides a personalized dashboard that displays participating  
32 physicians' areas of strength and weakness. To date, more than 7,000 physicians are active on  
33 CertLink. These physicians have answered 200,000-plus questions across the seven member boards  
34 and have given CertLink a 96 percent approval rating.

35  
36 Several ABMS member boards are participating in a Research and Evaluation Collaborative,  
37 sponsored by the ABMS and ABMS Research and Education Foundation, to develop metrics to  
38 define the success of the pilots, facilitate research and evaluation in areas of common interest, and  
39 share findings on the longitudinal assessment pilots. The evaluations will be used to inform ABMS  
40 member boards on how longitudinal assessment for learning and improvement can be used in  
41 conjunction with other information, such as portfolios of assessment modalities, to reach  
42 summative decisions on specialty certification status.<sup>12</sup>

43  
44 Other member board efforts to improve Part III, Assessment of Knowledge, Judgment, and Skills,  
45 include more diplomate input into exam blueprints; integrating journal article-based core questions  
46 into assessments; modularization of exam content that allows for tailoring of assessments to reflect  
47 physicians' actual areas of practice; access during the exam to resources similar to those used at the  
48 point of care; remote proctoring to permit diplomates to be assessed at home or in the office; and  
49 performance feedback mechanisms. All boards also provide multiple opportunities for physicians  
50 to retake the Part III exam. These program enhancements will significantly reduce the cost

1 diplomates incur to participate in MOC by reducing the need to take time off or travel to a testing  
2 center for the assessment; ensure that the assessment is practice-relevant; emphasize the role of  
3 assessment for learning; assure opportunities for remediation of knowledge gaps; and reduce the  
4 stress associated with a high-stakes test environment.

5  
6 *Progress with Improving MOC Part IV, Improvement in Medical Practice*

7  
8 The ABMS member boards have broadened the range of acceptable activities that meet the  
9 Improvement in Medical Practice (IMP) requirements, including those offered at the physician's  
10 institution and/or individual practices, to address physician concerns about the relevance, cost, and  
11 burden associated with fulfilling the IMP requirements (Appendix F). In addition to improving  
12 alignment between national value-based reporting requirements and continuing certification  
13 programs, the boards are implementing a number of activities related to registries, practice audits,  
14 and systems-based practice.

15  
16 Patient registries (also known as clinical data registries) provide information to help physicians  
17 improve the quality and safety of patient care—for example, by comparing the effectiveness of  
18 different treatments for the same disease. While many member boards allow physicians to earn Part  
19 IV credit for participating in externally developed patient registries, the American Board of  
20 Ophthalmology (ABO), ABOHNS, and American Board of Family Medicine (ABFM) have  
21 designed performance improvement initiatives that are supported by registry data.

22  
23 Several ABMS member boards have developed online practice assessment protocols that allow  
24 physicians to assess patient care using evidence-based quality indicators. Other initiatives include:

- 25  
26
- Free tools to complete an IMP project, including a simplified and flexible template to document small improvements, educational videos, infographics, and enhanced web pages;
  - Partnerships 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 (for example, one board has aggressively addressed the issue of cost and unnecessary procedures with an audit and feedback program);
  - Integration of simulation options; and
  - A process for individual physicians to develop their own improvement exercises that address an issue of personal importance, using data from their own practices, built around the basic Plan-Do-Study-Act (PDSA) process.
- 37

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



### 1 *ABMS Multi-Specialty Portfolio Program™*

2  
3 The ABMS Multi-Specialty Portfolio Program (Portfolio Program™) offers health care  
4 organizations a way to support physician involvement in their institution's quality and performance  
5 improvement initiatives by offering credit for the IMP component of the ABMS Program for MOC  
6 (mocportfolioprogram.org). Originally designed as a service for large hospitals, the Portfolio  
7 Program™ is extending its reach to physicians whose practices are not primarily in institutions.  
8 This includes non-hospital organizations such as academic medical centers, integrated delivery  
9 systems, interstate collaboratives, specialty societies, and state medical societies. Recent additions  
10 among the nearly 100 current sponsors include the American Society of Anesthesiologists,  
11 Minnesota Hospital Association, Hospital Quality Institute of the California Hospital Association,  
12 and Columbus Medical Association.

13  
14 More than 3,100 types of QI projects have been approved by the Portfolio Program™, in which 19  
15 ABMS member boards participate, focusing on such areas as advanced care planning, cancer  
16 screening, cardiovascular disease prevention, depression screening and treatment, provision of  
17 immunizations, obesity counseling, patient-physician communication, transitions of care, and  
18 patient-safety related topics including sepsis and central line infection reduction. Many of these  
19 projects have had a profound impact on patient care and outcomes. For example, during the past  
20 two years, Portfolio Program™ initiatives at the Children's Hospital of Philadelphia have been  
21 responsible for decreasing inpatient hospital days for oncology patients with fever and neutropenia  
22 by more than 35 percent, preventable readmissions for neurology patients by approximately 80  
23 percent, and rates of urinary catheterization for febrile infants by 65 percent. Additionally, rates of  
24 pneumococcal immunization among patients with chronic kidney disease have increased by 79  
25 percent, and the application of evidence-based practices to evaluate and manage children with  
26 attention deficit disorder and hyperactivity has increased by 50 percent. There have been nearly  
27 26,000 instances of physicians receiving MOC IMP credit through participation in the program.

### 28 29 *Update on the Emerging Data and Literature Regarding the Value of Continuing Board* 30 *Certification*

31  
32 The Council on Medical Education has continued to review published literature and emerging data  
33 as part of its ongoing efforts to critically review continuing board certification issues. Although  
34 physicians still report some frustrations with the ABMS MOC process,<sup>13-15</sup> many improvements  
35 have been made to the MOC program, making participation more relevant, efficient, convenient,  
36 and cost-effective as well as less burdensome. The member boards are utilizing a variety of ways to  
37 incorporate important quality and patient safety activities in their continuing certification  
38 programs.<sup>16</sup> In addition, important peer-reviewed studies published during the last year demonstrate  
39 the benefits of participating in a continuous certification program. These studies are summarized  
40 below.

### 41 42 Association between Continuous Certification and Practice-related Outcomes

- 43  
44 • A study that evaluated a QI intervention that trained providers on human papillomavirus (HPV)  
45 vaccination recommendations and communication methods showed that a learning  
46 collaborative model provides an effective forum for practices to improve HPV vaccine  
47 delivery. This QI intervention reduced missed opportunities for HPV vaccination in 33  
48 community practices and 14 pediatric continuity clinics over nine months. This QI effort

- 1 offered ABP MOC Part IV credit, as well as ABFM MOC Part IV credit, as incentives for  
2 participation.<sup>17</sup>
- 3 • A QI effort utilizing an injury prevention screening tool at pediatric offices to facilitate  
4 discussions and rescreenings with families at subsequent practitioner visits resulted in  
5 substantially improved practitioner-patient communications and more families reporting safer  
6 behaviors at later visits. Physicians who participated and submitted data for the QI effort  
7 received ABP MOC Part IV credit.<sup>18</sup>
  - 8 • A QI effort to evaluate how a distance-learning, QI intervention to improve pediatric primary  
9 care physicians' use of attention-deficit/hyperactivity disorder parent and teacher rating scales  
10 showed that the level of engagement in this QI effort was an important consideration. The  
11 results of the study, involving 105 clinicians at 19 sites, showed that those who participated in  
12 at least one feedback call, and those who participated in MOC, had higher rates of sending  
13 parent rating scales.<sup>19</sup>
  - 14 • A study to determine the impact of a multi-component QI intervention on Chlamydia screening  
15 rates for young women showed that this practice-based QI intervention resulted in a 21 percent  
16 increase in annual Chlamydia screening rates among adolescent females without lengthening  
17 median visit time. This effort offered ABP MOC Part IV credit as an incentive for  
18 participation.<sup>20</sup>
  - 19 • A study that assessed whether participation by Georgia pediatricians in the Healthy Weight  
20 Counseling MOC program was associated with greater use of weight management strategies  
21 showed that such participation was indeed associated with increased use of health messages  
22 and behavior change goal-setting. Importantly, weight-related counseling practices were  
23 sustained six months after the program ended.<sup>21</sup>
  - 24 • A QI effort to review an electronic medical records tool called My Personal Outcomes Data  
25 (MyPOD) that tracked surgical outcomes at the Nemours-AI duPont Hospital for Children  
26 compared MyPOD and the National Surgical Quality Improvement Program (NSQIP)  
27 databases. The NSQIP program and similar EMR-driven tools are becoming essential  
28 components of the American Board of Surgery (ABS) MOC process. The study showed how  
29 problems that can occur with self-reporting can be addressed through the MOC Part IV  
30 process.<sup>22</sup>
  - 31 • A study to determine if a decrease in CT scans for emergency department patients with a chief  
32 complaint of headache was followed by an increase in missed diagnoses or an increase in  
33 mortality rates showed that out of 582 patients, there were 10 missed diagnoses and 9 deaths,  
34 but no difference in mortality rate, after a reduction in CT scans. The authors concluded that  
35 these results show that the use of CT scans may be safely reduced for emergency department  
36 patients. The study fulfilled the American Board of Emergency Medicine (ABEM) MOC QI  
37 requirement, which required collecting data before and after the intervention.<sup>23</sup>
  - 38 • In a study presenting the results of a survey of 112 radiology departments across the United  
39 States regarding quality indicators, MOC participation was found to be varied and a  
40 requirement of employment for nearly half of the respondents. The authors note that MOC is  
41 currently the best measure of a radiologist staying current with recommended practices.<sup>24</sup>
  - 42 • A study to examine the practice behavior of emergency medicine physicians when caring for  
43 patients with chest pain showed that resident emergency physicians were more likely to  
44 hospitalize patients and board-certified physicians were more likely to discharge patients,  
45 which the study attributes to possible levels of clinical experience among these physicians and  
46 a concern that an acute coronary syndrome (ACS) diagnosis could be missed. The authors  
47 conclude that the overestimation of ACS without risk assessment was prevalent among  
48 emergency resident physicians.<sup>25</sup>

- 1 • A study conducted to determine if the imposition of American Board of Internal Medicine  
2 (ABIM) MOC completion requirements affected adherence to guideline-compliant  
3 mammography screening for Medicare beneficiaries showed that the MOC requirement was  
4 associated with an increase in annual screening and biennial screening, leading to improved  
5 guideline-compliant mammography screening.<sup>26</sup>
- 6 • A study to assess associations between MOC and performance on Healthcare Effectiveness  
7 Data and Information Set (HEDIS) process measures showed that maintaining certification was  
8 positively associated with performance scores on these process measures.<sup>27</sup>
- 9 • Price et al. evaluated 39 studies to examine the relationship of MOC to physician knowledge,  
10 clinical practice processes, or patient care outcomes. The studies in this analysis offered  
11 examples of how continuing certification can work or how it is currently working and showed  
12 positive associations between participation in MOC program activities and physician and  
13 patient outcomes.<sup>28</sup>
- 14 • A literature review by Holloway examined evidence for improved HPV vaccination rates from  
15 46 studies. The studies show that using a multi-method approach—such as a MOC PI CME  
16 intervention that combines repeated contacts, education, individualized feedback, and strong  
17 quality improvement incentives to increase both initiation and completing dosing of the HPV  
18 vaccine series among male and female adolescents—will increase vaccination rates.<sup>29-30</sup>

#### 19 20 Standardized Simulation-based Assessment, Performance Gaps, and Opportunities for 21 Improvement

- 22  
23 • A study to determine whether mannequin-based simulation can reliably characterize how  
24 board-certified anesthesiologists manage simulated medical emergencies showed that  
25 standardized simulation-based assessment identified performance gaps and informed  
26 opportunities for improvement. The study involved 263 consenting board-certified  
27 anesthesiologists participating in existing simulation-based MOC courses at one of eight  
28 simulation centers.<sup>31</sup>
- 29 • Based on a literature review, the author discusses how obstetric simulation and simulation  
30 hands-on courses, used by the American College of Obstetricians and Gynecologists, the  
31 Society for Maternal-Fetal Medicine, and the ABOG, fulfill continuing certification/MOC  
32 requirements.<sup>32</sup>

#### 33 34 Comparison of Continuous Certification to Medical Licensure Actions

- 35  
36 • The ABS analyzed loss of license actions for 15,500 general surgeons who were initially  
37 certified by the ABS. The study authors found that surgeons who recertified on time following  
38 initial board certification (who did not allow their initial certification to lapse) had a  
39 significantly lower likelihood of future loss of medical license than those who allowed their  
40 initial certification to lapse or never recertified.<sup>33</sup>
- 41 • Research that compared the medical license actions of 15,486 anesthesiologists certified  
42 between 1994 and 1999 (non-time-limited certificate holders who are not required to  
43 participate in MOCA<sup>®</sup>) and those certified between 2000 and 2005 (time-limited certificate  
44 holders who are required to participate in MOCA) showed that board-certified  
45 anesthesiologists who met MOCA program requirements were less likely to be disciplined by a  
46 state medical licensing agency. There was also evidence that voluntary participation in MOCA  
47 by lifetime certificate holders was linked to a lower occurrence of license actions.<sup>34</sup>
- 48 • A study that examined the association between family physicians receiving a disciplinary  
49 action from a state medical board and certification by the American Board of Family Medicine,

1 using data from 1976 to 2017, showed that 95 percent (114,454 of 120,443) of the family  
2 physicians studied had never received any disciplinary action. The authors concluded that  
3 family physicians who had ever been ABFM-certified were less likely to receive an action; the  
4 most severe actions were associated with decreased odds of being board certified at the time of  
5 the action; and receiving the most severe action type increased the likelihood of physicians  
6 holding a prior but not current certification.<sup>35</sup>

- 7 • A study that compared the association of disciplinary actions with passing the ABIM MOC  
8 examination within ten years of initial certification showed that disciplinary actions decreased  
9 with better MOC examination scores.<sup>36</sup>

### 10 11 The Importance of Continuous Certification and Physician Satisfaction with Continuous 12 Certification

- 13  
14 • A study involving 8,714 diplomates that examined the number of practicing pediatricians who  
15 participate in QI activities showed that nearly 87 percent of diplomates indicated participation  
16 in a QI project. While maintaining certification was identified as the main driver for  
17 participation, respondents also indicated identification of practice gaps, implementing change  
18 in practice, and collaborating with others as factors for participation.<sup>37</sup>
- 19 • A survey study of 289 dermatologists who completed ABD MOC-focused Practice  
20 Improvement (fPI) modules, showed that participants identified the module activities as  
21 relevant and helpful in identifying practice gaps. Most participants (254 [87.9 percent]) felt that  
22 the activities reaffirmed their practice, and would recommend the fPI modules.<sup>38</sup>
- 23 • An evaluation of the ABFM diplomate feedback survey data to examine family physician  
24 opinions about ABFM self-assessment module (SAM) content (448,408 SAM feedback  
25 surveys were completed within the period 2006-2016) showed that family medicine diplomates  
26 generally value SAMs. Respondents felt that the SAM content is appropriate, and favorability  
27 ratings increased as diplomates engaged in more SAM activities.<sup>39</sup>
- 28 • A study that examined how improving ABFM's SAM content and technical interface could  
29 make SAMs more meaningful to ABFM diplomates resulted in mixed feedback between  
30 separate modules; overall, respondents indicated satisfaction with and positive reactions to the  
31 SAMs, with 80 percent giving SAMs a positive rating. The authors conclude that the results of  
32 this study can assist in understanding physicians' perceptions and inform MOC program  
33 activities of other specialties.<sup>40</sup>

34  
35 More than 60 sessions at the ABMS annual QI Forum held during the 2018 ABMS Conference  
36 (<https://www.abmsconference.com/session-descriptions-2018/>) focused on innovations in board  
37 certification, the science of assessment and learning, quality improvement, health policy research,  
38 and patient safety. Posters presented by the ABMS Portfolio Program™ sponsors and other health  
39 care researchers underscored best practices and research in continuing certification and QI  
40 activities (<https://www.abmsconference.com/posters-2018/>).

41  
42 The Council on Medical Education is committed to monitoring emerging data and the literature to  
43 identify improvements to continuing board certification programs, especially those that improve  
44 physician satisfaction and patient outcomes and those that enable physicians to keep pace with  
45 advances in clinical practice, technology, and assessment.

1 UPDATE ON OSTEOPATHIC CONTINUOUS CERTIFICATION

2  
3 The American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) was  
4 organized in 1939 as the Advisory Board for Osteopathic Specialists to meet the needs resulting  
5 from the growth of specialization in the osteopathic profession. Today, 18 AOA-BOS specialty  
6 certifying boards offer osteopathic physicians the option to earn board certification in several  
7 specialties and subspecialties. As of December 31, 2017, 31,762 osteopathic physicians were  
8 certified by the AOA and held a combined total of 36,982 active certifications, representing a 7  
9 percent increase over the number of active certifications held in 2016 (34,555). In 2017, 2,206 new  
10 certifications were processed as follows:

- 11
- 12 • Primary specialty: 1,891
  - 13 • Subspecialty: 224
  - 14 • Certification of added qualifications (family medicine and preventive medicine only): 91
- 15

16 Additionally, 1,357 OCC completions were processed in 2017.

17

18 In January 2017, the AOA impaneled the AOA Certifying Board Services (CBS) Task Force II to  
19 address the directive of enhancing board certification services and marketability to make AOA  
20 board certification more attractive. Specifically, the Task Force was charged with addressing the  
21 following goals:

22

- 23 • Aligning AOA board leadership structure to strengthen physician-led, professionally managed  
24 relationships. The demands on CBS have grown substantially, and the expectations placed on  
25 the CBS are more than the current system can handle. The goal is to have working physicians  
26 serve as the backbone of AOA certification while allowing them to focus on specific tasks that  
27 require a physician's skill set and expertise, with administrative support of these efforts  
28 delegated to non-physicians.
  - 29 • Unifying the osteopathic certifying boards through common practices, bylaws, reporting  
30 processes, operational alignment, and expenses, and developing uniform, reasonable, and  
31 competitive examination fees.
- 32

33 The CBS presented its recommendations to the BOS at its midyear meeting on April 8, 2017.  
34 Several of these recommendations are currently being implemented by CBS. For example, board  
35 meetings are being aligned into a cluster-based system to facilitate communication. Initiatives to  
36 standardize operations to ensure consistent products are also underway.<sup>41</sup> All 18 boards also  
37 submitted their new OCC plans to the BOS for review and approval.

38

39 The following is a summary of the OCC components listed in the most current BOS Handbook  
40 (<https://certification.osteopathic.org/wp-content/uploads/2017/05/bos-handbook.pdf>):

41

- 42 • Component 1 - Active Licensure:  
43 AOA board-certified physicians must hold a valid, active license to practice medicine in one of  
44 the 50 states or Canada. In addition, they are required to adhere to the AOA's Code of Ethics.
- 45
- 46 • Component 2 - Life Long Learning/CME:  
47 CME requirements for diplomates participating in OCC are as follows:  
48 1. A minimum of 60 CME credits in the specialty area of certification during the specialty  
49 boards' 2016-2018 CME cycle.

- 1           2. There are variances across the 18 boards with regards to specific CME inclusions. It is  
2           important to refer to each specialty board’s website (certification.osteopathic.org) or the  
3           current AOA CME Guide (osteopathic.org/cme/cme-guide) for those specifics.  
4
- 5           • Component 3 – Cognitive Assessment:  
6           1. Diplomates must sit for/complete and pass one (or more) psychometrically valid, ongoing  
7           assessments during each OCC cycle.  
8           2. The assessment must evaluate the diplomate’s knowledge and skill in the given specialty or  
9           subspecialty.  
10
- 11          • Component 4 - Practice Performance Improvement and Assessment:  
12          Diplomates must engage in continuous quality improvement by satisfying one of the following:  
13          1. Attestation to or online submission of evidence of participation in quality improvement  
14          activities.  
15          2. Completion of Practice Performance Assessment Modules (PPAs) developed by specialty  
16          boards and approved by the Standards Review Committee (SRC) of the BOS.  
17          3. Completion of verifiable, quality-driven, or clinically focused encounters that assess the  
18          physician’s clinical acumen.  
19

#### 20 CERTIFYING BODIES THAT COMPETE WITH THE ABMS

21  
22          AMA Policy D-275.954 (39), “Maintenance of Certification and Osteopathic Continuous  
23          Certification,” asks the AMA to continue studying the certifying bodies that compete with the  
24          ABMS. Appendix G provides information on the recertification requirements of the ABMS, AOA,  
25          American Board of Physician Specialties, National Board of Physicians and Surgeons (NBPAS),  
26          American Board of Facial Plastic and Reconstructive Surgery, and the American Board of  
27          Cosmetic Surgery.  
28

29          In its previous reports,<sup>2-3</sup> the Council noted that wide-scale use of long-standing traditional  
30          recertification programs, such as the ABMS MOC, are reflected in training and delivery systems,  
31          and based on core competencies developed and adopted by the ABMS and the Accreditation  
32          Council for Graduate Medical Education. The MOC program was designed to provide a  
33          comprehensive approach to physician lifelong learning, self-assessment, and practice improvement,  
34          and strives to identify those physicians capable of delivering high-quality specialized medical  
35          care.<sup>42</sup>  
36

37          Newer alternative pathways to specialty board recertification, such as the NBPAS, have been  
38          formed to provide a type of recertification that is less rigorous than that obtained via the ABMS  
39          MOC process.<sup>43</sup> Ongoing concerns have been registered about administrative burdens, value of the  
40          program, relevance and cost of the ABMS MOC process, and time away from patient care. It is  
41          important to note that the NBPAS does not have an external assessment or IMP requirements.  
42

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

1 CURRENT AMA POLICIES RELATED TO MOC AND OCC

2  
3 The ABMS Board of Directors is currently using a new name, “Continuing Board Certification,”  
4 for its MOC Program (although some ABMS member boards are still referring to the program as  
5 MOC). To be consistent with this change, this report recommends that the terms “Maintenance of  
6 Certification” that appear in the title and body of HOD Policies H-275.924, “AMA Principles on  
7 Maintenance of Certification,” and D-275.954, “Maintenance of Certification and Osteopathic  
8 Continuous Certification,” should be changed to “Continuing Board Certification” or “CBC” as  
9 shown in Appendix H.

10  
11 SUMMARY AND RECOMMENDATIONS

12  
13 The Council on Medical Education is committed to ensuring that continuing board certification  
14 programs support physicians’ ongoing learning and practice improvement and serve to assure the  
15 public that physicians are providing high-quality patient care. The AMA will continue to advocate  
16 for a certification process that is evidence-based and relevant to clinical practice as well as cost-  
17 effective and inclusive to reduce duplication of work. During the last year, the Council has  
18 continued to monitor the development of continuing board certification programs and to work with  
19 the ABMS, ABMS member boards, AOA, and state and specialty medical societies to identify and  
20 suggest improvements to these programs. The AMA has also been involved in the Continuing  
21 Board Certification: Vision for the Future Commission and in the development of the  
22 Commission’s recommendations for the future continuing board certification process.

23  
24 The Council on Medical Education therefore recommends that the following recommendations be  
25 adopted in lieu of Resolution 316-A-18 and the remainder of the report be filed.

26  
27 1. That our American Medical Association (AMA), through its Council on Medical Education,  
28 continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee  
29 on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to  
30 implement the recommendations of the Continuing Board Certification: Vision for the Future  
31 Commission and AMA policies related to continuing board certification. (Directive to Take  
32 Action)

33  
34 2. That our AMA, to be consistent with terminology now used by the American Board of Medical  
35 Specialties, amend the following policies by addition and deletion to read as follows:

36  
37 Policy H-275.924, Amend the title to read, “~~Maintenance of~~ Continuing Board Certification”  
38 (AMA Principles on ~~Maintenance of~~ Continuing Board Certification), and replace the terms  
39 “Maintenance of Certification” and “MOC” with “Continuing Board Certification” and “CBC”  
40 throughout the policy, as shown in Appendix H.

41  
42 Policy D-275.954, Amend the title to read, “~~Maintenance of Certification and Osteopathic~~  
43 ~~Continuous Certification~~ Continuing Board Certification,” and replace the terms “Maintenance  
44 of Certification” and “MOC” with “Continuing Board Certification” and “CBC” throughout  
45 the policy, as shown in Appendix H. (Modify Current HOD Policy)

- 1 3. That our AMA rescind Policy D-275.954 (37), “Maintenance of Certification and Osteopathic  
2 Continuous Certification,” that asks the AMA to “Through its Council on Medical Education,  
3 continue to be actively engaged in following the work of the ABMS Continuing Board  
4 Certification: Vision for the Future Commission,” as this has been accomplished. (Rescind  
5 HOD Policy)  
6
- 7 4. That our AMA rescind Policy D-275.954 (38), which asks our AMA to “Submit commentary  
8 to the American Board of Medical Specialties (ABMS) Continuing Board Certification: Vision  
9 for the Future initiative, asking that junior diplomates be given equal opportunity to serve on  
10 ABMS and its member boards,” as this has been accomplished. (Rescind HOD Policy)  
11
- 12 5. That our AMA rescind Policy D- 275.954 (39) “Maintenance of Certification and Osteopathic  
13 Continuous Certification,” as this has been accomplished through this report. (Rescind HOD  
14 Policy)

Fiscal Note: \$2,500.



APPENDIX A



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January 15, 2019

Christopher Colenda, MD, MPH  
William J. Scanlon, PhD  
Co-Chairs, Continuing Board Certification: Vision for the Future Commission

Dear Drs. Colenda and Scanlon,

Thank you for the opportunity to review and comment on the draft report and recommendations from the Continuing Board Certification: Vision for the Future Commission (the "Commission"). The American Medical Association (AMA) Council on Medical Education (the "Council") values your efforts to make continuing certification more relevant, meaningful, and of value to both physicians and patients alike.

The Council applauds the Commission not only for producing such a thorough report, but equally for acknowledging long-standing physician frustrations, such as the concern that the benefits of the continuing certification process traditionally have not been worth the time or financial investment required for participation.

As the report and recommendations are finalized, the Council invites the Commission to consider the following comments.

**Preamble**

The Council strongly objects to the second paragraph of the section "Purpose and Value of Continuing Certification" on page 7 of the Preamble (which starts, "A fundamental axiom...").

Historically, diplomates have consistently and vocally expressed concern regarding linkages between continuing certification and licensure, and AMA policy with respect to this issue explicitly rejects any such association. Additionally, renewal of licensure in many states is primarily based on completion of CME hours; this does not support the general premise of this report, which argues that rigorous standards must be met to achieve meaningful lifelong learning and assure patient safety.

The Council, therefore, recommends that this paragraph be carefully considered and rewritten; left as is, it may undermine the thoughtful work that characterizes the remainder of the report.

**Recommendation 2**

*Continuing certification should incorporate assessments that support diplomate learning and retention, identify knowledge and skill gaps, and help diplomates learn advances in the field.*

The Commission should employ stronger language regarding secure, high-stakes examinations for knowledge assessment. While the Council believes that flexibility in the certification process is important, the Commission should recommend that all Boards incorporate models based on ongoing assessment and feedback, which are better exemplars of contemporary standards of adult learning principles.

**Recommendation 4**

*Standards for learning and practice improvement must expect diplomate participation and meaningful engagement in both lifelong learning and practice improvement. ABMS Boards should seek to integrate readily available information from a diplomate's actual clinical practice into any assessment of practice improvement.*

The Commission should recommend that all Boards utilize stronger language regarding the acceptance of quality data already being reported by individual physicians. If a physician is actively participating in the Centers for Medicare and Medicaid Services (CMS) Quality Payment Program (QPP) via the Merit-based Incentive Payment System (MIPS) or an Advanced Alternative Payment Model (APM), the Commission should recommend that all Boards accept this participation as a satisfactory requirement for certification.

**Recommendation 5**

*ABMS Boards have the responsibility and obligation to change a diplomate's certification status when certification standards are not met.*

The Council feels strongly that Recommendation 5 should be edited as follows:

*"ABMS Boards have the responsibility and obligation to change a diplomate's continuing certification status when continuing certification standards are not met."*

Likewise, the first sentence of the explanation for Recommendation 5 should be modified:

*"The Commission supports the ABMS Boards in making decisions about the continuing certification status of a diplomate and changing the diplomate's status when continuing certification standards are not met."*

At no time can a Board revoke or change an individual physician's original certification solely on the basis of non-participation in the continuing certification process.

**Recommendation 8**

*The certificate has value, meaning and purpose in the health care environment.*

Although the report does specify that board certification should not be tied to credentialing, there is no parallel mention of this with respect to medical licensure. The Commission should address this explicitly to assuage long-held and expressed concerns that the Federation of State Medical Boards (FSMB) may at some point tie certification to licensure (although the Council recognizes that this is not the current policy of the FSMB).

**Recommendation 11**

*ABMS Boards must comply with all ABMS certification and organizational standards.*

The Council notes that while financial transparency is included in the findings of both Recommendations 10 and 11, it is not specifically referenced in either of the Recommendations themselves. Detailed financial transparency regarding fiscal responsibility toward diplomates must be a cornerstone of all Board models, and may help communicate the message that the concerns of many diplomates who have expressed anxiety on this point have been heard and are being addressed.

The Council applauds the report for its recommendation of inclusion with respect to Board composition; the Commission may wish specifically to include mention of young physicians.

**Recommendation 14**

*ABMS Boards should have consistent certification processes for certain elements.*

The Council appreciates the intention behind this Recommendation, and recognizes that diplomates of certain Boards have expressed frustration regarding their individual Board's lack of momentum with respect to innovation. While it may make sense to standardize terminology across Boards, a more cautious approach may be appropriate when thinking about standardization of processes, as different specialties require varied approaches to ongoing certification and diplomates in many specialties are satisfied with their individual Board's innovations to date.

The Council, therefore, recommends that the Commission strongly encourage the ABMS to develop and publicly share its plans to actively oversee and navigate its approach to consistency. The Council also recommends that the Commission strongly encourage the ABMS to consider the negative public impact that less innovative Boards may be having on those that have dedicated significant time and resources to improving their processes for diplomates. Further, the Council recommends that the Commission encourage the ABMS to publicize its newly established Accountability and Resolution Committee (ARC), tasked with addressing and making recommendations to resolve complaints and problems related to non-compliance, both organizational and individual, that have not been resolved through other mechanisms, and to ensure that the ARC's processes and decisions are transparent to the public.

**General Comments**

- The Council feels that the final sentence in the Concluding Comments, which references "better doctors," is somewhat subjective, and suggests that the Commission consider language that recognizes the importance of doctors who remain current in the appropriate competencies to best serve their patients.
- Continuing medical education (CME) activities are discussed in detail on page 18 of the report. The Commission may wish to modify the sentence that references the ACCME, as entities beyond the ACCME are involved in this important process:  
  
"Those involved in developing and approving CME activities, and setting standards for such activities, should be encouraged to establish processes to encourage high quality CME and remediate or eliminate lower quality activities."
- Page 21 of the report focuses on the public's expectations. The Council believes it is important to acknowledge that continuing certification is but one component to promote patient safety and quality. Health care is a systems-based team effort, and changes to continuing certification should not create the unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

Page 4

Again, thank you for the opportunity to participate in this important process. If the Council may be of further assistance to you in this matter, please do not hesitate to communicate with us.

Sincerely,

A handwritten signature in cursive script, appearing to read "Jacqueline A. Bello".

Jacqueline A. Bello, MD, FACR  
Chair-Elect, AMA Council on Medical Education

cc: Susan E. Skochelak, MD  
Richard E. Hawkins, MD

APPENDIX B

Impact of the Council on Medical Education’s Comments on the Final Recommendations of the Continuing Board Certification: Vision for the Future Commission

Draft Recommendations/Council on Medical Education Comments	Final Recommendations*
<p><i>2. Continuing certification should incorporate assessments that support diplomate learning and retention, identify knowledge and skill gaps, and help diplomates learn advances in the field.</i></p> <p>The Commission should employ stronger language regarding secure, high-stakes examinations for knowledge assessment. While the Council believes that flexibility in the certification process is important, the Commission should recommend that all Boards incorporate models based on ongoing assessment and feedback, which are better exemplars of contemporary standards of adult learning principles.</p>	<p>2. Continuing certification must change to incorporate longitudinal and other innovative formative assessment strategies that support learning, identify knowledge and skills gaps, and help diplomates stay current. The ABMS Boards must offer an alternative to burdensome highly-secure, point-in-time examinations of knowledge.</p>
<p><i>4. Standards for learning and practice improvement must expect diplomate participation and meaningful engagement in both lifelong learning and practice improvement. ABMS Boards should seek to integrate readily available information from a diplomate’s actual clinical practice into any assessment of practice improvement.</i></p> <p>The Commission should recommend that all Boards utilize stronger language regarding the acceptance of quality data already being reported by individual physicians. If a physician is actively participating in the Centers for Medicare and Medicaid Services (CMS) Quality Payment Program (QPP) via the Merit-based Incentive Payment System (MIPS) or an Advanced Alternative Payment Model (APM), the Commission should recommend that all Boards accept this participation as a satisfactory requirement for certification.</p>	<p>13. ABMS and the ABMS Boards should collaborate with specialty societies, the CME/CPD community, and other expert stakeholders to develop the infrastructure to support learning activities that produce data-driven advances in clinical practice. The ABMS Boards must ensure that their continuing certification programs recognize and document participation in a wide range of quality assessment activities in which diplomates already engage.</p>
<p><i>5. ABMS Boards have the responsibility and obligation to change a diplomate’s certification status when certification standards are not met.</i></p> <p>Recommendation 5 should be edited as follows:  “ABMS Boards have the responsibility and obligation to change a diplomate’s continuing certification status when continuing certification standards are not met.”  Likewise, the first sentence of the explanation for Recommendation 5 should be modified:  “The Commission supports the ABMS Boards in making decisions about the continuing certification status of a diplomate and changing the diplomate’s status when continuing certification standards are not met.”  At no time can a Board revoke or change an individual physician’s original certification solely on the basis of non-participation in the continuing certification process.</p>	<p>7. The ABMS Boards must change a diplomate’s certification status when continuing certification standards are not met.</p>

<p><i>8. The certificate has value, meaning and purpose in the health care environment.</i></p> <p>Although the report does specify that board certification should not be tied to credentialing, there is no parallel mention of this with respect to medical licensure. The Commission should address this explicitly to assuage long-held and expressed concerns that the Federation of State Medical Boards (FSMB) may at some point tie certification to licensure (although the Council recognizes that this is not the current policy of the FSMB).</p>	<p>11. ABMS must demonstrate and communicate that continuing certification has value, meaning, and purpose in the health care environment.</p> <p>a. Hospitals, health systems, payers and other health care organizations can independently decide what factors are used in credentialing and privileging decisions.</p> <p>b. ABMS must inform these organizations that continuing certification should not be the only criterion used in these decisions and these organizations should use a wide portfolio of criteria in these decisions.</p> <p>c. ABMS must encourage hospitals, health systems, payers, and other health care organizations to not deny credentialing or privileging to a physician solely on the basis of certification status.</p>
<p><i>11. ABMS Boards must comply with all ABMS certification and organizational standards.</i></p> <p>While financial transparency is included in the findings of both Recommendations 10 and 11, it is not specifically referenced in either of the Recommendations themselves. Detailed financial transparency regarding fiscal responsibility toward diplomates must be a cornerstone of all Board models, and may help communicate the message that the concerns of many diplomates who have expressed anxiety on this point have been heard and are being addressed. The Council applauds the report for its recommendation of inclusion with respect to Board composition; the Commission may wish specifically to include mention of young physicians.</p>	<p>10. The ABMS Boards must comply with all ABMS certification and organizational standards, including financial stewardship and ensuring that diverse groups of practicing physicians and the public voice are represented.</p>
<p><i>14. ABMS Boards should have consistent certification processes for certain elements.</i></p> <p>The Council appreciates the intention behind this Recommendation, and recognizes that diplomates of certain Boards have expressed frustration regarding their individual Board's lack of momentum with respect to innovation. While it may make sense to standardize terminology across Boards, a more cautious approach may be appropriate when thinking about standardization of processes, as different specialties require varied approaches to ongoing certification and diplomates in many specialties are satisfied with their individual Board's innovations to date.</p> <p>The Council, therefore, recommends that the Commission strongly encourage the ABMS to develop and publicly share its plans to actively oversee and navigate its approach to consistency. The Council also recommends that the Commission strongly encourage the ABMS to consider the negative public impact that less innovative Boards may be having on those that have dedicated significant time and resources to improving their processes for diplomates. Further, the Council recommends that the Commission encourage the ABMS to publicize its newly established Accountability and</p>	<p>4. The ABMS and the ABMS Boards must have consistent processes and requirements for continuing certification that are fair, equitable, transparent, effective, and efficient.</p>

Resolution Committee (ARC), tasked with addressing and making recommendations to resolve complaints and problems related to non-compliance, both organizational and individual, that have not been resolved through other mechanisms, and to ensure that the ARC's processes and decisions are transparent to the public.	
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\* Several of the final recommendations were revised, reorganized, and renumbered in the Continuing Board Certification: Vision for the Future Commission's Final Report.

APPENDIX C

Final Recommendations of the Continuing Board Certification: Vision for the Future Commission and Related AMA Policy

Final Recommendations	Related AMA Policy
<p>1. Continuing certification must integrate professionalism, assessment, lifelong learning, and advancing practice to determine the continuing certification status of a diplomate.</p>	<p>H-300.958 (7) Our AMA affirms that lifelong learning is a fundamental obligation of our profession and recognizes that lifelong learning for a physician is best achieved by ongoing participation in a program of high quality continuing medical education appropriate to that physician's medical practice as determined by the relevant specialty society.</p>
<p>2. Continuing certification must change to incorporate longitudinal and other innovative formative assessment strategies that support learning, identify knowledge and skills gaps, and help diplomates stay current. The ABMS Boards must offer an alternative to burdensome highly-secure, point-in-time examinations of knowledge.</p>	<p>H-275.924 (22) There should be multiple options for how an assessment could be structured to accommodate different learning styles.</p> <p>D-275.954 Our AMA will...(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. (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. (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. (36) 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.</p>
<p>3. The ABMS Boards must regularly communicate with their diplomates about the standards for the specialty and encourage feedback about the program.</p>	<p>H-275.924 (13) The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.</p> <p>D-275.954 Our AMA will...(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.</p>
<p>4. The ABMS and the ABMS Boards must have consistent processes and requirements for continuing certification that are fair, equitable, transparent, effective, and efficient.</p>	<p>H-275.924 (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. (27) Our AMA will continue to work with the national</p>



	<p>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.</p>
<p>5. The ABMS Boards must enable multi-specialty and subspecialty diplomates to remain certified across multiple ABMS Boards without duplication of effort.</p>	<p>D-275.954 Our AMA will...(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.</p>
<p>6. ABMS and the ABMS Boards must facilitate and encourage independent research to build on the existing evidence base about the value of continuing certification.</p>	<p>D-275.954 Our AMA will...(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.</p>
<p>7. The ABMS Boards must change a diplomate's certification status when continuing certification standards are not met.</p>	<p>H-275.924 (24) No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC. (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.</p>
<p>8. The ABMS Boards must have clearly defined remediation pathways to enable diplomates to meet continuing certification standards in advance of and following any loss of certification.</p>	<p>D-295.325 (4) Our AMA will partner with the FSMB and state medical licensing boards, hospitals, professional societies and other stakeholders in efforts to support the development of consistent standards and programs for remediating deficits in physician knowledge and skills.</p>
<p>9. ABMS and the ABMS Boards must make publicly available the certification history of all diplomates, including their participation in the continuing certification process. The ABMS Boards must facilitate voluntary re-engagement into the continuing certification process for lifetime certificate holders and others not currently participating in the continuing certification process.</p>	<p>H-275.924 (24) No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC. (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.</p>

<p>10. The ABMS Boards must comply with all ABMS certification and organizational standards, including financial stewardship and ensuring that diverse groups of practicing physicians and the public voice are represented.</p>	<p>H-275.924 (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.</p> <p>D-275.954 Our AMA will...(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.</p>
<p>11. ABMS must demonstrate and communicate that continuing certification has value, meaning, and purpose in the health care environment.</p> <p>a. Hospitals, health systems, payers and other health care organizations can independently decide what factors are used in credentialing and privileging decisions.</p> <p>b. ABMS must inform these organizations that continuing certification should not be the only criterion used in these decisions and these organizations should use a wide portfolio of criteria in these decisions.</p> <p>c. ABMS must encourage hospitals, health systems, payers, and other health care organizations to not deny credentialing or privileging to a physician solely on the basis of certification status.</p>	<p>H-275.924 (15) The MOC program should not be a mandated requirement for licensure, credentialing, recertification, privileging, reimbursement, network participation, employment, or insurance panel participation. (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.</p> <p>D-275.954 Our AMA will...(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. (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 recertification; (b) insurance panel participation; or (c) state medical licensure.</p>
<p>12. ABMS and the ABMS Boards must seek input from other stakeholder organizations to develop consistent approaches to evaluate professionalism and professional standing while ensuring due process for the diplomate when questions of professionalism arise.</p>	<p>9.4.1 Peer Review &amp; Due Process. Physicians have mutual obligations to hold one another to the ethical standards of their profession. Peer review, by the ethics committees of medical societies, hospital credentials and utilization committees, or other bodies, has long been established by organized medicine to scrutinize professional conduct. Peer review is recognized and accepted as a means of promoting professionalism and maintaining trust. The peer review process is intended to balance physician' right to</p>

	<p>exercise medical judgment freely with the obligation to do so wisely and temperately.</p> <p>Fairness is essential in all disciplinary or other hearings where the reputation, professional status, or livelihood of the physician or medical student may be adversely affected.</p> <p>Individually, physicians and medical students who are involved in reviewing the conduct of fellow professionals, medical students, residents or fellows should:</p> <p>(a) Always adhere to principles of a fair and objective hearing, including:</p> <ul style="list-style-type: none"> <li>(i) a listing of specific charges,</li> <li>(ii) adequate notice of the right of a hearing,</li> <li>(iii) the opportunity to be present and to rebut the evidence, and</li> <li>(iv) the opportunity to present a defense.</li> </ul> <p>(b) Ensure that the reviewing body includes a significant number of persons at a similar level of training.</p> <p>(c) Disclose relevant conflicts of interest and, when appropriate, recuse themselves from a hearing.</p> <p>Collectively, through the medical societies and institutions with which they are affiliated, physicians should ensure that such bodies provide procedural safeguards for due process in their constitutions and bylaws or policies.</p>
<p>13. ABMS and the ABMS Boards should collaborate with specialty societies, the CME/CPD community, and other expert stakeholders to develop the infrastructure to support learning activities that produce data-driven advances in clinical practice. The ABMS Boards must ensure that their continuing certification programs recognize and document participation in a wide range of quality assessment activities in which diplomates already engage.</p>	<p>D-275.954 Our AMA will...(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. (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.</p>
<p>14. The ABMS Boards must collaborate with professional and/or CME/CPD organizations to share data and information to guide and support diplomate engagement in continuing certification.</p>	<p>D-275.954 Our AMA will...(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.</p>

## APPENDIX D

### Current HOD Policies Related to Maintenance of Certification and Osteopathic Continuous Certification

#### **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, recertification, 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.

36. 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.

37. 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.

38. (a) Submit commentary to the American Board of Medical Specialties (ABMS) Continuing Board Certification: Vision for the Future initiative, asking that junior diplomates be given equal opportunity to serve on ABMS and its member boards; and (b) work with the ABMS and member boards to encourage the inclusion of younger physicians on the ABMS and its member boards.

39. Continue studying the certifying bodies that compete with the American Board of Medical Specialties and provide an update in the Council on Medical Education's annual report on maintenance of certification at the 2019 Annual Meeting.

(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 Appended: CME Rep. 02, A-18 Appended: Res. 320, A-18 Appended: Res. 957, I-18)



## APPENDIX E

## ABMS Committee on Continuing Certification (3C) Supplemental Information

## 1. List of ABMS pilots and substantive changes approved at 3C Meetings

**APPROVED – Substantive Changes**

Board	MOC Component	Pilot	Announced	Approved
American Board of Anesthesiology	Assessment of Knowledge, Judgment, and Skills	MOCA Minute	April 2015	April 2018
American Board of Thoracic Surgery	Assessment of Knowledge, Judgment, and Skills	Mastery Learning Process Using SESATS	April 2015	November 2015
American Board of Pathology	Assessment of Knowledge, Judgment, and Skills	Remote Proctoring	April 2015	July 2016
American Board of Dermatology	Improvement in Medical Practice	Practice Improvement Pilot	November 2015	April 2018
American Board of Obstetrics and Gynecology	Lifelong Learning and Self-Assessment, Knowledge, Judgment, and Skills	Integration of MOC Parts II & III	November 2015	April 2018
American Board of Emergency Medicine	Professionalism and Professional Standing	Improvements to Communication/Professionalism Requirement	April 2016	April 2018
American Board of Pediatrics	Assessment of Knowledge, Judgment, and Skills	MOCAPeds	November 2016	April 2018
American Board of Emergency Medicine	Lifelong Learning and Self-Assessment	Lifelong Learning and Self-Assessment Requirements Update	November 2018	November 2018

## 2. List of ABMS active pilots announced at 3C Meetings

**ACTIVE - Pilots**

Board	MOC Component	Pilot	Announced
American Board of Internal Medicine	Improvement in Medical Practice	Improvements to Part IV	April 2015
American Board of Neurological Surgery	Assessment of Knowledge, Judgment, and Skills	Cognitive Assessment/Learning Tool	November 2016
American Board of Radiology	Assessment of Knowledge, Judgment, and Skills	Online Longitudinal Assessment (OLA)	November 2016
American Board of Ophthalmology	Assessment of Knowledge, Judgment, and Skills	Quarterly Questions	November 2016
American Board of Pathology	Assessment of Knowledge, Judgment, and Skills	Longitudinal Assessment Program: CertLink	November 2016
American Board of Medical Genetics and Genomics	Assessment of Knowledge, Judgment, and Skills	Longitudinal Assessment Program: CertLink	April 2017
American Board of Nuclear Medicine	Assessment of Knowledge, Judgment, and Skills	Longitudinal Assessment Program: CertLink	April 2017
American Board of Allergy and Immunology	Assessment of Knowledge, Judgment, and Skills	Continuous Assessment Program	April 2017
American Board of Internal Medicine	Assessment of Knowledge, Judgment, and Skills	Knowledge Check-Ins	April 2017
American Board of Colon and Rectal Surgery	Assessment of Knowledge, Judgment, and Skills	Longitudinal Assessment Program: CertLink	November 2017
American Board of Physical Medical and Rehabilitation	Assessment of Knowledge, Judgment, and Skills	Longitudinal Assessment Program: CertLink	November 2017
American Board of Plastic Surgery	Lifelong Learning and Self-Assessment, Knowledge, Judgment, and Skills	Lifelong Learning and Self-Assessment and Knowledge, Judgment, and Skills	November 2017
American Board of Psychiatry and Neurology	Lifelong Learning and Self-Assessment, Knowledge, Judgment, and Skills	Lifelong Learning and Self-Assessment and Knowledge, Judgment, and Skills	November 2017

American Board of Surgery	Assessment of Knowledge, Judgment, and Skills	New Assessment Process	November 2017
American Board of Otolaryngology – Head and Neck Surgery	Assessment of Knowledge, Judgment, and Skills	Longitudinal Assessment Program: CertLink	April 2018
American Board of Orthopaedic Surgery	Assessment of Knowledge, Judgment, and Skills	Web-based Longitudinal Assessment (WLA)	April 2018
American Board of Emergency Medicine	Assessment of Knowledge, Judgment, and Skills	MyEMCert	April 2018
American Board of Dermatology	Assessment of Knowledge, Judgment, and Skills	Longitudinal Assessment Program: CertLink	July 2018
American Board of Family Medicine	Assessment of Knowledge, Judgment, and Skills	Family Medicine Certification Longitudinal Assessment	November 2018

APPENDIX F

Improvements to the American Board of Medical Specialties (ABMS) Part III, Assessment of Knowledge, Judgment, and Skills and Part IV, Improvement in Medical Practice\*

American Board of:	Original Format	New Models/Innovations
<p><b>Allergy and Immunology (ABAI)</b>  <a href="http://abai.org">abai.org</a></p>	<p><b>Part III:</b>                      Computer-based, secure exam was administered at a proctored test center once a year. Diplomates were required to pass the exam once every 10 years.</p>	<p><b>Part III:</b>                      In 2018, ABAI-Continuous Assessment Program Pilot was implemented in place of current exam:</p> <ul style="list-style-type: none"> <li>• A 10-year program with two 5-year cycles;</li> <li>• Diplomates take exam where and when it is convenient;</li> <li>• Open-book annual exam with approximately 80 questions;</li> <li>• Mostly article-based with some core questions during each 6-month cycle. Diplomates must answer three questions for each of ten journal articles in each cycle. The articles are posted in January and July and remain open for 6 months.</li> <li>• Questions can be answered independently for each article;</li> <li>• Diplomate feedback required on each question;</li> <li>• Opportunity to drop the two lowest 6-month cycle scores during each 5-year period to allow for unexpected life events; and</li> <li>• Ability to complete questions on PCs, laptops, MACs, tablets, and smart phones by using the new diplomate dashboard accessed via the existing ABAI Web Portal page.</li> </ul>
	<p><b>Part IV<sup>2</sup>:</b>                      ABAI diplomates receive credit for participation in registries.</p>	<p><b>Part IV<sup>2</sup>:</b>                      In 2018, new Part IV qualifying activities provided credit for a greater range of improvement in medical practice (IMP) activities that physicians complete at their institutions and/or individual practices. A practice assessment/quality improvement (QI) module must be completed once every 5 years.</p>
<p><b>Anesthesiology (ABA)</b>  <a href="http://theaba.org">theaba.org</a></p>	<p><b>Part III:</b>                      MOCA 2.0 introduced in 2014 to provide a tool for ongoing low-stakes assessment with more extensive, question-specific feedback. Also provides focused content that could be reviewed periodically to refresh knowledge and document cognitive expertise.</p>	<p><b>Part III:</b>                      MOCA Minute<sup>®</sup> replaced the MOCA exam. Diplomates must answer 30 questions per calendar quarter (120 per year), no matter how many certifications they are maintaining.</p>

	<p><i>All diplomates with time-limited certification in anesthesiology that expired on or before December 31, 2015 and diplomates whose subspecialty certificates expired on or before December 31, 2016, must complete the traditional MOCA<sup>®</sup> requirements before they can register for MOCA 2.0<sup>®</sup>.</i></p>	
	<p><b>Part IV<sup>2</sup>:</b> Traditional MOCA requirements include completion of case evaluation and simulation course during the 10-year MOCA cycle. One activity must be completed between Years 1 to 5, and the second between Years 6 to 10. An attestation is due in Year 9.</p>	<p><b>Part IV<sup>3-4</sup>:</b> ABA is adding and expanding multiple activities for diplomates to demonstrate that they are participating in evaluations of their clinical practice and are engaging in practice improvement. Diplomates may choose activities that are most relevant to their practice; reporting templates no longer required for self-report activities; simulation activity no longer required following diplomate feedback that it was expensive and time-consuming.</p>
<p><b>Colon and Rectal Surgery (ABCRS)</b> <a href="http://abcrs.org">abcrs.org</a></p>	<p><b>Part III:</b> Computer-based secure exam administered at a proctored test center once a year (in May). Diplomates must pass the exam once every 10 years.</p>	<p><b>Part III<sup>1</sup>:</b> ABCRS is exploring ways to modify the exam experience to provide a more consistent assessment process and to replace the exam as it presently is administered.</p> <p>The first diplomates enrolled in CertLink<sup>TM</sup> MOC included those sitting for the ABCRS certifying exam in September 2017. These diplomates started CertLink<sup>TM</sup> MOC in the Spring of 2018. Other diplomates will be able to enroll in the near future. The computer-based secure exam will not be offered after 2019.</p>
	<p><b>Part IV:</b> Requires ongoing participation in a local, regional, or national outcomes registry or quality assessment program.</p>	<p><b>Part IV<sup>3-4</sup>:</b></p>
<p><b>Dermatology (ABD)</b> <a href="http://abderm.org">abderm.org</a></p>	<p><b>Part III:</b> 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.</p> <p>Test preparation material available 6 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.</p>	<p><b>Part III<sup>1</sup>:</b> ABD successfully completed trials employing remote proctoring technology to monitor exam administration in the diplomates' homes or offices.</p> <p>ABD is developing a longitudinal assessment as an alternative to the traditional MOC exam (pilot scheduled for 2019, launch tentatively scheduled for 2020).</p>

	<p>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.</p>	
	<p><b>Part IV<sup>2</sup>:</b>                  Tools diplomates can use for Part IV include:</p> <ul style="list-style-type: none"> <li>• Focused practice improvement modules.</li> <li>• ABD’s basal cell carcinoma registry tool.</li> </ul> <p>Partnering with specialty society to transfer any MOC-related credit directly to Board.</p>	<p><b>Part IV:</b>                  ABD developed more than 40 focused practice improvement modules that are simpler to complete and cover a wide range of topics to accommodate different practice types.</p> <p>Peer and patient communication surveys are now optional.</p>
<p><b>Emergency Medicine (ABEM)</b>  <a href="http://abem.org">abem.org</a></p>	<p><b>Part III:</b>                  ABEM’s ConCert™, computer-based, secure exam administered at a proctored test center twice a year. Diplomates must pass the exam once every 10 years.</p>	<p><b>Part III:</b>                  In 2020, a second way to demonstrate physicians continue to possess the knowledge and cognitive skills of an ABEM-certified emergency physician—MyEMCert—will be piloted. MyEMCert will consist of:</p> <p>Shorter, more frequent tests: Each test will assess one or more specific content areas relevant to the clinical practice of emergency medicine, such as cardiovascular disorders or trauma. The tests will be about an hour long, with the ability to retake a test again if it is not passed the first time, providing physicians with a clearer idea of what topics need to be reviewed. Physicians will take the test remotely and have access to references.</p>
	<p><b>Part IV<sup>2</sup>:</b>                  Physicians may complete practice improvement efforts related to any of the measures or activities listed on the ABEM website. Others that are not listed, may be acceptable if they follow the four steps ABEM requirements.</p>	<p><b>Part IV:</b>                  ABEM is developing a pilot program to incorporate clinical data registry.</p> <p>ABEM diplomates receive credit for improvements they are making in their practice setting.</p>
<p><b>Family Medicine (ABFM)</b>  <a href="http://theabfm.org">theabfm.org</a></p>	<p><b>Part III:</b>                  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.</p> <p>Improving relevance of exam by using national study of care content in family medicine practices.</p> <p>Providing feedback to residents and practicing physicians about the “anatomy” of</p>	<p><b>Part III:</b>                  In December 2018, the ABFM launched a pilot to study the feasibility and validity of an alternative to the 10-year examination, called Family Medicine Certification Longitudinal Assessment (FMCLA). Limited to diplomates who are currently certified and are in the tenth year of certification due to end December 31, 2019, this approach is more aligned with adult learning principles, and when coupled</p>

	<p>the exam and their specific knowledge gaps (this effort has resulted in significant improvement in passing rates and improved feedback regarding relevance).</p>	<p>with modern technology, promotes more enduring learning, retention, and transfer of knowledge than episodic examinations.</p>
	<p><b>Part IV<sup>2</sup>:</b> IMP Projects include:</p> <ul style="list-style-type: none"> <li>• Collaborative Projects: Structured projects that involve physician teams collaborating across practice sites and/or institutions to implement strategies designed to improve care.</li> <li>• Projects Initiated in the Workplace: These projects are based on identified gaps in quality in a local or small group setting.</li> <li>• Web-based Activities: Self-paced activities that physicians complete within their practice setting (these activities are for physicians, who do not have access to other practice improvement initiatives).</li> </ul>	<p><b>Part IV<sup>2-3</sup>:</b> ABFM developed and launched the national primary care registry (PRIME) to reduce time and reporting requirements.</p>
<p><b>Internal Medicine</b> (ABIM) <a href="http://abim.org">abim.org</a></p>	<p><b>Part III:</b> Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.</p> <p>ABIM introduced grace period for physicians to retry assessments for additional study and preparation if initially unsuccessful.</p>	<p><b>Part III:</b> In 2018, two assessment options were offered:</p> <ol style="list-style-type: none"> <li>1) Certified physicians (internal medicine, cardiovascular disease, geriatric medicine, endocrinology, diabetes, and metabolism, gastroenterology, hematology, infectious disease, nephrology, pulmonary disease, and rheumatology with more specialties to roll out in 2020) will be eligible to take the Knowledge Check-In, a new 2-year open-book (access to <i>UpToDate</i><sup>®</sup>) 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.</li> <li>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 <i>UpToDate</i><sup>®</sup>) that physicians requested.</li> </ol>

		<p><i>ABIM is also working with specialty societies to explore the development of collaborative pathways through which physicians can maintain board certification.</i></p>
	<p><b>Part IV<sup>2</sup>:</b> Practice assessment/QI activities include identifying an improvement opportunity in practice, implementing a change to address that opportunity, and measuring the impact of the change.</p> <p>Diplomates can earn MOC points for many practice assessment/QI projects through their medical specialty societies, hospitals, medical groups, clinics, or other health-related organizations.</p>	<p><b>Part IV:</b> Increasing number of specialty-specific IMP activities recognized for credit (activities that physicians are participating in within local practice and institutions).</p>
<p><b>Medical Genetics and Genomics (ABMGG)</b> <a href="http://abmgg.org">abmgg.org</a></p>	<p><b>Part III:</b> Computer-based secure exam administered at a proctored test center once a year (August). Diplomates must pass the exam once every 10 years.</p>	<p><b>Part III<sup>1</sup>:</b> In 2018, CertLink Pilot Program launched:</p> <ul style="list-style-type: none"> <li>• Twenty-four questions distributed every 6 months throughout pilot period, regardless of number of specialties in which a diplomate is certified;</li> <li>• All questions must be answered by end of each 6-month timeframe (~5 minutes allotted per question);</li> <li>• Resources allowed, collaboration with colleagues not allowed;</li> <li>• Realtime feedback and performance provided for each question; and</li> <li>• “Clones” of missed questions will appear in later timeframes to help reinforce learning.</li> </ul>
	<p><b>Part IV<sup>2</sup>:</b> Diplomates can choose from the list of options to complete practice improvement modules in areas consistent with the scope of their practice.</p>	<p><b>Part IV<sup>3-4</sup>:</b> ABMGG is developing opportunities to allow diplomates to use activities already completed at their workplace to fulfill certain requirements.</p> <p>Expanding accepted practice improvement activities for laboratorians.</p>
<p><b>Neurological Surgery (ABNS)</b> <a href="http://abns.org">abns.org</a></p>	<p><b>Part III:</b> 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.</p> <p>On applying to take the exam, a diplomate must assign a person to be his or her proctor.</p>	<p><b>Part III:</b> In 2018, the 10-year exam was replaced with an annual adaptive cognitive learning tool, Core Neurosurgical Knowledge:</p> <ul style="list-style-type: none"> <li>• Open book exam focusing on 30 or so evidence-based practice</li> </ul>



	<p>Prior to the exam, that individual will participate in an on-line training session and “certify” the exam computers.</p>	<p>principles critical to emergency, urgent, or critical care;</p> <ul style="list-style-type: none"> <li>• Shorter, relevant, and more focused questions than the prior exam;</li> <li>• Web-based format with 24/7 access from the diplomates’ home or office; and</li> <li>• Immediate feedback to each question and references with links and/or articles are provided.</li> </ul>
	<p><b>Part IV:</b> Diplomates receive credit for documented participation in an institutional QI project.</p>	<p><b>Part IV:</b> Diplomates are required to participate in a meaningful way in morbidity and mortality conferences at his or her primary hospital.</p> <p>For those diplomates participating in the Pediatric Neurosurgery, CNS-ES, NeuCC focused practice programs, a streamlined case log is required to confirm that their practice continues to be focused and the diplomate is required to complete a learning tool that includes core neurosurgery topics and an additional eight evidence-based concepts critical to providing emergency, urgent, or critical care in their area of focus.</p>
<p><b>Nuclear Medicine</b> (ABNM) <a href="http://abnm.org">abnm.org</a></p>	<p><b>Part III:</b> Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.</p>	<p><b>Part III<sup>1</sup>:</b> Diplomates can choose between the 10-year exam or a longitudinal assessment pilot program (CertLink™). CertLink™ periodically delivers nuclear medicine questions with detailed explanations and references directly to diplomates.</p>
	<p><b>Part IV:</b> Diplomates must complete one of the three following requirements each year.</p> <ol style="list-style-type: none"> <li>1) Attestation that the diplomate has participated in QI activities as part of routine clinical practice, such as participation in a peer review process, attendance at tumor boards, or membership on a radiation safety committee.</li> <li>2) Participation in an annual practice survey related to approved clinical guidelines released by the ABNM. The survey has several questions based on review of actual cases. Diplomates receive a summary of the answers</li> </ol>	<p><b>Part IV<sup>3-4</sup>:</b> ABNM recognizes QI activities in which physicians participate in their clinical practice.</p>

	<p>provided by other physicians that allows them to compare their practice to peers.</p> <p>3) Improvement in medical practice projects designed by diplomates, or provided by professional groups such as the Society of Nuclear Medicine and Molecular Imaging (SNMMI). Project areas may include medical care provided for common/major health conditions, physician behaviors, such as communication and professionalism, as they relate to patient care, and many others. The projects typically follow the model of Plan-Do-Study-Act. The ABNM has developed a few IMP modules for the SNMMI, Alternatively, diplomates may design their own project.</p>	
<p><b>Obstetrics and Gynecology (ABOG)</b>  <a href="http://abog.org">abog.org</a></p>	<p><b>Part III:</b>                  The secure, external assessment is offered in the last year of each ABOG diplomate’s 6-year cycle in a modular test format; diplomates can choose two selections that are the most relevant to their current practice.</p>	<p><b>Part III:</b>                  ABOG completed a pilot program and integrated the article-based self-assessment (Part II) and external assessment (Part III) requirements, allowing 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 5 years of the self-assessment program.</p> <p>In 2019, diplomates can choose to take the 6-year exam or participate in Performance Pathway, an article-based self-assessment (with corresponding questions) which showcases new research studies, practice guidelines, recommendations, and up-to-date reviews. Diplomates who participate in Performance Pathway are required to read a total of 180 selected articles and answer 720 questions about the articles over the 6-year MOC cycle.</p>
	<p><b>Part IV<sup>2</sup>:</b>                  Diplomates required to participate in one of the available IMP activities yearly in MOC Years 1-5.</p> <p>ABOG will consider structured QI projects (IMP modules, QI efforts, simulation courses) in obstetrics and gynecology for</p>	<p><b>Part IV:</b>                  ABOG recognizes work with QI registries for credit.</p> <p>ABOG continues to expand the list of approved activities which can be used to complete the Part IV.</p>

	<p>Part IV credit. These projects must demonstrate improvement in care and be based on accepted improvement science and methodology.</p> <p>Newly developed QI projects from organizations with a history of successful QI projects are also eligible for approval.</p>	<p>The number of hours required for approval of simulation course credit has been decreased to 4 hours of instruction.</p>
<p><b>Ophthalmology</b> (ABO) <a href="http://abop.org">abop.org</a></p>	<p><b>Part III:</b> The Demonstration of Ophthalmic Cognitive Knowledge (DOCK) high-stakes, 10-year exam administered through 2018.</p>	<p><b>Part III:</b> In 2019, Quarterly Questions™ will replace the DOCK Examination for all diplomates:</p> <ul style="list-style-type: none"> <li>• Will deliver 50 questions (40 knowledge-based and 10 article-based);</li> <li>• Offered remotely at home or office through computer, tablet, or mobile apps;</li> <li>• The questions should not require preparation in advance, but a content outline for the multiple-choice questions will be available;</li> <li>• Diplomates will receive instant feedback and recommendations for resources related to gaps in knowledge; and</li> <li>• Key ophthalmic journal articles with questions focused on the application of this information to patient care. The journal portion will require reading five articles from a list of 30 options.</li> </ul>
	<p><b>Part IV<sup>2</sup>:</b> Diplomates whose certificates expire on or before December 31, 2020 must complete one of the following options; all other diplomates complete two activities:</p> <ol style="list-style-type: none"> <li>1) Read QI articles through Quarterly Questions;</li> <li>2) Choose a QI CME activity;</li> <li>3) Create an individual IMP activity; or</li> <li>4) Participate in the ABMS multi-specialty portfolio program pathway.</li> </ol>	<p><b>Part IV<sup>3-4</sup>:</b> Diplomates can choose to:</p> <ol style="list-style-type: none"> <li>1) Design a registry-based IMP Project using their AAO IRIS® Registry Data;</li> <li>2) Create a customized, self-directed IMP activity; or</li> <li>3) Participate in the ABMS multi-specialty portfolio program through their institution.</li> </ol>
<p><b>Orthopaedic Surgery</b> (ABOS) <a href="http://abos.org">abos.org</a></p>	<p><b>Part III:</b> 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.</p> <p>Diplomates without subspecialty certifications can take practice-profiled</p>	<p><b>Part III:</b> In 2019, a new web-based longitudinal assessment program (ABOS WLA) the Knowledge Assessment, will be piloted. ABOS diplomates may choose this pathway instead of an ABOS computer-based or oral recertification 10-year exam:</p>

	<p>exams in orthopaedic sports medicine and surgery of the hand.</p> <p>General orthopaedic questions were eliminated from the practice-profiled exams so diplomates are only tested in areas relevant to their practice.</p> <p>Detailed blueprints are being produced for all exams to provide additional information for candidates to prepare for and complete the exams.</p> <p>Eight different practice-profiled exams offered to allow assessment in the diplomate's practice area.</p>	<ul style="list-style-type: none"> <li>• Offered remotely at home or office through computer, tablet, or mobile apps;</li> <li>• Thirty questions must be answered between April 15, 2019 and May 20, 2019 (two questions will come from each Knowledge Source).</li> <li>• The assessment is open-book and diplomates can use the Knowledge Sources, if the questions are answered within the 3-minute window and that the answer represents the diplomate's own work.</li> </ul>
	<p><b>Part IV<sup>2</sup>:</b> Case lists allow diplomates to review their practice including adhering to accepted standards, patient outcomes, and rate and type of complications.</p> <p>Case list collection begins on January 1st of the calendar year that the diplomate plans to submit their recertification application, and is due by December 1. The ABOS recommends that this be done in Year 7 of the 10-year MOC Cycle, but it can be done in Year 8 or 9. A minimum of 35 cases is required for the recertification candidate to sit for the recertification exam of their choice.</p> <p>Diplomates receive a feedback report based on their submitted case list.</p>	<p><b>Part IV<sup>3-4</sup>:</b> ABOS is streamlining the case list entry process to make it easier to enter cases and classify complications.</p>
<p><b>Otolaryngology</b> – Head and Neck Surgery (ABOHNS) <a href="http://aboto.org">aboto.org</a></p>	<p><b>Part III:</b> Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.</p> <p><b>Part IV<sup>2</sup>:</b> The three components of Part IV include: 1) A patient survey; 2) A peer survey; and 3) A registry that will be the basis for QI activities.</p>	<p><b>Part III<sup>1</sup>:</b> ABOHNS is piloting a CertLink™-based longitudinal assessment in 2019 (20 questions per quarter) to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam. Diplomates whose certificates expire in 2019 are eligible to participate on a voluntary basis.</p> <p><b>Part IV:</b> ABOHNS is partnering with the American Academy of Otolaryngology-Head and Neck Surgery in their development of a RegentSM registry. Selected data will be extracted from RegentSM for use in practice improvement modules that diplomates can use to meet IMP requirements.</p>

<p><b>Pathology</b> (ABPath) <a href="http://abpath.org">abpath.org</a></p>	<p><b>Part III:</b> Computer-based secure modular exam administered at the ABP Exam Center in Tampa, Florida twice a year (March and August).</p> <p>Remote computer exams can be taken anytime 24/7 that the physician chooses during the assigned 2-week period (spring and fall) from their home or office.</p> <p>Physicians can choose from more than 90 modules, covering numerous practice areas for a practice-relevant assessment.</p> <p><i>Diplomates must pass the exam once every 10 years.</i></p>	<p><b>Part III<sup>1</sup>:</b> The ABPath CertLink<sup>®</sup> pilot program is available for all diplomates:</p> <ul style="list-style-type: none"> <li>• Diplomates can log in anytime to answer 15 multiple-choice questions assigned per quarter;</li> <li>• Each question must be answered within 5 minutes;</li> <li>• Can use any resources (e.g. internet, textbooks, journals) except another person;</li> <li>• Immediate feedback on whether each question is answered correctly or incorrectly, with a short narrative about the topic (critique), and references; and</li> <li>• Customization allows diplomates to select questions from practice (content) areas relevant to their practice.</li> </ul>
	<p><b>Part IV<sup>2</sup>:</b> Diplomates must participate in at least one inter-laboratory performance improvement and quality assurance programs per year appropriate for the spectrum of anatomic and clinical laboratory procedures performed in that laboratory.</p>	<p><b>Part IV<sup>3-4</sup>:</b></p>
<p><b>Pediatrics</b> (ABP) <a href="http://abp.org">abp.org</a></p>	<p><b>Part III:</b> Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.</p>	<p><b>Part III:</b> In 2019 Maintenance of Certification Assessment for Pediatrics (MOCA-Peds), a new testing platform with shorter and more frequent assessments, will be rolled out</p> <ul style="list-style-type: none"> <li>• A series of questions released through mobile devices or a web browser at regular intervals;</li> <li>• Twenty multiple choice questions that are available quarterly and may be answered at any time during the quarter;</li> <li>• Immediate feedback and references;</li> <li>• Resources (i.e., internet, books) can be used when taking the exam; and</li> <li>• Allows for questions to be tailored to the pediatrician’s practice profile.</li> </ul> <p>Physicians will provide feedback on individual questions so the exam can be continuously improved.</p>

		Those who wish to continue taking the exam once every 5 years in a secure testing facility will be able to do so.
	<p><b>Part IV<sup>2</sup>:</b> Diplomates must earn at least 40 points every 5 years, in one of the following activities:</p> <ul style="list-style-type: none"> <li>• Local or national QI projects</li> <li>• Diplomates’ own project</li> <li>• National Committee for Quality Assurance Patient-Centered Medical Home or Specialty Practice</li> <li>• Institutional QI leadership</li> <li>• Online modules (PIMS)</li> </ul>	<p><b>Part IV:</b> ABP is enabling new pathways for pediatricians to claim Part IV QI credit for work they are already doing. These pathways are available to physicians who are engaged in QI projects alone or in groups, and include a pathway for institutional leaders in quality to claim credit for their leadership.</p> <p>ABP is also allowing trainees (residents and fellows) to “bank” MOC credit for quality improvement activities in which they participate. The pediatricians supervising these trainees also may claim MOC credit for qualifying projects.</p>
<p><b>Physical Medicine and Rehabilitation (ABPMR)</b> <a href="http://abpmr.org">abpmr.org</a></p>	<p><b>Part III:</b> Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.</p> <p>Released MOC 100, a set of free practice questions pulled directly from the ABPMR exam question banks to help physicians prepare for the exam.</p>	<p><b>Part III<sup>1</sup>:</b> ABPMR is conducting a CertLink™-based longitudinal assessment pilot through 2020 to explore and evaluate shorter, more frequent assessment methods and provision of immediate, personalized feedback as an alternative to the high-stakes exam.</p> <p>ABPMR is also working with its specialty society to produce clinical updates that will integrate with the longitudinal assessment tool.</p>
	<p><b>Part IV<sup>2</sup>:</b> Guided practice improvement projects are available through ABPMR.</p>	<p><b>Part IV<sup>3-4</sup>:</b> ABPMR is introducing several free tools to complete an IMP project, including: simplified and flexible template to document small improvements and educational videos, infographic, and enhanced web pages.</p> <p>ABPMR is seeking approval from the National Committee for Quality Assurance Patient-Centered Specialty Practice Recognition for Part IV IMP credit. ABPMR is also working with its specialty society to develop relevant registry-based QI activities.</p>
<p><b>Plastic Surgery (ABPS)</b> <a href="http://abplasticsurgery.org">abplasticsurgery.org</a></p>	<p><b>Part III:</b> Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.</p>	<p><b>Part III:</b> Piloting online delivery of Part III exam in place of centralized in-person testing center to reduce costs and time away from practice. Diplomates will be</p>

	<p>Modular exam to ensure relevance to practice.</p> <p>ABPS offers a Part III Study Guide with multiple choice question items derived from the same sources used for the exam.</p>	<p>given immediate feedback on answers and offered an opportunity to respond again. If successful, this pilot may replace the high-stakes exam.</p> <p>Instituting online longitudinal learning program that will assess the physician's knowledge, provide immediate feedback, and reinforce areas of knowledge deficiency throughout the 5-year cycle.</p>
	<p><b>Part IV<sup>2</sup>:</b> ABPS provides Part IV credit for registry participation.</p> <p>ABPS also allows Part IV credit for IMP activities that a diplomate is engaged in through their hospital or institution. Diplomates are asked to input data from 10 cases from any single index procedure every 3 years, and ABPS provides feedback on diplomate data across five index procedures in four subspecialty areas.</p>	<p><b>Part IV<sup>3-4</sup>:</b> Allowing MOC credit for Improvement in Medical Practice activities that a diplomate is engaged in through their hospital or institution.</p> <p>Physician participation in one of four options can satisfy the diplomate's Practice Improvement Activity:</p> <ul style="list-style-type: none"> <li>• Quality improvement publication</li> <li>• Quality improvement project</li> <li>• Registry participation</li> <li>• Tracer procedure log</li> </ul>
<p><b>Preventive Medicine (ABPM)</b> <a href="http://theabpm.org">theabpm.org</a></p>	<p><b>Part III:</b> 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).</p> <p><i>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.</i></p>	<p><b>Part III:</b> Changes to the ABPM MOC exam are not being considered at this time.</p>
	<p><b>Part IV<sup>2</sup>:</b> Diplomates must complete two IMP activities. One of the activities must be completed through a preventive medicine specialty or subspecialty society (ACOEM, ACPM, AMIA, AsMA, or UHMS).</p>	<p><b>Part IV<sup>3-4</sup>:</b> Partnering with specialty societies to design quality and performance improvement activities for diplomates with population-based clinical focus (i.e., public health).</p>
<p><b>Psychiatry and Neurology (ABPN)</b> <a href="http://abpn.com">abpn.com</a></p>	<p><b>Part III:</b> Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.</p> <p>ABPN is developing MOC exams with committees of clinically active diplomates to ensure relevance to practice.</p>	<p><b>Part III:</b> ABPN is implementing a Part III pilot program through 2021 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.</p>

	<p>ABPN is also enabling diplomates with multiple certificates to take all of their MOC exams at once and for a reduced fee.</p> <p>Grace period so that diplomates can retake the exam.</p>	
	<p><b>Part IV<sup>2</sup>:</b> Diplomates satisfy the IMP requirement by completing one of the following:</p> <ol style="list-style-type: none"> <li>1) Clinical Module: Review of one's own patient charts on a specific topic (diagnosis, types of treatment, etc.).</li> <li>2) Feedback Module: Obtain personal feedback from either peers or patients regarding your own clinical performance using questionnaires or surveys.</li> </ol>	<p><b>Part IV<sup>3-4</sup>:</b> ABPN is allowing Part IV credit for IMP and patient safety activities diplomates complete in their own institutions and professional societies, and those completed to fulfill state licensure requirements.</p> <p>Diplomates participating in registries, such as those being developed by the American Academy of Neurology and the American Psychiatric Association, can have 8 hours of required self-assessment CME waived.</p>
<p><b>Radiology (ABR)</b> <a href="http://theabr.org">theabr.org</a></p>	<p><b>Part III:</b> Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.</p>	<p><b>Part III:</b> An Online Longitudinal Assessment (OLA) model replaces the 10-year traditional exam. OLA includes modern and more relevant adult learning concepts to provide psychometrically valid sampling of the diplomate's knowledge.</p> <p>Diplomates must 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.</p> <p>Diplomates will receive weekly emails with links to questions relevant to their registered practice profile.</p> <p>Questions may be answered singly or, for a reasonable time, in small batches, in a limited amount of time.</p> <p>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.</p> <p>Those who answer questions incorrectly will receive future questions on the same topic to gauge whether they have learned the material.</p>



	<p><b>Part IV<sup>2</sup>:</b> Diplomates must complete at least one practice QI project or participatory quality improvement activity in the previous 3 years at each MOC annual review. A project or activity may be conducted repeatedly or continuously to meet Part IV requirements.</p>	<p><b>Part IV<sup>3-4</sup>:</b> ABR is automating data feeds from verified sources to minimize physician data reporting.</p> <p>ABR is also providing a template and education about QI to diplomates with solo or group projects.</p>
<p><b>Surgery (ABS)</b> <a href="http://absurgery.org">absurgery.org</a></p>	<p><b>Part III:</b> Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.</p> <p>Transparent exam content, with outlines, available on the ABS website and regularly updated.</p> <p>The ABS is coordinating with the American College of Surgeons and other organizations to ensure available study materials align with exam content.</p>	<p><b>Part III:</b> In 2018, the ABS began offering shorter, more frequent, open-book, modular, lower-stakes assessments required every 2 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:</p> <ul style="list-style-type: none"> <li>• Diplomates will select from four practice-related topics: general surgery, abdomen, alimentary tract, or breast;</li> <li>• More topics based on feedback from diplomates and surgical societies are being planned;</li> <li>• Diplomates can take the assessment through their own computer at a time and place of their choosing within the assessment window;</li> <li>• 40 questions total (20 core surgery, 20 practice-related);</li> <li>• Open book (topics and references provided in advance);</li> <li>• Individual questions are untimed (with 2 weeks to complete); and</li> <li>• Immediate feedback and results (two opportunities to answer a question correctly).</li> </ul>
<p><b>Thoracic Surgery (ABTS)</b> <a href="http://abts.org">abts.org</a></p>	<p><b>Part III:</b> Remote, secure, computer-based exams can be taken any time 24/7 that the physician chooses during the assigned 2-month period (September-October) from their home or office. Diplomates must pass the exam once every 10 years.</p>	<p><b>Part IV:</b> The ABS allows multiple options for registry participation, including individualized registries, to meet IMP requirements.</p>

	<p>Modular exam, based on specialty, and presented in a self-assessment format with critiques and resources made available to diplomates.</p>	
	<p><b>Part IV<sup>2</sup>:</b>                  ABTS diplomates must complete at least one practice quality improvement project within 2 years, prior to their 5-year and 10-year milestones. There are several pathways by which diplomates may meet these requirements: individual, group or institutional.</p>	<p><b>Part IV<sup>3-4</sup>:</b></p>
<p><b>Urology (ABU)</b>  <a href="http://abu.org">abu.org</a></p>	<p><b>Part III:</b>                  Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.</p> <p>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.</p> <p>Diplomates required to take the 40-question core module on general urology, and choose one of four 35-question content specific modules.</p> <p>ABU provides increased feedback to reinforce areas of knowledge deficiency.</p>	<p><b>Part III:</b>                  The knowledge assessment portion of the lifelong learning program will not be used as a primary single metric that influences certificate status but rather to help the diplomate to identify those areas of strength versus weakness in their medical knowledge (knowledge that is pertinent to their practice). To that end ABU will continue the modular format for the lifelong learning knowledge assessment.</p> <p>The knowledge assessment will be based on criterion referencing, thus allowing the identification of two groups, those who unconditionally pass the knowledge assessment and those who are given a conditional pass. The group getting a conditional pass will consist of those individuals who score in the band of one standard error of measurement above the pass point down to the lowest score. That group would be required to complete additional CME in the areas where they demonstrate low scores. After completion of the designated CME activity, they would continue in the lifelong learning process and the condition of their pass would be lifted.</p>
	<p><b>Part IV<sup>2</sup>:</b>                  Completion of Practice Assessment Protocols.</p> <p>ABU uses diplomate practice logs and diplomate billing code information to identify areas for potential performance or QI.</p>	<p><b>Part I<sup>3-4</sup>:</b>                  ABU allows credit for registry participation (i.e., participation in the MUSIC registry in Michigan, and the AUA AQUA registry).</p> <p>Another avenue to receive credit is participation in the ABMS multi-specialty portfolio program (this is more likely to be used by Diplomates who are part of a large health system,</p>

		e.g. Kaiser, or those in academic practices).
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\* The information in this table is sourced from ABMS Member Board websites and is current as of January 15, 2019.

<sup>1</sup> Utilizing CertLink™, an ABMS web-based platform that leverages smart mobile technology to support the design, delivery, and evaluation of longitudinal assessment programs, some of which launched in 2017-2018. More information is available at: [abms.org/news-events/american-board-of-medical-specialties-announces-development-of-new-web-based-platform/](https://www.abms.org/news-events/american-board-of-medical-specialties-announces-development-of-new-web-based-platform/) (accessed 1-2-19).

<sup>2</sup> Participates in the ABMS Portfolio Program.

<sup>3</sup> Improving alignment between national value-based reporting requirements and continuing certification programs.

<sup>4</sup> Aligning MOC activities with physician well-being, public health initiatives, and national quality strategies via the ABMS MOC Directory.

APPENDIX G

Alternative Pathways to Board Recertification\*

Recertification Program	Recertification Requirements	Exceptions
<p><b>American Board of Medical Specialties (ABMS) Maintenance of Certification (MOC)</b></p> <p>The ABMS (abms.org), founded in 1933 as the Federation of Independent Specialty Boards, bases its certification on collective standards of training, experience, and ethical behavior. Each of the ABMS member boards develops its specific standards for certification, and together they certify more than 880,000 allopathic and osteopathic physicians in 40 primary specialties and 85 subspecialties. The wide-scale use of ABMS board certification is reflected in both training and delivery systems, and based on core competencies developed and adopted by the ABMS and the Accreditation Council for Graduate Medical Education (ACGME): practice-based learning and improvement, patient care and procedural skills, systems-based practice, medical knowledge, interpersonal and communication skills, and professionalism.</p>	<p>The continuing board certification requirements differ among the ABMS member boards; however, at minimum, to be eligible for recertification, diplomates must meet the standards in each of these areas:</p> <ul style="list-style-type: none"> <li>• Part I: Professionalism and Professional Standing (maintain a valid, unrestricted medical license)</li> <li>• Part II: Lifelong Learning and Self-Assessment (complete a minimum of 25 continuing medical education [CME] credits per year [averaged over 2 to 5 years])</li> <li>• Part III: Assessment of Knowledge, Judgment, and Skills (pass a secure examination to assess cognitive skills at periodic intervals)</li> <li>• Part IV: Improvement in Medical Practice (participate in practice assessment and quality improvement every 2 to 5 years)</li> </ul>	<p>Diplomates with lifetime (grandfathered) certification are not required to participate in the ABMS MOC program.</p>
<p><b>American Osteopathic Association (AOA) Osteopathic Continuous Certification (OCC)</b></p> <p>The AOA Bureau of Osteopathic Specialists (AOA-BOS) (<a href="http://osteopathic.org/inside-aoa/development/aoa-board-certification/Pages/bos-history.aspx">osteopathic.org/inside-aoa/development/aoa-board-certification/Pages/bos-history.aspx</a>) 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 and recertification in numerous specialties and subspecialties. As of December 31, 2007, 31,762 physicians were certified by the AOA, and 1,357 diplomates completed OCC.</p>	<p>Osteopathic physicians who hold a time-limited certificate are required to participate in the following five components of OCC to maintain osteopathic board certification:</p> <ul style="list-style-type: none"> <li>• Component 1 - Active Licensure (maintain a valid, active license to practice medicine in one of the 50 states, and adhere to the AOA's Code of Ethics)</li> <li>• Component 2 – Life Long Learning/CME (fulfill a minimum of 120 - 150 hours of CME credit during each 3-year CME cycle)</li> <li>• Component 3 - Cognitive Assessment (pass one, or more, proctored examinations to assess specialty medical knowledge and core competencies in the provision of health care)</li> <li>• Component 4 - Practice Performance Assessment and Improvement (engage in continuous quality improvement through comparison of personal practice performance measured against national standards for the physician's medical specialty)</li> <li>• Component 5 - Continuous AOA Membership</li> </ul>	<p>Osteopathic physicians who hold non-time-limited (non-expiring) certificates are not required to participate in OCC. To maintain their certification, they must continue to meet licensure, membership, and CME requirements (120-150 credits every three-year CME cycle, 30 of which are in AOA CME Category 1A).</p>

<p><b>American Board of Physician Specialties (ABPS)</b></p> <p>ABPS (abpsus.org) is a multi-specialty board certifying body of the American Association of Physician Specialists (AAPS), Inc., which was founded by surgeons in 1950. The member boards of the ABPS offer specialty certification examinations for qualified allopathic and osteopathic physicians. The ABPS is governed by a board of directors and chief executive officer, who oversee eligibility requirements and testing standards. The 12-member boards of the ABPS offer certification in 18 specialties. To achieve recertification, an ABPS board certified physician must participate in a regular schedule of maintenance and enhancement of competency (MAEC) in his or her specialty.</p>	<p>The eligibility requirements for recertification differ among the ABPS member boards; however, at minimum, the boards require that physicians meet the following MAEC requirements every 8 years:</p> <ul style="list-style-type: none"> <li>• Maintain a full and unrestricted license in every state where he or she practices</li> <li>• Complete a non-remedial medical ethics program</li> <li>• Complete 400 CME hours during the 8-year cycle, and must have had at least an average of 25 CME hours per year in his or her specialty (also, an average of 50 questions of self-assessment CME examinations [as approved by the physician’s certifying board] must be completed annually until the final year of the 8-year cycle.)</li> <li>• Pass a 100-question, securely administered, written examination in the final year of the 8-year cycle</li> </ul>	<p>Physician recertification through the ABMS and the AOA-BOS does not preclude practicing physicians who qualify from seeking recertification through the ABPS. Many of the ABPS Diplomates in leadership positions are dual-certified through the ABPS and either the ABMS or AOA-BOS.</p>
<p><b>National Board of Physicians and Surgeons (NBPAS)</b></p> <p>The NBPAS (nbpas.org) offers a two-year recertification program in all current ABMS specialties for physicians (MDs and DOs) who meet its criteria. The NBPAS has more than 6,000 participants, and is working to gain acceptance by hospitals and payers. As of January 1, 2018, 70 hospitals (credentials committees, medical executive committees and/or hospital boards) had voted to accept the NBPAS as an alternative to ABMS recertification.</p>	<p>To be eligible for NBPAS recertification, candidates must meet the following criteria:</p> <ul style="list-style-type: none"> <li>• Previous certification by ABMS/AOA member board</li> <li>• Valid medical license (hold a valid, unrestricted license to practice medicine in at least one U.S. state; candidates who only hold a license outside of the U.S. must provide evidence of an unrestricted license from a valid non-U.S. licensing body)</li> <li>• Submission of CME credits (complete a minimum of 50 hours of CME within the past 24 months; CME must be related to one or more of the specialties in which the candidate is applying; and re-entry for physicians with lapsed certification requires 100 hours of CME within the past 24 months)</li> <li>• Active hospital privileges (for some specialties, i.e., interventional cardiology, electrophysiology, surgical specialties, must have active privileges to practice that specialty in at least one U.S. hospital licensed by a nationally recognized credentialing organization with authority from the Centers for Medicare &amp; Medicaid Services (CMS), i.e., The Joint Commission, Healthcare Facilities Accreditation Program, and DNV [Det Norske Veritas] Healthcare)</li> <li>• Medical staff appointment/membership (a candidate who has had their medical staff appointment/ membership or clinical privileges in the specialty for which they are seeking certification involuntarily revoked and not reinstated, must have subsequently maintained medical staff appointment/membership or clinical</li> </ul>	<p>Physicians in or within two years of training are exempt from CME requirements.</p> <p>Physicians who are grandfathered and whose certification has not, by definition, expired must have completed at least 50 hours (not 100 hours) of CME in the past 24 months.</p>

	<p>privileges for at least 24 months in another U.S. hospital licensed by a nationally recognized credentialing organization with authority from CMS [as listed above])</p>	
<p><b>American Board of Facial Plastic and Reconstructive Surgery (ABFPRS)</b></p> <p>The ABFPRS (<a href="http://abfprs.org">abfprs.org</a>) was established in 1986 to improve the quality of medical and surgical treatment available to the public by examining for professional expertise in facial plastic and reconstructive surgery. Since January 2001, the certificates issued by the ABFPRS been valid for 10 years only. Diplomates who were certified since then and who want to maintain their certification must participate in the ABFPRS Maintenance of Certification in Facial Plastic and Reconstructive Surgery® (MOC in FPRS®) program. As of January 2019, the total number of active ABFPRS diplomates was 1,353 and of these 333 diplomates have completed the MOC in FPRS requirements.</p>	<p>ABFPRS recertification has four components. To be eligible for recertification, diplomates must meet standards in each of these four areas:</p> <ol style="list-style-type: none"> <li>1. Professional Standing: <ul style="list-style-type: none"> <li>• Previous certification by the ABFPRS, American Board of Otolaryngology, American Board of Plastic Surgery or Royal College of Physicians and Surgeons of Canada in otolaryngology/head-and-neck surgery or plastic surgery</li> <li>• An unrestricted U.S. or Canadian medical license</li> <li>• Acceptable responses to a questionnaire regarding past or pending adverse actions</li> <li>• Satisfactory status with the Federation of State Medical Boards and the National Practitioners Data Bank</li> <li>• Documentation of privileges to practice facial plastic surgery in an accredited institution(s) or facility</li> <li>• Compliance with the ABFPRS Code of Ethics</li> </ul> </li> <li>2. CME: <ul style="list-style-type: none"> <li>Complete 50 hours of CME during the 2 years preceding recertification</li> </ul> </li> <li>3. Cognitive Expertise: <ul style="list-style-type: none"> <li>Pass proctored written and oral examinations</li> </ul> </li> <li>4. Practice Performance: <ul style="list-style-type: none"> <li>Submit a 12-month sequential operative log of eligible procedures performed during the year preceding submission of an application, with a minimum of 50 procedures, and operative reports for the last 35 sequential cases on the operative log</li> </ul> </li> </ol>	
<p><b>American Board of Cosmetic Surgery (ABCS)</b></p> <p>The ABCS (<a href="http://americanboardcosmeticsurgery.org">americanboardcosmeticsurgery.org</a>), established in 1979, offers board certification exclusively in cosmetic surgery to qualifying surgeons. As of January 4, 2019, approximately 350 surgeons were certified by the ABCS. ABCS certification is valid for 10 years. All ABCS diplomates must be re-examined and complete all recertification requirements prior to completion of their 10th year of certification.</p>	<p>To be eligible for recertification, a surgeon must:</p> <ul style="list-style-type: none"> <li>• Hold at least one board certificate, recognized by the ABMS or the equivalent from the AOA, Royal College of Physicians and Surgeons of Canada, or American Board of Oral &amp; Maxillofacial Surgery, in one of nine medical specialties related to cosmetic surgery</li> <li>• Maintain an unrestricted medical license</li> <li>• Complete 75 hours of CME during the immediate 3-years preceding recertification</li> <li>• Pass a comprehensive written exam</li> <li>• Demonstrate a high level of patient satisfaction based on surveys</li> </ul>	

\* The information in this table is sourced from the noted recertification program websites and is current as of January 15, 2019.

## APPENDIX H

### Recommended Changes to HOD Policies Related to Maintenance of Certification and Osteopathic Continuous Certification

#### H-275.924, ~~Maintenance of Certification~~ Continuing Board Certification

#### AMA Principles on ~~Maintenance of Certification~~ Continuing Board Certification (MOCCBC)

1. Changes in specialty-board certification requirements for MOCCBC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOCCBC must be reasonable and take into consideration the time needed to develop the proper MOCCBC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOCCBC 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 MOCCBC 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. MOCCBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOCCBC 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 MOCCBC 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 MOCCBC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOCCBC 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 MOCCBC Part II. The content of CME and self-assessment programs receiving credit for MOCCBC 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 MOCCBC 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. MOCCBC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOCCBC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. MOCCBC 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 MOCCBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. MOCCBC should be used as a tool for continuous improvement.
15. The MOCCBC 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 MOCCBC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. MOCCBC activities and measurement should be relevant to clinical practice.
19. The MOCCBC process should be reflective of and consistent with the cost of development and administration of the MOCCBC 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 MOCCBC.
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 MOCCBC.
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~~ Continuing Board Certification from their specialty boards. Value in MOCCBC should include cost effectiveness with full financial transparency, respect for physicians time and their patient care commitments, alignment of MOCCBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOCCBC 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~~Continuing Board Certification

Our AMA will:

1. Continue to monitor the evolution of ~~Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC)~~Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for ~~MOCCBC~~, and prepare a yearly report to the House of Delegates regarding the ~~MOC and OCC~~CBC 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~~CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of ~~MOCCBC~~, and encourage the ABMS to report its research findings on the issues surrounding certification and ~~MOCCBC~~ 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 ~~MOCCBC~~.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of ~~MOCCBC~~, 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 ~~MOCCBC~~ uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that ~~MOCCBC~~ 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 ~~MOCCBC~~ 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 ~~MOCCBC~~ and certifying examinations.
10. Encourage the ABMS to ensure that ~~MOCCBC~~ 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 ~~MOCCBC~~ on physicians with multiple board certifications, particularly to ensure that ~~MOCCBC~~ 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 ~~MOCCBC~~; (b) support ABMS member board activities in facilitating the use of ~~MOCCBC~~ quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQR 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 ~~MOCCBC~~ 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 ~~MOCCBC~~ 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 MOCCBC 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 OCCBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOCCBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOCCBC.
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 MOCCBC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOCCBC 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 MOCCBC process be required to participate in MOCCBC.
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 MOCCBC.
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 MOCCBC 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 MOCCBC 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/Continuing Board 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/continuing board 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~~Continuing Board 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~~continuing board 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~~CBC Part IV.

36. 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.

37. 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.

38. (a) Submit commentary to the American Board of Medical Specialties (ABMS) Continuing Board Certification: Vision for the Future initiative, asking that junior diplomates be given equal opportunity to serve on ABMS and its member boards; and (b) work with the ABMS and member boards to encourage the inclusion of younger physicians on the ABMS and its member boards.

39. Continue studying the certifying bodies that compete with the American Board of Medical Specialties and provide an update in the Council on Medical Education's annual report on maintenance of certification at the 2019 Annual Meeting.

(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 Appended: CME Rep. 02, A-18 Appended: Res. 320, A-18 Appended: Res. 957, I-18)

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