

REPORT OF THE BOARD OF DIRECTORS

Subject: Report of the Maintenance of Licensure Implementation Group

Background

In April 2010, the Federation of State Medical Boards (FSMB) House of Delegates (HOD) adopted the three recommendations contained in *Board Report 10-3: Maintenance of Licensure*:

1. Revise one of the principles for guiding future FSMB activities related to maintenance of licensure to read: Maintenance of licensure should not compromise patient care or create barriers to physician practice.
2. Adopt as policy the maintenance of licensure framework and recommendations as proposed by the Advisory Group on Continued Competence of Licensed Physicians.
3. The FSMB continue pursuing the following scope of work and report back to the House of Delegates at the FY2011 annual business meeting:
 - Continue the work of the Maintenance of Licensure Implementation Workgroup to develop a template proposal for state medical boards' use in implementing Maintenance of Licensure and to identify potential challenges to implementation of MOL programs and propose possible solutions to overcome these challenges.
 - Conduct, collect and disseminate research on the evidence for the need for initiating an MOL program and the effects of such a program on patient care and physician practice; and
 - In collaboration with appropriate stakeholders, support/fund one or more pilot projects centering on issues relevant to MOL discussions.

The following provides an update on FSMB's continued work on Maintenance of Licensure over the past year as directed by the House of Delegates.

Maintenance of Licensure Implementation Group

The FSMB Maintenance of Licensure (MOL) Implementation Group was convened in January 2010 by then-FSMB Chair Martin Crane, MD, and charged to:

- Create a template proposal available to assist state medical boards in the implementation of an MOL program within and across their jurisdictions.
- Identify potential challenges to implementation of MOL programs and propose possible solutions to overcome these challenges.

Several members of FSMB's prior Maintenance of Licensure workgroup, the Advisory Group on Continued Competence of Licensed Physicians, agreed to serve on the MOL Implementation Group to ensure continuity in the discussions, including Steven J. Stack, MD, who served as Chair of the MOL Implementation Group. Kathleen Henrichs, PhD, of Henrichs & Associates, was hired to facilitate the group's work. The MOL Implementation Group met seven times from January 2010 through January 2011, including two in-person meetings and five conference calls, to complete its charge and develop a final report for presentation to the FSMB Board of Directors in February 2011.

In July 2010, the MOL Implementation Group presented a first draft of its report to the FSMB Board of Directors for review and comment. The Board of Directors' discussion and feedback on the draft report centered around issues such as reciprocity of MOL requirements between state boards; non-clinically active physicians; data needs around MOL; remediation opportunities for physicians; and physicians who fail to comply with MOL requirements. The Board's feedback was presented to the MOL Implementation Group at its September 9-10 meeting, as it considered further changes to the draft report and additional issues that needed to be addressed within the report prior to distribution to FSMB's member boards and other external stakeholders. Feedback from the CEO Advisory Council, established in spring 2010 to serve as an advisory body to the MOL Implementation Group (see additional details in "CEO Advisory Council" section below), was also provided to the MOL Implementation Group.

A revised copy of the Implementation Group's draft report was subsequently presented to the Board of Directors in October 2010. At that time, the Board of Directors 1) reviewed and revised the report and 2) subsequently approved the report for distribution to FSMB's member boards and other key stakeholders within the medical community for comment.

The draft report of the MOL Implementation Group was distributed via email in November 2010 to the state medical and osteopathic boards, followed by a first round of external stakeholders – e.g., American Medical Association (AMA), the American Osteopathic Association (AOA), American Osteopathic Association-Bureau of Osteopathic Specialists (AOA-BOS), American Board of Medical Specialties (ABMS), American Medical Colleges (AAMC), Accreditation Council for Continuing Medical Education (ACCME), Accreditation Council for Graduate Medical Education (ACGME), Council of Medical Specialty Societies (CMSS) and the public. The report was also distributed to a subsequent second-round of external stakeholders – e.g., ABMS/AOA-BOS member boards and state medical and osteopathic associations. The deadline for submitting feedback was December 31, 2010.

Additional feedback was solicited from FSMB's member boards via a Roundtable conference call in December 2010. During the call, questions were received regarding the evidence supporting continuing medical education (CME), the three individual components for MOL as set forth in the MOL framework, and minimal data sets for state boards to use to identify the clinical practice status of their licensees. Twenty state boards participated in the call, as well as members of the MOL Implementation Group. In addition, the CEO Advisory Council held a conference call in January 2011 to review and provide feedback on the draft report.

During the comment period, feedback was received on a variety of issues, including the impact of MOL on state boards and physicians, especially those not in active clinical practice; the role of AMBS' Maintenance of Certification (MOC) program and the AOA-BOS' Osteopathic Continuous Certification (OCC) in MOL; the evidence-base regarding CME; the need for consistency in MOL requirements across states; and the periodicity of the MOL requirements. The MOL Implementation Group held a final conference call in January 2011 to review the comments received on the draft report and to make additional revisions prior to presentation of a final report to the FSMB Board of Directors in February 2011.

Using the MOL framework and recommendations adopted by the FSMB House of Delegates in April 2010, the report is written to be consistent with the report of the FSMB Advisory Group on Continued Competence of Licensed Physicians but provides more detailed guidance to state boards as they develop and implement MOL. The report specifically contains eight recommendations:

- The entire MOL program should be implemented as expeditiously as possible with SMBs moving forward together. For practical reasons, some SMBs may institute MOL in a phased implementation. Regardless of the implementation approach, all SMBs should complete the implementation process within a 10 year period.
- MOL Component One (Reflective Self-assessment): State medical and osteopathic boards should require each licensee to complete certified and/or accredited Continuing Medical Education (CME), a majority of which is practice-relevant and supports performance improvement.
- MOL Component Two (Assessment of Knowledge and Skills): State medical and osteopathic boards should require licensees to undertake objective knowledge and skills assessments to identify learning opportunities and guide improvement activities.

Component Two activities should meet all of the following criteria:

- 1) be developed by an objective third-party with demonstrated expertise in these activities;
 - 2) be a structured, validated and consistently reproducible tool/activity;
 - 3) be credible with the public and profession;
 - 4) provide meaningful assessment feedback to the physician licensee appropriate to the scope of the activity to guide subsequent education; and
 - 5) provide formal documentation that describes both the nature of the activity (i.e., content and areas assessed) and successful completion of the activity as designed.
- MOL Component Three (Performance in Practice): State medical and osteopathic boards should require licensees to use comparative data and, when available, evolving performance expectations to assess the quality of care they provide and then apply best evidence or consensus recommendations to improve and subsequently reassess their care.
 - State medical and osteopathic boards should require each licensee to complete a minimum Component One activity on an annualized basis, as defined by the SMBs, a majority of which is devoted to practice-relevant CME that supports performance improvement, and to document completion of both one Component Two and one Component Three activity every five years.
 - State medical and osteopathic boards should consider physicians who provide evidence of successful ongoing participation in ABMS Maintenance of Certification (MOC) or AOA-BOS Osteopathic Continuous Certification (OCC) to have fulfilled all three components of MOL.
 - State medical and osteopathic boards should regularly collect data from individual licensees about the extent of their engagement in direct patient care and the nature of their daily professional work.
 - State medical and osteopathic boards should strive for consistency in the creation and execution of MOL programs.

A copy of the *Report of the Maintenance of Licensure Implementation Group: A MOL Proposal Template* as approved by the FSMB Board of Directors in February 2011 is provided as **Attachment 1**.

CEO Advisory Council

In spring 2010, then-FSMB Chair Martin Crane, MD, convened a CEO Advisory Council comprising chief executive officers of a number of external stakeholder organizations to serve as an advisory body to the FSMB MOL Implementation Group and to discuss other issues and work related to the Maintenance of Licensure initiative, such as pilot implementation projects. The CEO Advisory Council currently consists of the chief executive officers or other executive staff of 14 organizations: American Association of Colleges of Osteopathic Medicine (AACOM), AAMC, ABMS, ACCME, ACGME, Administrators in Medicine (AIM), AMA, AOA, AOA-BOS, Citizen Advocacy Center (CAC), CMSS, Educational Commission for Foreign Medical Graduates (ECFMG), National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME). FSMB President and CEO, Humayun Chaudhry, DO, was appointed to serve as Chair of the Council.

The Advisory Council has held three conference calls (May 2010, August 2011 and January 2011), during which it reviewed and provided feedback on drafts of the MOL Implementation Group report. This feedback was subsequently shared with the MOL Implementation Group for consideration in revising and finalizing its report.

MOL Pilot Projects

The FSMB has begun the process of designing one or more pilot projects to test the feasibility of implementing the Maintenance of Licensure framework and recommendations approved by the FSMB House of Delegates in April 2010, as well as the further recommendations contained in the report of the MOL Implementation Group. Throughout 2010, approximately six boards expressed interest in participating in pilot projects. In early 2011 FSMB sent a communication to all of its member boards about the pilot projects to confirm interest from these boards and to determine the level of interest from additional boards. The FSMB will use the feedback from this communication to develop a final “roster” of boards to participate in the pilot projects, which are anticipated to begin implementation in late 2011. Once underway, updates about the progress of the pilot projects will be posted in the MOL Information Center on the FSMB website. In the meantime, the FSMB is exploring opportunities for grant funding to support implementation of the pilot projects.

Communication Efforts

Over the past year, FSMB Board of Directors and staff have participated in a number of activities to communicate with its member boards, external stakeholders, the public and the practicing community about Maintenance of Licensure. In addition to distribution of the draft MOL Implementation Group report, these activities have included a revision of the MOL Information Center on the FSMB website; presentations to FSMB’s member boards; participation in and presentations at various national and international meetings; participation in radio programs; and communication through various other media outlets, both in electronic (e.g., web, blogs) and print (e.g., journals) format. FSMB also retained the services of Paul Larson of

Paul Larson Communications to assist with the development of key messages and media opportunities for MOL.

Highlights from FSMB's communication efforts are provided below. A detailed listing of FSMB's communication efforts over the past year, including a list of presentations to FSMB's member boards and external stakeholders, is provided as **Attachment 2**.

MOL Information Center: In May 2010, the MOL Information Center on the FSMB was redesigned to focus more on FSMB's current efforts on MOL. Background information (e.g., prior MOL reports), FAQs and a May 2010 press release announcing the House of Delegates' adoption of a Maintenance of Licensure framework and recommendations were posted to the MOL Information Center. Subsequently, a new, updated version of the MOL FAQs and a set of MOL "Fast Facts," developed by FSMB staff in consultation with Paul Larson, were also posted. The MOL Information Center is accessible from the homepage of the FSMB website and at: <http://www.fsmb.org/mol.html>.

MOL Background Paper: In July 2010, the FSMB Board of Directors approved a background paper on the history of the MOL initiative. The paper was posted on the homepage of the FSMB's website and was subsequently published in the October 2010 edition of FSMB's *Journal of Medical Regulation* (see **Attachment 3**).

MOL and Electronic Health Records (EHRs): On August 5, 2010, FSMB President and CEO, Humayun Chaudhry, DO, participated in the "Advancing Electronic Health Records Adoption and Meaningful Use" forum hosted by the Health Industry Forum of Brandeis University and *Health Affairs*. During the forum, FSMB announced that it recognizes that the widespread adoption of electronic health records could be used by doctors to improve patient outcomes and to assess ongoing clinical competence for purposes of medical licensure, in particular for Maintenance of Licensure.

As part of the meeting, *Health Affairs* also posted a "blog" about advancing EHR adoption and meaningful use, in which participants in the meeting, including FSMB, ABMS and others, posted additional information about their event presentations. The FSMB's posting included information about MOL, FSMB and the role of state medical and osteopathic boards. A copy of the blog is available at:

<http://healthaffairs.org/blog/2010/08/05/advancing-electronic-health-record-adoption-and-meaningful-use/>

A news release issued by FSMB regarding its announcement at the meeting is available via the MOL Information Center on the FSMB website.

IAMRA 9th International Conference on Medical Regulation: On September 26-29, 2010, the FSMB, in conjunction with the NBME and the ECFMG, hosted the International Association of Medical Regulatory Authorities (IAMRA) International Conference in Philadelphia, Pennsylvania. The FSMB Executive Committee and senior staff participated in the meeting, and FSMB President and CEO, Humayun Chaudhry, DO, served as Moderator for the Opening Session. The conference featured a series of small group work sessions focused on developing

best practices in three critical content areas of medical regulation: Registration/Licensure, Complaints and Resolutions, and Quality Assurance (Currency of Competence/MOL). Over 220 medical regulators and educators and others from more than 90 organizations in 32 countries registered for the conference.

International Revalidation Symposium: On December 2-3, 2010, the FSMB, in conjunction with the General Medical Council of the United Kingdom and The Health Foundation (also based in the UK), hosted the International Revalidation Symposium in London. FSMB representatives at the meeting were: Freda Bush, MD (Chair); Martin Crane, MD (Immediate Past Chair); Humayun Chaudhry, DO (President and CEO); Steven J. Stack, MD (Chair, MOL Implementation Group); and Frances Cain (Director, Post-Licensure Services). The meeting was convened as an opportunity for representatives from medical and regulatory agencies across the world to learn about and discuss the various international Maintenance of Licensure (or “Revalidation”) initiatives currently underway in various countries, the evidence base to support such efforts, the challenges of implementation and lessons learned. This was the first time such a meeting has been held. Representatives from the US, UK, Ireland, Canada, New Zealand, Australia, and the Netherlands attended the meeting.

During the meeting, FSMB Chair, Freda Bush, MD, provided an overview of FSMB’s MOL efforts to date and the recommendations from the MOL Implementation Group. At the conclusion of the meeting, it was agreed that it would be beneficial for this group to meet again in a few years, once current international MOL/Revalidation efforts are further underway, to share additional experiences, research, evidence and best practices.

MOL Administrative Organizational Structure

In July 2010, the FSMB Board of Directors approved the establishment of a budget-neutral administrative organizational structure to handle implementation of the different components of the MOL initiative, such as pilot projects and outreach. A formal proposal for such an administrative structure was presented to and approved by the FSMB Board of Directors in October 2010. The administrative structure comprises FSMB executive staff; senior staff from marketing and communications, public relations, and post-licensure services; and administrative support. The group meets regularly to discuss operational and implementation strategies to further FSMB’s ongoing MOL work and to remain informed about the status of work currently underway. Regular reports on staff’s work are provided as part of the MOL update to the FSMB Board of Directors at their quarterly meetings.

RECOMMENDATION:

For information only.



**Report from the Maintenance of Licensure
Implementation Group**

**A companion report to the
Advisory Group on Continued Competence of Licensed Physicians
Report on FSMB Maintenance of Licensure Initiative**

February 14, 2011

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**FEDERATION OF STATE MEDICAL BOARDS (FSMB)
REPORT OF THE MAINTENANCE OF LICENSURE
IMPLEMENTATION GROUP**

EXECUTIVE SUMMARY

The Maintenance of Licensure Implementation Group Report is a follow-up to the recommendations of the Report of the Advisory Group on Continued Competence of Licensed Physicians adopted by the FSMB House of Delegates in April 2010 (Attachment A). Together, these reports advance the Federation of State Medical Boards' (FSMB) policy that state boards have a responsibility to the public to ensure the ongoing competence of physicians seeking license renewal. This Implementation Group Report provides more detailed guidance to FSMB's state member boards (SMBs) as they design and implement Maintenance of Licensure (MOL) programs.

Overall Goal of Maintenance of Licensure

When MOL is fully implemented nationwide, it is anticipated that all licensed physicians will be engaged in a culture of continuous quality improvement and lifelong learning assisted by objective data and resulting in significant and demonstrable actions, resulting in the improvement of patient care and physician practices.

This report offers recommendations for every state board to consider. It is built on the belief that the attached plan represents a rational and well-considered proposal to facilitate the engagement of physicians in a culture of continuous improvement and to assure the public, through a verifiable and reproducible system, that physicians are actively participating in such an effort. Additionally, we believe that MOL can be a proactive and reasonable expectation of physicians – an expectation that enables them to demonstrate their commitment to continual improvement without being overly burdensome or creating barriers to patient care or physician practice.

Establishing a Maintenance of Licensure Program

Maintenance of Licensure is a system of continuous professional development that requires all licensed physicians to demonstrate, as a condition of license renewal, their involvement in lifelong learning that is objective, relevant to practice and improves performance over time. The FSMB is committed to providing SMBs with guidance and support so that the entire community of state boards can move forward to fully implement Maintenance of Licensure within 10 years.

<p>Recommendation: The entire MOL program should be implemented as expeditiously as possible with SMBs moving forward together. For practical reasons, some SMBs may institute MOL in a phased implementation. Regardless of the implementation approach, all SMBs should complete the implementation process within a 10-year period.</p>

Lifelong Professional Improvement: Three Components

After a careful SMB preparation phase, all fully implemented MOL programs should have three components:

- MOL Component One: Reflective Self-assessment
- MOL Component Two: Assessment of Knowledge and Skills
- MOL Component Three: Performance in Practice

As part of their professional obligation, physicians engage in lifelong learning to maintain and improve their skills and to learn new and updated knowledge affecting their medical practices. Building on this long-standing professional commitment, Component One begins with the established CME system. Component One of MOL is designed to be the licensee's self-directed, but objectively verifiable, learning activity.

MOL Component One: Reflective Self-assessment

Recommendation: State member boards should require each licensee to complete certified and/or accredited Continuing Medical Education (CME), a majority of which is practice-relevant and supports performance improvement.

Component Two relies on objective or external knowledge and skills assessments to produce data to identify learning opportunities. Many types of external assessments are structured, valid and practice-relevant and can provide valuable individual and comparative data for physicians to use to maintain their skills and knowledge. A variety of external assessment options from which physicians can choose should be included in the implementation of MOL Component Two.

MOL Component Two: Assessment of Knowledge and Skills

Recommendation: State member boards should require licensees to undertake objective knowledge and skills assessments to identify learning opportunities and guide improvement activities.

Component Two activities should meet all of the following criteria:

- 1) be developed by an objective third-party with demonstrated expertise in these activities;
- 2) be structured, validated and consistently reproducible;
- 3) be credible with the public and profession;
- 4) provide meaningful assessment feedback to the licensee appropriate to the scope of the activity to guide subsequent education; and
- 5) provide formal documentation that describes both the nature of the activity (i.e., content and areas assessed) and successful completion of the activity as designed.

Component Three qualifying activities could include a variety of methods that incorporate reference data to assess physician performance in practice as a guide to improvement. In order to continually improve performance, physicians should use their practice data to evaluate outcome

variation both internally within their own practices as well as externally compared to their local and national peers when such data is available.

MOL Component Three: Performance in Practice

Recommendation: State member boards should require licensees to use comparative data and, when available, evolving performance expectations to assess the quality of care they provide and then apply best evidence or consensus recommendations to improve and subsequently reassess their care.

Periodicity Requirements

MOL is conceptualized as a multi-year cycle, with each Component being documented periodically. Regardless of the actual licensure cycle within each SMB jurisdiction, the goal of MOL is continuous, ongoing professional development. To facilitate license portability, SMBs should strive for consistency in the creation and execution of MOL programs.

Recommendation: State member boards should require each licensee to complete a minimum Component One activity on an annualized basis, a majority of which is devoted to practice-relevant CME that supports performance improvement; and to document completion of both one Component Two and one Component Three activity every five to six years.

Board Certification in the Context of MOL

MOL will enable SMBs to demonstrate that their physician licensees are actively engaged in a lifelong program of professional assessment and improvement. The American Board of Medical Specialties' (ABMS) Maintenance of Certification (MOC) program and the American Osteopathic Association Bureau of Osteopathic Specialists' (AOA-BOS) Osteopathic Continuous Certification (OCC) program are similar to MOL, although by no means identical in purpose or design, in that they each demonstrate a commitment on behalf of a physician to lifelong learning and self-assessment through a variety of approaches. Ongoing successful participation in ABMS MOC or AOA-BOS OCC should fulfill all three components of MOL; it is understood that maintenance of board certification and maintenance of licensure program elements and periodicity will not correspond directly.

Along with the three MOL Components, SMBs will have additional requirements for license renewal that are mandated by state law. These may include payment of a licensure fee and submission of demographic data. The MOL Implementation Group desires to make clear its intention that ABMS MOC and AOA-BOS OCC, as comprehensive programs, fulfill all three components of MOL. MOL represents an important advance in medical regulation and licensure as a means to shift the profession to a culture of objective and continuous improvement in a constructive and verifiable manner.

Recommendation: State member boards should consider physicians who provide evidence of successful ongoing participation in ABMS Maintenance of Certification (MOC) or AOA-BOS Osteopathic Continuous Certification (OCC) to have fulfilled all three components of MOL.

Need For More Information about Physician Practices

Two aspects of physician practice are particularly challenging within the MOL paradigm: 1) actual clinical practice versus specialty training/designation and 2) physicians not involved in direct patient care. In both instances, there is little data about individual licensees and their types of practices and the nature of those practices. Further study and consideration is necessary in these two areas.

Recommendation: State member boards should regularly collect data from individual licensees about the extent of their engagement in direct patient care and the nature of their daily professional work.

Consistency across Jurisdictions

One of the key issues identified in discussions with SMBs and other stakeholders has been the desire for uniform implementation across states. Recognizing the differences in resources, statutes and operations across states and acknowledging that implementation of MOL should be within the discretion and purview of each SMB, this MOL program is designed to be flexible. At the same time, physicians are concerned about an overly burdensome MOL program where they might have to meet varying and confusing criteria to maintain licensure in different states. Widely divergent standards from state to state may hinder physician mobility and thus impact patient care.

Recommendation: State member boards should strive for consistency in the creation and execution of MOL programs.

Role of FSMB

The FSMB will continue to support its member boards as they undertake the implementation of Maintenance of Licensure across their jurisdictions. As part of these efforts, the FSMB will engage in activities such as the development of a “Toolbox” of resources to assist SMBs and physicians in navigating the MOL landscape, including further exploration and explanation of potential tools that physicians could use to comply with MOL requirements; assistance, when necessary, with development of model statutory language to enable a board to implement MOL; and clear and consistent communication with SMBs and the broader medical community regarding MOL.

The FSMB also remains committed to the continued refinement of these recommendations to best support and serve its membership in the development, implementation and maintenance of MOL programs that, we believe, will have a positive impact on patient care and physician practice.

Future Directions

Maintenance of Licensure will be an evolving program and will take time and attention to be fully realized nationwide. During that time, the Implementation Group recommends that FSMB continue to serve as a “center” for MOL development and implementation and, as a part of this role, lead an organized effort to encourage states to share with each other what is working and what may need improvement in order to define best practices for all MOL programs.

**FEDERATION OF STATE MEDICAL BOARDS (FSMB)
MAINTENANCE OF LICENSURE
IMPLEMENTATION GROUP**

FINAL REPORT

PREAMBLE

This report is a follow-up to the recommendations in the Report of the Advisory Group on Continued Competence of Licensed Physicians adopted by the FSMB House of Delegates (HOD) in April 2010 (Attachment A). This Report is intended to provide more detailed guidance to FSMB's state member boards (collectively referred to as SMBs throughout this report) as they consider implementation of Maintenance of Licensure (MOL) programs. We are indebted to Dr. J. Lee Dockery, Chair of the Advisory Group, and his team of experts who provided an excellent basis for this report.

The Maintenance of Licensure Implementation Group acts in support of FSMB policy stating that state boards have an obligation to assure the public of the ongoing competence of physicians seeking license renewal. We have developed the recommendations that follow to enable state boards to implement MOL programs that are consistent with FSMB policy.

There is concern within the United States regarding the high costs of medical care, variation in medical practice, lapses in quality resulting in potentially preventable medical harm, and health care disparities. Additionally, the Implementation Group is well aware of the historic and sweeping changes in our nation's health system as a result of the Patient Protection and Affordable Care Act of 2010 (PL 111-148 & PL 111-152). We recognize that physicians practice within this complex environment and that in order to be successful, a comprehensive approach to health reform is necessary. In this context, we believe the plan presented below represents a rational and well-considered proposal to facilitate the engagement of physicians in a culture of continuous improvement and to assure the public, through a verifiable and reproducible system, that physicians are active in such an effort. We also hope that this can serve as a model for other health care professions as they look at developing their own continuous improvement processes.

Although we recognize MOL presents some challenges to state boards and physicians, we believe these can be overcome through good program design, a compelling rationale, strong leadership and resources. Several states are anticipating MOL and are eager for FSMB guidance. Additionally, we believe that MOL can be a proactive and reasonable expectation of physicians – an expectation that enables them to demonstrate their commitment to continual improvement without being overly burdensome or creating barriers to patient care or physician practice.

We encourage SMBs to implement MOL expeditiously. Even the voluntary specialty board maintenance of certification process, though, has taken nearly a decade to execute and is still evolving. Moreover, MOL has numerous additional challenges not faced by specialty certifying boards in that it:

- 1) will impact every licensed physician in the United States;
- 2) must reasonably address a more heterogeneous physician population;
- 3) relies upon financial resources and support that are in short supply at this time; and
- 4) is subject to variable state laws and regulations that may require medical practice act amendments.

Thus, while we acknowledge the frustration some have voiced regarding the pace at which MOL is likely to be adopted, we have consciously maintained our focus on the deliberate design and patient execution of a meaningful system of MOL that will serve the public good and that will have the ability to adapt to changing circumstances as needed over time.

MOL will evolve as the science and tools of practice assessment and improvement evolve. The ultimate goals are to:

- 1) engage physicians in a culture of lifelong learning and practice improvement; and
- 2) demonstrate physicians' effort and success in measurably improving their patient care processes and outcomes.

The FSMB will provide SMBs guidance and support so that the entire community of state boards can move forward to fully implement MOL within 10 years. Although SMBs will each have different starting points and will establish varying timeframes for implementation, if they begin now and work diligently, most will be on the road to meaningfully assuring the public of ongoing physician engagement in lifelong learning and performance improvement through this new licensure paradigm.

WHAT IS MAINTENANCE OF LICENSURE?

Maintenance of Licensure is a system of continuous professional development that requires all licensed physicians to demonstrate, as a condition of license renewal, their involvement in lifelong learning that is objective, relevant to practice and improves care.

We believe SMBs should require, as a condition of license renewal, that all licensed physicians periodically demonstrate their engagement in an ongoing culture of professional assessment and continuous improvement throughout their careers.

PHASED APPROACH

Recommendation: The entire MOL program should be implemented as expeditiously as possible with SMBs moving forward together. For practical reasons, some SMBs may institute MOL in a phased implementation. Regardless of the implementation approach, all SMBs should complete the implementation process within a 10-year period.

Many SMBs and their licensees may best undertake the MOL implementation process in a phased and evolutionary approach. In this regard, the efforts of the American Board of Medical

Specialties (ABMS) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) in their continuous certification efforts are illustrative, as these programs have been and are still being developed, implemented and revised over an extended period of time. The evolution to a process of continual licensure is a substantial paradigm shift, no less substantial than the Flexner report was to undergraduate medical education a century ago, and is deserving of reasonable time and attention.

As a starting point, if SMBs follow the guidance in this report, then nearly half of U.S. physicians already fulfill the intent of MOL through their participation in ABMS and AOA-BOS continuous certification programs. Ongoing successful participation in ABMS MOC or AOA-BOS OCC should fulfill all three components of MOL; it is understood that maintenance of board certification and maintenance of licensure program elements and periodicity will not correspond directly.

Additionally, this Implementation Group knows that some states may be ready, willing and able to move more quickly than proposed below. In these jurisdictions, MOL may be implemented in an accelerated manner.

The Implementation Group also notes that the state licensure system in the U.S. is complex, with varying financial and staff resources as well as oversight by state legislative and executive branches. As a result of this state-to-state variation, MOL implementation will require differing amounts of time and effort due to influences beyond the direct control of SMBs. For this reason, the Implementation Group stresses the urgency for SMBs to begin immediately in order to allow sufficient time for SMBs to adequately address those issues that they can influence.

We suggest a pragmatic approach in which SMBs implement each component in a phased approach over time. SMBs that want to expedite this process are encouraged to do so. Regardless of the actual implementation timeline, however, fully executed MOL programs will include all three components and may be staged as follows:

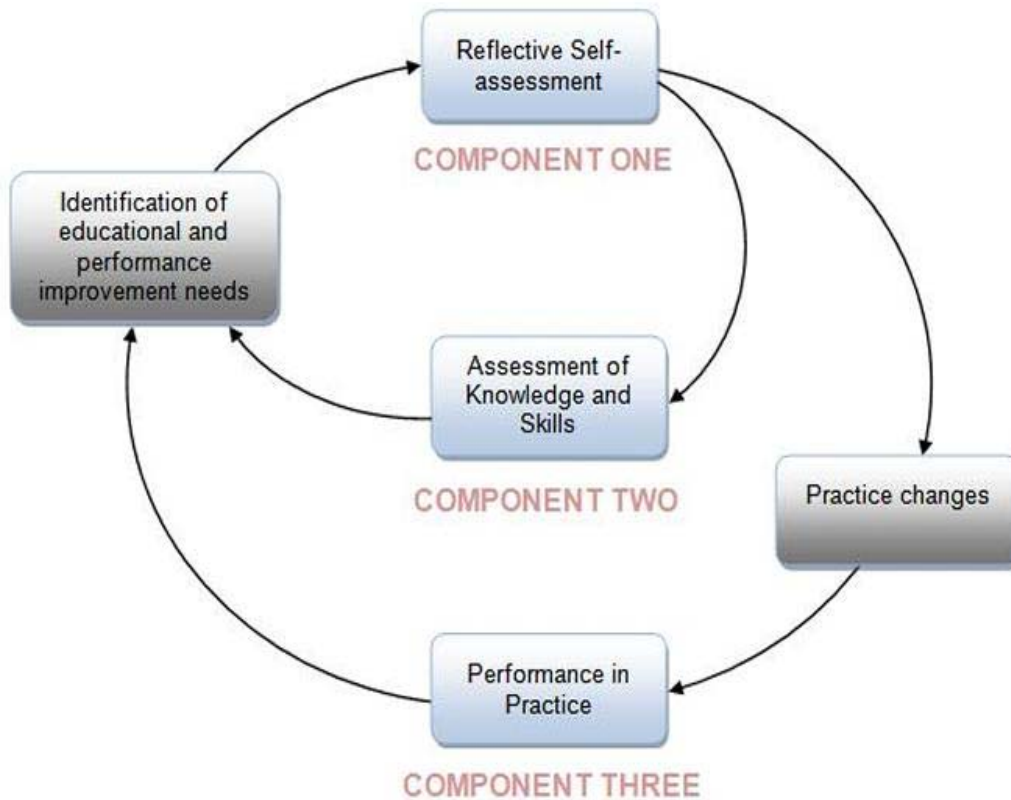
Preparation – SMB readiness assessment, preparatory steps, initial communication to licensed physicians, involvement of stakeholders

Component One – Require Reflective Self-assessment demonstrated by certified and/or accredited CME

Component Two – Require Assessment of Knowledge and Skills

Component Three – Require Measurement of Performance in Practice

The diagram below demonstrates how the MOL components reinforce each other to advance the overarching goal of improving physician performance in clinical practice. Once MOL is fully implemented by an SMB, all licensed physicians will be expected to comply with the entire MOL program as designed. Attachment B provides examples of the types of activities that SMBs could consider as they implement each component.



Preparation

State member boards may want to undertake a readiness assessment when they begin an MOL program within their jurisdiction to:

- 1) communicate with licensees, training programs and medical schools about the MOL changes, available support resources and suggested preparations;
- 2) review their medical practice act, policies, rules and regulations to identify any modifications required to enable the SMB to implement MOL in the short and longer term; anticipate any legal or legislative opportunities or challenges;
- 3) take inventory of SMB financial and staff resources and make any changes possible to align them with the final scope and design of the SMB's MOL program;
- 4) review and make use of the FSMB "MOL Toolbox" that will consist of practical guidance, assistance and resources;
- 5) evaluate data needs and determine if additional physician demographic and practice data will be collected at the state level or secured from a third party repository (as available);

- 6) make concrete decisions on program design and determine which activities will be deemed approved by the SMB as meeting MOL requirements (see examples in Attachment B);
- 7) determine the manner of verification of licensee participation in each component of MOL (e.g. physician attestation with verifying audit of a defined percentage of licensees each license cycle, electronic/automated reporting of compliance with certain elements, 3rd party attestation, etc.);
- 8) meet with legislators, state medical and osteopathic societies, the physician community, the public and other key stakeholders to explain MOL changes and to discuss the impact of MOL on physicians and the public;
- 9) revise the license renewal application as needed to collect information about licensees' scope of practice and practice status; and
- 10) evaluate "types" of licenses available and whether additional license categories need to be created to accommodate licensees' expected participation in MOL. As part of this evaluation, SMBs are encouraged to consider, in particular, licensees not involved in direct patient care, including any fiscal or other impact to the SMB.

MOL Component One: Reflective Self-assessment

Recommendation: State member boards should require each licensee to complete certified and/or accredited Continuing Medical Education (CME), a majority of which is practice-relevant and supports performance improvement.

As part of their professional obligation, physicians commit to ongoing lifelong learning to maintain their skills and to learn new and updated knowledge affecting their medical practices. Building on this long-standing professional commitment, Component One begins with the established CME system. While we anticipate an evolution in the substance of Component One over time, by beginning with the established CME system we hope to:

- 1) demonstrate early success in MOL implementation to build momentum for MOL Components Two and Three;
- 2) build on the known and familiar to make best use of existing resources and to ease the transition to this new paradigm of continuous licensure; and
- 3) develop buy-in over time for even more effective professional development activities.

There is wide variability across SMBs, with existing CME requirements ranging from zero to 50 hours required per year. Additionally, physicians undertake a great deal of self-directed learning for which no formal CME credit is available or granted. We envision the continued evolution of CME into a more meaningful, effective and relevant experience that is not necessarily simultaneously more time-consuming or laborious.

As MOL implementation progresses, the assessment tools employed in Components Two and Three will provide more structured and objective identification of relative weaknesses in physician knowledge and/or skills that will, in turn, provide actionable information to guide the educational activities undertaken in Component One. Over time, we anticipate that SMBs may

also want to encourage Continuous Professional Development (CPD) activities that include a CME component integrated with self-directed learning moments sparked by clinical experiences or by attempts to monitor and improve one's clinical care.

For Component One, SMBs should qualify licensees who are actively involved in the Maintenance of Certification (MOC) program through the ABMS or the AOA-BOS Osteopathic Continuous Certification (OCC) program, since these programs incorporate activities generally consistent with the intentions of MOL. Such qualification would greatly reduce the administrative burden both for SMBs and for those physicians participating in ABMS MOC or AOA-BOS OCC.

Component One of MOL is designed to be the licensee's self-directed, but objectively verifiable, learning activity. Conversely, Component One is not designed to be a rigorous objective assessment tool; rather, the objective assessment elements of MOL are contained in Components Two and Three. This was done by conscious design, not oversight, and we remind the various parties interested in MOL that the program must be viewed as an integrated whole to fully appreciate its comprehensive approach to physician regulation through licensure.

MOL Component Two: Assessment of Knowledge and Skills

Recommendation: State member boards should require licensees to undertake objective knowledge and skills assessments to identify learning opportunities and guide improvement activities.

Component Two activities should meet all of the following criteria:

- 1) be developed by an objective third party with demonstrated expertise in these activities;**
- 2) be structured, validated, and consistently reproducible;**
- 3) be credible with the public and profession;**
- 4) provide meaningful assessment feedback to the licensee appropriate to the scope of the activity to guide subsequent education; and**
- 5) provide formal documentation that describes both nature of the activity (i.e., content and areas assessed) and successful completion of the activity as designed.**

By intentional design, formalized examinations are only one of many options that SMBs may want to adopt for MOL Component Two. Component Two relies on objective or external knowledge and skills assessments to produce data to identify learning opportunities. Many types of external assessment are structured, valid and practice-relevant. These external assessments can provide valuable individual and comparative data for physicians to evaluate their skills and knowledge. SMBs may want to concentrate their efforts on requesting physicians to document use of tools from objective third parties with demonstrated expertise in these activities to assess their own knowledge and skills. We would not expect that SMBs would have to develop external assessments, although this is a possibility if they so choose; rather, we envision that SMBs would accept objective assessments that met their licensure requirements.

Regardless of the SMB decision about requirements for Component Two, it is suggested that SMBs should qualify licensees who are actively involved in ABMS MOC or AOA-BOS OCC since these programs incorporate activities generally consistent with the intentions of MOL.

MOL Component Three: Performance in Practice

Recommendation: State member boards should require licensees to use comparative data and, when available, evolving performance expectations to assess the quality of care they provide and then apply best evidence or consensus recommendations to improve and subsequently reassess their care.

The last implementation phase of a fully realized MOL program focuses on Component Three – Performance in Practice. Qualifying activities could include a variety of methods that incorporate reference data to assess physician performance in practice as a guide to improvement. In order to continually improve performance, physicians should use their practice data to evaluate outcome variation both internally within their own practices as well as externally compared to their local and national peers when such data is available. Such information would be used to align their clinical practices with national recommendations. We recommend that SMBs consider the full range of ongoing high-quality practice improvement activities that are now being implemented by specialty and professional societies, certifying boards, hospitals, physician groups and quality improvement organizations (see Attachment B, pages 30-31).

Again, it is suggested that SMBs should qualify those licensees who are actively involved in ABMS MOC or AOA-BOS OCC since these programs incorporate activities generally consistent with the intentions of MOL.

Component Three of MOL will evolve with time. Increasingly robust use of health information technology will enable physicians to more easily and comprehensively understand the impact of their efforts on patient outcomes and to learn how their personal outcomes compare to those of fellow physicians. These developments could provide physicians with powerful and previously unavailable tools to learn from their own professional practice and to engage in a cycle of continuous quality improvement to the benefit of both patients and physicians. The ability for physicians to make use of real-time comparative practice data to guide their ongoing practice improvement holds remarkable potential to improve individual clinician performance in a constructive manner.

PERIODICITY OF MOL REQUIREMENTS

Recommendation: State member boards should require each licensee to complete a minimum Component One activity on an annualized basis, a majority of which is devoted to practice-relevant CME that supports performance improvement, and to document completion of both one Component Two and one Component Three activity every five to six years.

Regardless of the actual licensure cycle within each SMB jurisdiction, the goal of MOL is continuous, ongoing professional development. It is an aspiration to have all activities done on a continuous basis. In the future, it may be possible for physicians and SMBs to demonstrate

continuous engagement in MOL activities in a rolling and uninterrupted manner through automated data reporting. Until this is practical, however, most SMBs will have to rely upon periodic documentation and verification as evidence of participation in required MOL activities.

Currently, all SMBs require physicians to re-register their licenses every one, two or three years. To accommodate this variation in licensure re-registration cycles, MOL components are conceptualized within a multi-year cycle, with each Component being documented periodically in the following manner:

- Component One: Each SMB should define a minimum Component One activity requirement on an annualized basis, a majority of which is devoted to practice-relevant CME that supports performance improvement.
- Component Two: Physicians should be required to undergo knowledge or skill assessments germane to their professional practice. Initially, it may be reasonable to expect such an assessment once every five to six years; frequency may be adjusted upward or downward in the future based on research exploring the impact of MOL.
- Component Three: Likewise, while physicians should be expected to continuously improve their performance in practice, they should document participation in an approved Component Three activity at least once every five to six years. With ongoing experience the frequency of this documentation may need to be adjusted upward or downward in the future.

The intent of MOL is to require physicians to demonstrate active participation and commitment to a program of lifelong self-assessment and improvement. We recognize that the above recommendations represent a substantial change to the medical regulatory process. Requiring completion of some Components less frequently than every license re-registration cycle will make implementation of MOL more administratively feasible for SMBs and strikes a balance between ensuring sufficient rigor in the MOL process and ensuring that compliance with MOL is not overly burdensome for licensees.

When fully implemented nationwide, it is anticipated that licensees will be engaged in a culture of continuous quality improvement assisted by objective data and resulting in significant and demonstrable actions that improve their practices and patient care. In addition, SMBs will be able to assure the public that physicians seeking license renewal are actively participating in a program of ongoing professional renewal.

BOARD CERTIFICATION IN THE CONTEXT OF MOL

Recommendation: State member boards should consider physicians who provide evidence of successful ongoing participation in ABMS Maintenance of Certification (MOC) or AOA-BOS Osteopathic Continuous Certification (OCC) to have fulfilled all three components of MOL.

MOL will enable SMBs to demonstrate that their physician licensees are actively engaged in a lifelong program of professional assessment and improvement. MOL, ABMS MOC and AOA-BOS OCC are similar in that they each demonstrate a commitment on behalf of a physician to lifelong learning and self-assessment through a variety of approaches. MOL does not distinguish between specialty and sub-specialty board certification; if ABMS MOC or AOA-BOS OCC is available for a specialty or sub-specialty and the physician is in good standing with the ABMS MOC or AOA-BOS OCC program, then this should fulfill MOL.

Along with the three MOL Components, SMBs will have additional requirements for license renewal that are mandated by state law. These may include payment of a licensure fee and submission of demographic data. The MOL Implementation Group desires to make clear its intention that ABMS MOC and AOA-BOS OCC, as comprehensive programs, fulfill all three components of MOL.

In the interest of clarity, the Implementation Group wishes to emphasize that, while MOL and ABMS MOC and AOA-BOS OCC are similar in their focus on physician lifelong learning and self-assessment, they are by no means identical in purpose or design. Specifically, MOL, unlike ABMS MOC and AOA-BOS OCC, will be mandatory for all physicians as a requirement of medical licensure and should be adaptable in order to reasonably address a more heterogeneous physician population. ABMS MOC and AOA-BOS OCC demonstrate a physician's attainment of and commitment to sustaining expertise in a specific field of medicine. In contrast, medical licensure is a threshold event, a minimum standard at/or above which every physician must perform, in order to be granted the societal privilege to engage in the practice of medicine. MOL represents an important advance in medical regulation and licensure as a means to shift the profession to a culture of objective and continuous improvement in a constructive and verifiable manner.

TYPES AND NATURE OF PHYSICIAN PRACTICES

Two aspects of physician practice are particularly challenging within the MOL paradigm: 1) actual clinical practice versus specialty training/designation and 2) non-clinically active physicians. In both instances, there is little data about individual licensees and their types of practice and the nature of those practices. The Implementation Group noted that this issue is being addressed by the FSMB and recommends that SMBs begin collecting data about licensees' practice status and scope of practice as part of license renewal process.

Recommendation: State member boards should regularly collect data from individual licensees about the extent of their engagement in direct patient care and the nature of their daily professional work.

As medical practice has become more specialized, a growing number of physicians are practicing medicine and surgery in areas not well-described by traditional specialty designation/ descriptions. As a result, specialty-specific resources may not accurately and adequately address the assessment and educational needs of a growing number of physician clinicians. This is a growing challenge and one for which this Implementation Group does not have a sufficient solution. It is our hope that SMBs will begin to collect more detailed demographic data regarding

actual physician clinical practice. Over time, we hope that this data will help the FSMB and its member boards to better understand the true scope and magnitude of this challenge. In turn, this improved understanding will help to guide future evolution of the MOL program and its supporting resources over time.

All licensed physicians should be required to comply with all elements of MOL as defined by the SMBs. This represents unique challenges, however, for physicians not engaged in direct patient care. Furthermore, this is an example of a specific area where the MOL differs from and bears a unique responsibility distinct from ABMS MOC and AOA-BOS OCC. A physician with an unrestricted medical license is granted the authority to practice medicine and prescribe medications at his/her personal discretion. As such, it becomes uniquely important that all physicians granted an unrestricted license demonstrate that they meet or exceed the threshold requirements for medical licensure. It is anticipated that once there is more data about those not engaged in direct patient care, FSMB will have a better understanding of the issues involved and be better informed to further address this topic.

CONSISTENCY OF MOL ACROSS JURISDICTIONS

Recommendation: State member boards should strive for consistency in the creation and execution of MOL programs.

One of the key issues identified in FSMB MOL discussions with SMBs and other stakeholders has been the desire for uniform implementation across states. Recognizing the differences in resources, statutes and operations across states and acknowledging that implementation of MOL should be within the discretion and purview of each SMB, this MOL program is designed to be flexible to meet local considerations. At the same time, physicians are concerned about an overly burdensome MOL program where they might have to meet varying criteria to maintain licensure in different states. Widely divergent standards from state to state may hinder physician mobility and thus impact patient care.

To advance this culture of continuous improvement and commitment to lifelong professional development, it is advised that, wherever possible, SMBs recognize compliance with MOL requirements of other states and/or compliance with ABMS MOC and AOA-BOS OCC as representing substantial compliance and fulfillment of its own MOL requirements, particularly for physicians who change their states of practice and otherwise meet licensure requirements.

There is great opportunity to create a more standardized and consistent system of medical licensure across SMBs that also facilitates license portability. Such standardization is consistent with the spirit of MOL, which invites and encourages physicians to practice patient-centered health care and to strive towards standardization that improves outcomes and results.

SUMMARY OF KEY IMPLEMENTATION ISSUES

The Implementation Group anticipated several key issues that may arise during MOL implementation by SMBs and licensees. While not exhaustive, below is a question-and-answer summary of our guidance.

- 1) How will SMBs know if a licensee has complied with the requirements?

Similar to the current CME system, physicians and/or third parties will attest to the completion of required activities. For privacy reasons and to simplify SMB record-keeping, it is recommended that SMBs not collect actual data, but only the attestation of completion of activities. Similar to current CME systems, a sample of such attestations should be audited annually. As health information technology advances, it may in time be feasible to electronically automate much of this reporting and, therefore, to reliably verify the compliance of 100 percent of licensees with little or no additional effort.

- 2) How will SMBs that are short on resources of all types be able to implement MOL?

Although new information will need to be collected, the MOL proposal for SMBs does not envision collection of primary data. It is anticipated that most resources will be needed for start up, and include time and other resources for structuring a program, amending legislation (if necessary), revising policies, and developing new tracking mechanisms. SMBs that do choose to develop a substantial infrastructure may wish to partner with other SMBs to defray expense and maximize benefit.

- 3) How can licensees who meet MOL in one state be assured that they will meet the requirements in another state where they are licensed?

We recommend that each state recognize the MOL requirements of other states. In order not to dilute the impact of MOL, physicians holding current licenses in more than one state should be deemed as meeting MOL requirements of all states in which s/he holds a license if s/he is fully compliant with the MOL requirements of the most stringent state.

- 4) What happens if a physician chooses not to participate in MOL?

SMBs should require MOL activities as a condition of license renewal and treat noncompliance in a manner similar to noncompliance with other licensure requirements.

- 5) What happens if a physician is unable to successfully complete one or more MOL Components?

Successful completion of all three components should be a requirement for compliance with MOL. If a physician is unable to comply, SMBs should treat noncompliance in a manner similar to noncompliance with other licensure requirements.

- 6) What if a physician is already involved in a national registry, for example, for Component Three; does he or she need to do any additional activity to get "credit" for completing the component?

If the registry meets the criteria listed on page 30, the licensee should be held in compliance with Component Three. Each SMB should have the discretion to decide what activities physicians should be required to participate in to comply with MOL,

notwithstanding the goal articulated above to work toward commonality across state borders. However, the idea of MOL is to encourage ongoing professional improvement, not create additional burdens. Physicians who currently engage in activities that meet all MOL components should be encouraged to continue such activities. MOL will ensure that all physicians are similarly engaged.

- 7) If a physician is solely an administrator or involved only in research, do they have to participate in MOL?

Yes, if they wish to maintain an active license. Regardless of practice choice, physicians have a professional obligation to engage in lifelong learning if they choose to maintain their medical licensure. There should be mechanisms for physician administrators and physician researchers to meet the component requirements by tailoring assessment and educational activities to their professional setting. For additional guidance, please see the “Types and Nature of Physician Practices” discussion above.

FUTURE DIRECTIONS

Maintenance of Licensure will be an evolving program and will not be fully realized nationwide for years. During that time, the Implementation Group recommends that FSMB lead an intense effort to encourage states to share with each other what is working and what may need improvement in order to define best practices.

Research efforts that compare results across states will be very important to an improved program. It will be particularly important to document the impact of MOL programs on physician practice and patient care.

As our knowledge of physician assessment advances, and as we learn which elements of MOL correlate most closely with improved patient outcomes, it is likely that requirements for each component of MOL may change. Ongoing research into the effects of MOL should inform the program’s evolution, and states may wish to consider how they may best reflect this evolution in their statutes, bylaws, policies and procedures so that timely updates are not ensnared in bureaucratic barriers.

The FSMB will continue to support its member boards as they undertake the implementation of MOL across their jurisdictions. As part of these efforts, the FSMB will engage in activities such as the development of a “Toolbox” of resources to assist SMBs and physicians in navigating the MOL landscape, including further exploration and explanation of potential tools that physicians could use to comply with MOL requirements, assistance with development of model statutory language to enable a board to implement MOL, and clear and consistent communication with SMBs and the broader medical community regarding MOL.

The FSMB also remains committed to the continued refinement of these guidelines to best support its membership in the development, implementation and maintenance of MOL programs that have a positive impact on physician practice and patient care.

ATTACHMENT A

**RECOMMENDATIONS FROM THE REPORT OF THE ADVISORY GROUP ON
CONTINUED COMPETENCE OF LICENSED PHYSICIANS
ADOPTED BY THE FSMB HOUSE OF DELEGATES IN APRIL 2010**

Maintenance of Licensure Framework

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

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

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

1. Reflective Self Assessment (What improvements can I make?)

Physicians must participate in an ongoing process of reflective self-evaluation, self-assessment and practice assessment, with subsequent successful completion of appropriate educational or improvement activities.

2. Assessment of Knowledge and Skills (What do I need to know and be able to do?)

Physicians must demonstrate the knowledge, skills and abilities necessary to provide safe, effective patient care within the framework of the six general competencies as they apply to their individual practice.

3. Performance in Practice (How am I doing?)

Physicians must demonstrate accountability for performance in their practice using a variety of methods that incorporate reference data to assess their performance in practice and guide improvement.

Recommendations

Documentation

Licensees should be expected to provide documented evidence of compliance with the state medical board's maintenance of licensure requirements. State medical boards should provide

guidance to licensees as to the types of evidence deemed acceptable and not acceptable for purposes of meeting maintenance of licensure requirements.

Licensed Physicians not in Active Clinical Practice

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

Physicians with Inactive Licenses

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

Practice Profile Data

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

Practice Performance Data

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

Research

The Federation of State Medical Boards and its member state medical boards should work with other stakeholder organizations to develop research aimed at assessing the impact of maintenance of licensure programs on physician practice and patient care.

Assessment Resources

Assessment tools used to meet maintenance of licensure requirements should be:

- valid, reliable, and feasible
- credible with the public and the profession
- provide adequate feedback to the licensee to facilitate practice improvement

Professional Development Activities

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

Board Certification in the Context of MOL

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

ATTACHMENT B**FSMB TOOLBOX FOR IMPLEMENTATION OF MAINTENANCE OF LICENSURE**

The Federation of State Medical Boards will be developing a “Toolbox” of resources to aid state member boards and licensees better understand and implement MOL. As an example of some of the resources, following is a list of potential activities that may satisfy the various Component requirements. Although revised and more detailed, the descriptions below are consistent with the components outlined in the Report of the Advisory Group on Continued Competence of Licensed Physicians. Following the chart is more detailed explanation of the individual activities.

COMPONENTS OF PROFESSIONAL DEVELOPMENT PROGRAMS AND ACTIVITIES

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

COMPONENTS	STRATEGY (HOW)	OPTIONS /EXAMPLES
<p>1. Reflective Self-assessment</p> <p>Physicians must participate in an ongoing process of reflective self-evaluation, self-assessment and practice assessment, with subsequent successful completion of CME activities.</p> <p>Attestation of participation would be required.</p>	<p>Self-assessment incorporates measures of knowledge and skills or performance benchmarks.</p> <p>Learners independently evaluate an aspect of their medical practice and skills, identify opportunities for improvement and then successfully complete a tailored educational or improvement activity.</p> <p>SMBs may want to use attestation by the physician as proof of completion.</p> <p>Licensees successfully engaged in ABMS MOC or AOA-BOS OCC automatically fulfill Components One, Two and Three.</p>	<p>Assessment tools could include:</p> <p>Self-review tests such as:</p> <ul style="list-style-type: none"> • ABMS MOC and AOA-BOS Osteopathic Continuous Certification (OCC) • Home study courses or web-based materials that meet SMB quality standards • Medical and osteopathic professional society/organization or institution-based simulations that meet SMB quality standards • Others approved by the state medical board <p>Professional development activities could include:</p> <ul style="list-style-type: none"> • Review of literature in the physician’s current practice area • CME in the physician’s current practice area that addresses an identified deficiency, enhances patient care, performance in practice and/or patient outcomes
<p>2. Assessment of Knowledge and Skills</p> <p>Physicians must demonstrate the knowledge, skills and abilities necessary to provide</p>	<p>External assessments of competencies should be structured, valid, practice-relevant, and should produce data to identify learning opportunities.</p>	<p>Examples of assessments addressing one or more of the competencies include but are not limited to:</p> <ul style="list-style-type: none"> • Practice relevant multiple choice exams, e.g., ABMS MOC and AOA-BOS OCC exams, National Board of

<p>safe, effective patient care within the framework of the six competencies as they apply to their individual practice.</p>	<p>SMBs may want to use third-party documentation as proof of completion.</p> <p>Licensees successfully engaged in ABMS MOC or AOA-BOS OCC automatically fulfill Components One, Two and Three.</p>	<p>Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME) subject exams</p> <ul style="list-style-type: none"> • Medical and osteopathic professional society assessment programs/tools • Standardized patient assessments • Computer-based clinical case simulations • Mentored or proctored observation of procedures • Procedural hospital privileging • Formalized assessment/PI programs overseen by health systems or robust medical groups (e.g. likely larger organizations) • Others approved by SMBs
<p>3. Performance in Practice</p> <p>Physicians must demonstrate accountability for performance improvement in their practice.</p>	<p>Physicians should use a variety of methods that incorporate reference data to assess their performance in practice and guide improvement.</p> <p>3rd party attestation of participation will satisfy this component.</p> <p>As a result of completion of Component Three, licensees may address areas for improvement via Component One as part of a continuing cycle of improvement.</p> <p>Licensees successfully engaged in ABMS MOC or AOA-BOS OCC automatically fulfill Components One, Two and Three.</p>	<p>Assessment tools could include but are not limited to:</p> <ul style="list-style-type: none"> • 360-degree/multi-source evaluations (self evaluation, peer assessment and patient surveys) • Patient reviews, such as satisfaction surveys • Performance Improvement CME • Collection and analysis of practice data such as medical records, claims review, chart review and audit, case review and submission of a case log • Participation in Registries • American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) Clinical Assessment Program • An approved American Board of Medical Specialties (ABMS) MOC Part IV Practice Improvement activity • An approved American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) OCC Practice Improvement activity • Medical professional society/organization clinical assessment/practice improvement programs • Centers for Medicare and Medicaid Services (CMS) and other similar institutional-based measures • Other performance improvement projects such as the Surgical Care

		<p>Improvement Project (SCIP), American Medical Institute (AMI), Institute for Healthcare Improvement (IHI), Improving Performance in Practice (IPIP), Healthcare Effectiveness Data and Information Set (HEDIS)</p> <ul style="list-style-type: none"> • Other tools approved by the state medical board
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COMPONENT ONE: REFLECTIVE SELF-ASSESSMENT

Some examples of activities that SMBs may want to accept as part of Component One include:

- ABMS member board MOC Part 2 activities, such as Lifelong Learning and Self-Assessment modules which require a physician to review articles from the medical literature and take an open-book quiz on which the physician must achieve at least a passing score to receive a certificate of completion.
- AOA-BOS Osteopathic Continuous Certification Part 2 activities, which center on lifelong learning and self-assessment.
- Performance Improvement (PI) CME offered by medical professional societies that provide for: assessment of current practice using evidence-based performance measures and feedback to physicians comparing their performance to national benchmarks and to their peers; implementation of an intervention based on the performance measures; and reevaluation of performance in practice resulting from the Performance Improvement CME activity.
- Webinar, podcast, online home study or traditional printed CME activities. A majority of the content of the CME selected by the physician should be germane to his/her actual professional practice. These activities should include self-assessment tools such as pre- and post-tests that will assist the clinician to better understand their baseline knowledge before and retention of key elements after completion of the learning experience.
- Live didactic activities such as lectures at medical conferences, professional society meetings, hospital-based programs, group practice lectures, etc. There are many benefits to the in-person education and the related exchange of ideas between the lecturer and students. The content of these activities should also be germane to the physician's actual professional practice and include pre- and post-event assessments similar to those outlined above.
- Participation in organized practice assessment and improvement efforts (Institute for Healthcare Improvement, Improving Performance in Practice, or local Practice-Based Research Network quality improvement projects or similar collaborative.)

COMPONENT TWO: ASSESSMENT OF KNOWLEDGE AND SKILLS

Some examples of activities* that SMBs may want to accept as part of Component Two include:

- Self-assessment modules, like those of the American Board of Family Medicine, test core competencies and require physicians to correctly answer eighty percent (80%) of the questions in each competency. If they are not initially successful, physicians enter a review mode that offers an opportunity to read a critique and reference for each incorrectly answered question before inputting new answers to the missed questions. This process offers the physician to assess their knowledge, learn from their mistakes, and successfully complete the component.
- Standardized patient assessments. These assessments can provide the physician with feedback on their communication and language skills, as well as other competencies.
- Computer-based clinical case simulations. These evaluation tools can provide the physician with simulated experience working through clinical scenarios to arrive at a diagnostic impression and treatment plan. Such assessments can offer the physician insight into both his/her factual knowledge base as well as his/her clinical problem-solving skills.
- Practice relevant multiple-choice exams (e.g., ABMS MOC and AOA-BOS OCC exams, National Board of Medical Examiners (NBME) subject exams, National Board of Osteopathic Medical Examiners (NBOME) Comprehensive Osteopathic Medical Achievement Tests (COMAT), the Special Purpose Examination (SPEX) and the NBOME Comprehensive Osteopathic Medical Variable-Purpose Examination for the United States of America COMVEX-USA) and activities such as these provide the physician with a structured examination experience designed to test their factual knowledge based on a specific topic(s).
- Mentored or proctored observation of procedures and/or hospital procedural privileging. For skill-based evaluation, the physician may benefit from the direct observation and professional feedback of a fellow physician trained in the same procedure(s).
- Others approved by SMBs. The fundamental objective in Component Two of MOL is for a physician to submit him/herself to an objective or 3rd party assessment of his/her knowledge and /or skills. The results of these assessments will serve at least two purposes: 1) assist the physician in the selection of future MOL Component One educational opportunities to enhance and improve his/her professional practice, and 2) serve as objective 3rd party evidence to the SMB that the physician has successfully completed (this includes “passing” the assessment with a sufficient “score”) validated knowledge and/or skill assessments in areas germane to his/her professional activities.

*As MOL unfolds, there will need to be some criteria for an acceptable third-party to accredit Component Two MOL activities.

COMPONENT THREE: PERFORMANCE IN PRACTICE

Some examples of Component Three activities include:

- Registry participation. There are numerous and increasing numbers of patient care registries available. For example, the Society of Thoracic Surgeons operates a highly regarded registry for cardiothoracic surgeons. Similarly, the American College of Cardiology operates a registry for cardiovascular care. The American Osteopathic Association's Clinical Assessment Program (CAP) includes similar registries for diabetes, coronary artery disease and women's health screening. Through their participation, physicians submit data to the registry on their own patient care activities and outcomes and, subsequently, receive reports that summarize the individual physician's outcomes and place those outcomes in the larger context of the performance of other physicians/patients. In this manner, the physician is able to identify personal successes as well as opportunities for further improvement in his/her own medical practice. To fulfill Component Three of MOL, registries should:
 - 1) be administered by a credible third party;
 - 2) collect individual physician data and aggregate data from numerous individual physicians to create a comparative database;
 - 3) provide reporting of individual physician performance in a comparative manner to peer-matched aggregated data;
 - 4) provide additional comparison of individual physician performance relative to evidence-based guidelines when available;
 - 5) define clear criteria for "successful" physician participation in the registry, such criteria to include: a) expectations for consistent submission of required data over time, and b) active acknowledgement of receipt and review of individualized comparative reports by the participating physician; and
 - 6) upon participating physician request, provide formal documentation to SMBs that the physician is successfully participating in the registry.

- Patient satisfaction surveys. Attention to patients' perceptions about their care and their physician can provide useful information to the physician. Through patient surveys, physicians can gain insight into the effectiveness of their communication and the impact (both positive and negative) of efforts to successfully partner with their patients in their care. Patient surveys may assess elements that are more subjective than, for example, medical knowledge; however, a well-designed patient satisfaction survey that is executed in a consistent and valid manner can provide useful trend data and feedback to the physician. Since there is mixed opinion, however, regarding the objectivity and reproducibility of patient satisfaction surveys, these tools should be used either as an element of a more comprehensive assessment tool or should be accepted on a periodic basis inter-mixed with other Component Three activities over a period of time.

- Practice data analysis. A number of physician practices already employ either manual chart reviews or have data management systems in place (either themselves or in partnership with hospitals or other entities) that enable them to analyze their own practice data to look for trends and outcomes. The use of such analytic tools affords the physician

the opportunity to see firsthand the direct impact of his/her efforts in patient care and to take action if/where needed to adjust his/her clinical practice.

- External quality reporting initiatives. Activities such as the Center for Medicare and Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI) and similar activities can provide physicians with data similar to registry participation and/or practice data analysis. Engagement in these activities is in concert with the spirit of Component Three of ABMS MOC and Practice Performance Assessment of AOA-BOS OCC.
- Participation in organized practice assessment and improvement efforts (Institute for Healthcare Improvement, Improving Performance in Practice, or local Practice-Based Research Network quality improvement projects, or similar collaborative).
- 360-degree/multi-source evaluations. Comprehensive personal assessments of the physician can be rigorous and enlightening. Such evaluation processes can provide the physician with robust and actionable feedback on the strengths and weakness of their professional efforts through the use of a number of subjective and objective assessment tools.
- Other tools approved by the SMB. The key concept behind Component Three of MOL is the physician's use of valid quantitative and/or qualitative tools to assess the results/outcomes of the physician's professional activities and for the physician to subsequently use this data to further improve his/her professional practice. It is not possible to fully anticipate the full array of tools that will be available to physicians in the future. As such, the MOL Implementation Group recommends that SMBs accept 3rd party attestation of a physician's successful participation in activities deemed by the SMB to substantially comply with this component.

ATTACHMENT 2
FSMB MOL Communication Efforts (April 2010 – February 2011)

Presentations to State Boards

Maintenance of Licensure continues to be a topic of focus during site visits with FSMB member boards. MOL-specific presentations are also provided to individual state boards as requested, as noted below.

October 2010:

- October 26, 2010: FSMB staff attended the meeting of the Minnesota Board of Medical Practice's Continuing Competence and MOL Taskforce to discuss FSMB's current MOL efforts. (Attended by Frances Cain – FSMB Director, Post-Licensure Services)

November 2010:

- November 10: MOL presentation to the State Medical Board of Ohio (presented by Humayun Chaudhry, DO – FSMB President and CEO)

May 2011:

- May 3, 2011: MOL presentation scheduled for the Delaware Board of Medical Licensure and Discipline (to be presented by Randal Manning, MBA – FSMB Board of Directors)

Upcoming presentations:

- MOL presentation to the Missouri Board of Registration for the Healing Arts (to be presented by Hedy Chang – FSMB Board of Directors; and Sandra Waters, MEM – FSMB Chief Operating Officer)

Presentations to / Meetings with External Stakeholders

April 2010:

- April 12-13: Meeting with Irish Medical Council – discussion of international MOL/Revalidation efforts (attended by Martin Crane, MD – FSMB Immediate Past Chair; and Humayun Chaudhry, DO – FSMB President and CEO)
- April 30: American Osteopathic Association (AOA) Bureau on Federal Healthcare Programs (presented by James Andriole, DO – FSMB Board of Directors)

May 2010:

- May 6-7: Coalition for Physician Enhancement (CPE) meeting (brief update on MOL provided by Humayun Chaudhry, DO – FSMB President and CEO)

June 2010:

- June 5-7: Federation of Medical Regulatory Authorities of Canada (FMRAC) General Meeting (discussion of MOL during plenary session provided by Humayun Chaudhry, DO – FSMB President and CEO)

July 2010:

- July 28: FSMB hosted a webinar with the American Medical Association (AMA) focused on what CME providers should know about CME requirements for licensure and MOL (MOL information presented by Humayun Chaudhry, DO – FSMB President and CEO)

August 2010:

- August 5: “Advancing Electronic Health Records Adoption and Meaningful Use” forum hosted by the Health Industry Forum of Brandeis University and *Health Affairs* (presented by Humayun Chaudhry, DO – FSMB President and CEO)

September 2010:

- September 15: Annual Liaison meeting of the leadership of the Association of American Medical Colleges (AAMC), the National Board of Medical Examiners (NBME) and the FSMB (presented by Freda Bush, MD – FSMB Chair; and Humayun Chaudhry, DO – FSMB President and CEO)
- September 24: Panel Presentation at the AMA Physician Consortium For Performance Improvement PCPI meeting (presented by Humayun Chaudhry, DO – FSMB President and CEO)
- September 26-29: IAMRA 9th International Conference on Medical Regulation
- FSMB received a request for information and slides on MOL from Stanley Brysacz, DO, a member of FSMB’s Special Committee on MOL and a former member of the Arizona Board of Osteopathic Examiners in Medicine and Surgery. Dr. Brysacz is currently an assistant professor for the School of Osteopathic Medicine in Arizona (SOMA) and wanted to include information about MOL as part of a presentation to the school’s first graduating class.
- FSMB accepted an invitation from the American College of Physicians (ACP) to participate in a panel presentation about physician accountability at the ACP 2011 Annual Meeting.

October 2010:

- October: FSMB submitted a proposal to do a brief, 20 minute presentation at the Joint American Association of Colleges of Osteopathic Medicine (AACOM) and Association of Osteopathic Directors and Medical Educators (AODME) Annual Meeting in April 2011. Notification that the proposal was accepted was received in December. (To be presented by Humayun Chaudhry, DO – FSMB President and CEO)
- October 2010: Panel presentation at AAMC e-folio meeting (presented by Freda Bush, MD – FSMB Chair)

November 2010:

- November 11-12: Citizen Advocacy Center (CAC) meeting (presented by Martin Crane, MD – FSMB Immediate Past Chair)
- November 12-14: Council of Medical Specialty Societies (CMSS) meeting (presented by Galicano Inguito, MD – FSMB Board of Directors; and Humayun Chaudhry, DO – FSMB President and CEO)
- November 18: American Association of Colleges of Osteopathic Medicine (AACOM) Board of Deans Meeting (presented by Humayun Chaudhry, DO – FSMB President and CEO)
- November 20: AOA Advocacy for Healthy Partnerships Meeting (presented by Humayun Chaudhry, DO – FSMB President and CEO)
- November 23, 2010: Received email request from Oklahoma Osteopathic Association (OOA), for FSMB President and CEO, Humayun Chaudhry, DO, to speak at OOA’s 111th annual convention on April 28-May 1, 2011. The request was declined since the meeting falls at the same time as the FSMB Annual Meeting, but FSMB staff indicated that FSMB welcomes any other future opportunities to speak with them.

December 2010:

- December 2: International Revalidation Symposium (presented by Freda Bush, MD – FSMB Chair)
- January 15, 2011: Florida Society of Ophthalmology (presented by Tully Patrowicz, MD – FSMB Board of Directors)
- January 2011: American Academy of Family Physicians (AAFP) Commission on Continuing Professional Development (presented by Donald Polk, DO – FSMB Board of Directors)
- February 4, 2011: National Credentialing Forum (presented by Janelle Rhyne, MD – FSMB Chair-elect)

Upcoming MOL presentations:

- March 2011: Conjoint Committee on Continuing Medical Education (CCCME) meeting (to be attended by Freda Bush, MD – FSMB Chair; Sandra Waters, MEM – FSMB Chief Operating Officer; and Frances Cain – FSMB Director, Post-Licensure Services)
- April 7-9: Panel presentation about physician accountability at the American College of Physicians (ACP) ACP 2011 Annual Meeting (to be presented by Humayun Chaudhry, DO – FSMB President and CEO)
- April 13-16, 2011: American Association of Colleges of Osteopathic Medicine (AACOM) and the Association of Osteopathic Directors of Medical Education (AODME) Annual Meeting regarding *Meeting Future Health Care Needs: The Role of Interprofessional Education* (to be presented by Humayun Chaudhry, DO – FSMB President and CEO)
- April 15, 2011: plenary session at Association for Hospital Medical Education (AHME) Educational Institute (to be presented by Janelle Rhyne, MD – FSMB Chair-elect)
- May 21, 2011: American Ophthalmological Society (AOS) 2011 Saturday Symposium titled “Maintenance of Certification/Maintenance of Licensure” (to be presented by Janelle Rhyne, MD – FSMB Chair-elect)

Media/Press:*April/May 2010:*

- MOL was the subject of, or included in, articles and blogs by: the *Wall Street Journal* (online blog), *Modern Healthcare* (electronic article), *Newswise* (electronic article), *Health Care Journal of Northern California*, National Association of Medical Staff Services (online blog), and WebTalkRadio.net (internet radio program featuring Humayun Chaudhry, DO, FSMB President and CEO, as a guest speaker).
- Articles about MOL were submitted by the FSMB to the *Journal of the American Medical Association*, a journal of the American Academy of Orthopedic Surgeons, and the *Journal of the American Osteopathic Association*.
- May 20: The Accreditation Council for Continuing Medical Education (ACCME) issued a press release indicating ACCME's endorsement of FSMB's adopted MOL policy.

August 2010:

- A number of medical and healthcare websites and blogs included information about FSMB's announcement about the relationship between EHRs and MOL as part of their coverage of the August 5th “Advancing Electronic Health Records Adoption and Meaningful Use” forum.

September 2010:

- AACOM's electronic newsletter, *OME Now*, included an editorial from Stephen Shannon, DO, President of AACOM, titled "Reflections on Competency and Maintenance of Licensure (MOL)". The editorial is available at: <http://www.aacom.org/resources/ome/2010-09/Pages/president.aspx>
- September 13: The American Academy of Family Physicians' (AAFP) *AAFP News* (online) included an article titled, "EHRs Valuable in Implementing Maintenance of Licensure, Says FSMB". The article is available at: <http://www.aafp.org/online/en/home/publications/news/news-now/professional-issues/20100913ehrs-mol.html>

October 2010:

- The October 2010 edition of *AAOS Now* included an article by FSMB Immediate Past Chair, Martin Crane, MD, and FSMB President and CEO, Humayun Chaudhry, DO, titled "Physician Maintenance of Licensure". The article is available at: <http://www.aaos.org/news/aaosnow/oct10/managing7.asp>
- FSMB's MOL background paper was published in the FSMB's *Journal of Medical Regulation*.

November 2010:

- November 23: Humayun Chaudhry, DO, FSMB President and CEO, was interviewed on ReachMD Radio about "New MOC and MOL Initiatives: Implications for Practicing Physicians". Audio from the program is available at: [www.reachmd.com](http://www.reachmd.com/xmsegment.aspx?sid=6148). <http://reachmd.com/xmsegment.aspx?sid=6148>

Commentary

Maintenance of Licensure: Protecting the Public, Promoting Quality Health Care

Humayun J. Chaudhry, D.O., Janelle Rhyne, M.D., Frances E. Cain, Aaron Young, Ph.D., Martin Crane, M.D. and Freda Bush, M.D.

IN BRIEF The authors describe a system in which physicians periodically demonstrate ongoing clinical competence as a condition of license renewal.

Introduction

The practice of medicine in the United States, according to the 2010 edition of *A Guide to the Essentials of a Modern Medical and Osteopathic Practice Act* of the Federation of State Medical Boards (FSMB), is “a privilege granted by the people acting through their elected representatives.”¹ Citing public health, safety and welfare, and the need for protection of the public from the “unprofessional, improper, incompetent, unlawful, fraudulent and/or deceptive practice of medicine,” the *Essentials* document—formally adopted by the FSMB’s House of Delegates—acknowledges the historical and constitutional role of the state medical and osteopathic boards “to provide laws and regulations to govern the granting and subsequent use of the privilege to practice medicine.”

While the granting of the initial privilege to practice medicine is generally viewed as a robust process along a rigorous continuum of medical education encompassing both undergraduate and graduate training, with multiple assessments and decision points that must be cleared along a prescribed pathway, the process for the subsequent use of that privilege has been the focus of increasing commentary and suggestions for improvement. This article summarizes the background and history by which the FSMB adopted, in April of 2010, a seminal policy recommendation outlining a framework by which state medical and osteopathic boards could require physicians with active medical licenses to periodically demonstrate their ongoing clinical competence as a condition for licensure renewal.

Medical Regulation in Service to the Public

While the earliest instance of medical regulation in the Americas dates to 1649,² and the first local government license to practice medicine was adopted in 1760 in New York City,³ the authority of state governments to regulate health care in the United States dates to the adoption, in 1791, of the 10th Amendment to the Constitution: “The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people.”

Some states initially gave local medical societies the power to examine and license prospective doctors,⁴ while others bestowed such a right to medical schools. The notion that medical licensure and discipline should best be regulated by state-appointed licensing boards, the majority of whom today include public members on their voting bodies, rather than medical societies (which ostensibly represent the interests of practicing physicians) or medical schools took several decades to gain traction. It has been postulated that what ultimately caused medical regulation, alongside coincidental public health legislation, to flourish between 1850 and 1900 was a combination of two factors: a failure of pure free-enterprise theory and the contribution of science.⁵ While “good” goods, like “good” doctors, should have ultimately driven out “bad” ones in a free market, a better informed public was no longer willing to wait that long; people also became aware of the fact that danger lurked in bad food and bad water, an awareness prompted by the discovery of germs, that prompted calls from many corners for better protection from poor sanitation as well as from “bad” doctors.

The FSMB, since its establishment in 1912 as the umbrella organization for all state medical and osteopathic licensing boards in the United States and its territories, has actively promoted or supported during its long history such activities as stronger entrance criteria for medical schools,

improvements in undergraduate medical education, closure of underperforming medical schools following the 1910 Flexner Report, passage of state medical practice acts, the formation of the American Board of Medical Specialties (ABMS) and the Educational Commission for Foreign Medical Graduates and, in 1991, the creation — in partnership with the National Board of Medical Examiners (NBME) — of the United States Medical Licensing Examination (USMLE). Physicians with the D.O. (doctor of osteopathic medicine) degree typically take the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) of the National Board of Osteopathic Medical Examiners (NBOME).

The FSMB, as stated in its current mission statement, seeks to lead by “promoting excellence in medical practice, licensure, and regulation as the national resource and voice on behalf of state medical boards in their protection of the public.” The FSMB has more recently served the public and its 70 state medical and osteopathic boards through the development of a national database of licensed

ADOPTION OF AN MOL FRAMEWORK BY THE FSMB, WITHIN THIS CONTEXT, IS CONSISTENT WITH STATE BOARDS’ DESIRE TO PROTECT THE PUBLIC AND PROMOTE QUALITY HEALTH CARE WITH ROBUST STANDARDS FOR PHYSICIAN LICENSURE.

physicians and physician assistants, a disciplinary alert service, a Federation Credentials Verification Service (FCVS) and a Uniform Application to speed state processing of licensure applications and facilitate license portability without infringing the states’ autonomy or rights. Adoption of a Maintenance of Licensure (MOL) framework by the FSMB, within this context, is consistent with state medical and osteopathic boards’ desire to protect the public and promote quality health care with robust standards for physician licensure.

Medical Regulation to Promote Health Care Quality

Significant technological and scientific advancements have been pioneered by physicians and scientists in the United States but there are several reasons why we do not have the very best health care system in the world (e.g., insufficient access to primary care services, a lack of coordination of

health care delivery, defensive medicine practices) despite all of our expenditures.^{6,7} The quality of the health care that is delivered is an area of inquiry that has garnered great attention in the last two decades. These analyses have sometimes offered specific recommendations to medical educators, health care leaders, medical regulators and federal and state government officials to help reform the health care workforce, decrease medical errors and promote best practices among health care providers. Many of these reports have also made specific recommendations about the standards and practices for renewal of medical licenses.

In 1995, the Pew Charitable Trust Health Professions Commission recommended that states “require each licensing board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals.”⁸ In 1999, the Institute of Medicine (IOM) said that consumers generally believe they are protected within the health care arena because “licensure and accreditation confer, in the eyes of the public, a ‘Good Housekeeping Seal of Approval,’ and suggested greater assessment of the physicians’ performance of skills after initial licensure.”⁹ Two years later, the IOM observed that in a profession with “a continually expanded knowledge base,” a mechanism was needed to ensure that practitioners remain up to date with current best practices.¹⁰ It also noted that medical regulation, when properly conceived and executed, “can both protect the public’s interest and support the ability of health care professionals and organizations to innovate and change to meet the needs of their patients.”

Rationale for Enhanced Medical Regulation

In the United States and United Kingdom, according to a survey of 18 countries conducted last year, more than 80 percent of the public consider physicians to be trustworthy.¹¹ To continue to earn such high regard in a climate of greater accountability and regulation, consistent with their own professional obligations to remain competent and up-to-date, physicians need to demonstrate to their patients and peers what most are already doing. The rationale to do so, however, is multifaceted and not limited to well-intentioned policy reports or professional obligations. While unequivocal, comprehensive and robust research in support of a multi-component program for maintenance of licensure is not yet available, simply because no medical regulatory authority

has fully implemented such a plan, there is growing evidence in the medical literature about 1.) the practice of physicians over time, and 2.) the value of enhanced continuing medical education or continued professional development. Both of these categories are addressed by the FSMB's MOL framework.

Several studies over the years have found, for instance, that practicing physicians who perform

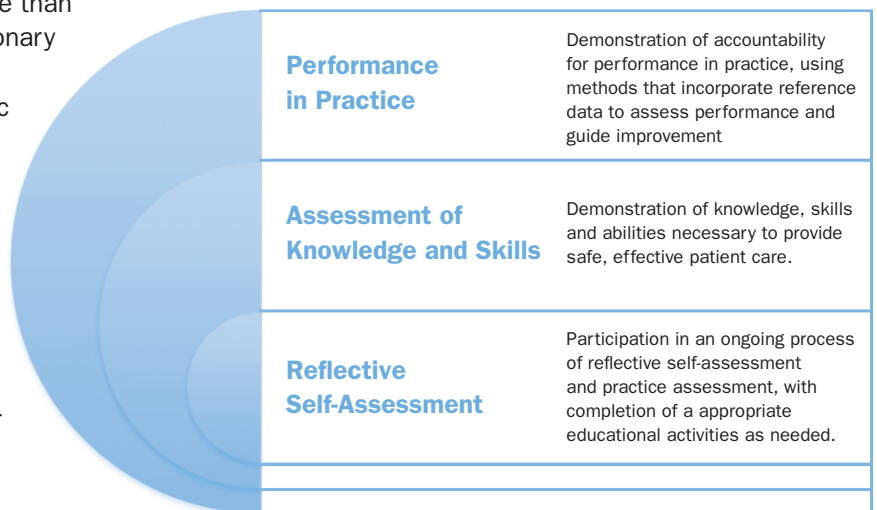
A COMPREHENSIVE PROGRAM FOR MAINTENANCE OF LICENSURE, IF ADOPTED BY ALL STATE MEDICAL AND OSTEOPATHIC BOARDS, COULD LOGICALLY AND OBJECTIVELY DEMONSTRATE WHICH PHYSICIANS ARE ENGAGED IN CLINICAL ACTIVITY AND HOW MUCH.

a lower volume of clinical or surgical procedures, or who have less experience with specific conditions or diseases, have higher rates of complications compared with their physician colleagues. As one researcher and his colleagues hypothesized in 1987, in the treatment of disease it would appear that practice makes perfect.¹² Kimmel and colleagues in 1995 studied more than 19,000 patients undergoing coronary angioplasty procedures by interventional cardiologists at cardiac catheterization laboratories across the United States and Canada and, after adjusting for case mix, found an inverse association between cardiac catheterization laboratory procedure volume and major complications.¹³ An inverse association between the number of coronary artery bypass graft surgeries performed by cardiac surgeons and subsequent mortality rates, after adjustment for clinical risk factors, has also been described.^{14, 15 16}

In a 1996 study of 403 adult male patients with the Acquired Immunodeficiency Syndrome (AIDS) who were cared for by 125 primary care physicians, after controlling for the severity of illness and the year of diagnosis, patients cared for by physicians with the most experience had a 31 percent lower risk of

death than patients cared for by physicians with the least experience.¹⁷ Nash and colleagues found a lower mortality rate from acute myocardial infarction among patients of both primary care physicians and cardiologists who had higher patient volumes than those physicians who provided care for this condition less frequently.¹⁸ A study by Tu and colleagues in 2001 found that patients with acute myocardial infarction who are treated by "high-volume admitting physicians" for that condition are comparatively more likely to survive at 30 days and at one year.¹⁹ And Freeman and colleagues found a substantial variation in the clinical outcomes of gastrointestinal endoscopy based on the ongoing case volume of the gastroenterologist.²⁰

Choudhry and colleagues conducted a systematic review of the relationship between clinical experience and quality of health care in 2005 and found that physicians who have been in practice longer may be at risk for providing lower quality care and that this subgroup of physicians may benefit from quality improvement interventions.²¹ While underperformance among physicians is neither very well studied nor defined, it has been suggested that age-related cognitive decline, impairment due to substance use disorders and other psychiatric



illness may contribute to underperformance, diminishing physicians' insight into their level of performance as well as their ability to benefit from an educational experience.²²

As for enhanced continuing medical education (CME) and continued professional development (CPD), the Johns Hopkins Evidence-based Practice Center for Healthcare Research and Quality

conducted a systematic review of the effectiveness of such education and reported in 2009 that multimedia, multiple instruction techniques and multiple exposures to content were associated with improvements in physician knowledge.²³ There is also evidence that such CME/CPD practices are effective in changing physician performance,²⁴ though more research is needed that focuses on the specific types of media and educational techniques that lead to the greatest improvements in performance. In a Cochrane database review of 81 trials looking at continuing medical education, Forsetlund and colleagues concluded that strategies to increase attendance at educational meetings, using mixed interactive and didactic formats, and focusing on outcomes that are likely to be perceived as serious may increase the effectiveness of educational meetings.²⁵

State medical and osteopathic boards have occasionally struggled with a subset of physicians with active licenses who are no longer clinically active, and have looked at how clinical inactivity should be defined, identified, monitored and communicated or shared with the public. In a 2007 telephone survey of 64 state medical and osteopathic boards in the United States, excluding its territories, Freed and colleagues found that only 22 state licensing boards (34%) query physicians regarding clinical activity at both initial licensure and licensure renewal, with the majority of boards permitting physicians to hold or renew an unrestricted active license to practice medicine, although they may not have cared for

ANY IMPROVEMENTS OR CHANGES IN LICENSURE RENEWAL SHOULD LOGICALLY AND APPROPRIATELY BE LED, AND GUIDED, BY STATE MEDICAL AND OSTEOPATHIC MEDICAL BOARDS. THE FSMB CAN ASSIST BY FACILITATING THE DEVELOPMENT OF POLICIES AND PROCEDURES.

a patient in years.²⁶ A comprehensive program for maintenance of licensure, if adopted by all state medical and osteopathic boards, could logically and objectively demonstrate which physicians are engaged in clinical activity and how much—a derivative benefit that would be useful for health care workforce analyses and predictions. A special committee commissioned this year by Freda Bush, M.D., FSMB Board Chair, to look at physician reentry and related issues on behalf of state medical and osteopathic

boards should be helpful in framing the context and offering guidance.

A rationale for a more robust or enhanced program of medical regulation is not only predicated on the need to protect the public and promote quality health care delivery. It has been argued that profligacy in the care of one patient within an increasingly cost-contained health care system or organization could lead to less adequate care for another patient.²⁷ A program to promote the ongoing clinical competence of actively licensed physicians could support the adoption, or awareness, of best practices in the management of all patients and their illnesses. A less obvious impetus for state medical and osteopathic boards to embrace changes and improvements in medical regulation is the concern that if they don't, others may. Medical regulation outside the bounds of state licensing authority could in turn, as one observer notes, lead to damaging effects to patients and society.²⁸ As representatives of the people of the state, usually appointed or elected by state officials (e.g., governor), state medical and osteopathic boards are sworn to protect the public and promote quality medical licensure and discipline. Any improvements or changes in licensure renewal should logically and appropriately be led, and guided, by state medical and osteopathic boards. The FSMB can assist by facilitating the development of policies and procedures, encouraging common practices while respecting states' autonomy and collaborating with health care organizations with expertise in physician assessment, public safety and practice performance.

Evolution of Maintenance of Licensure

All actively licensed physicians in the United States and its territories are required to renew their license every one to three years, depending upon the requirements of their state medical or osteopathic board.²⁹ Most state boards use a variety of information sources to document and verify the competence of physicians seeking licensure renewal: prescribed hours of accredited continuing medical education (CME), information that is usually self-reported but sometimes verified by random audits; hospital privilege reports; disciplinary data banks—such as the Federation of State Medical Boards' (FSMB) Board Action Data Bank or the National Practitioner Data Bank; patient complaints; and medical malpractice reports.

In May of 2003, following discussions centered around the need to improve the capability of state

medical and osteopathic boards to protect the public and promote quality health care, the FSMB, under its Board Chair, Thomas D. Kirksey, M.D., convened a special committee to make recommendations about the possibility of a system for the periodic assessment of the ongoing clinical competence of actively licensed physicians, what came to be known as “maintenance of licensure” (MOL).³⁰ Following discussions and review of existing practices, the committee recommended a substantive policy statement that was adopted the following year by the FSMB’s House of Delegates: “State medical boards have a responsi-

...PHYSICIANS ENROLLED IN THE ABMS’ MAINTENANCE OF CERTIFICATION (MOC) PROGRAM, OR THE AMERICAN OSTEOPATHIC ASSOCIATION BUREAU OF OSTEOPATHIC SPECIALISTS’ OSTEOPATHIC CONTINUOUS CERTIFICATION (OCC) PROGRAM, COULD SUBSTANTIALLY COMPLY WITH A STATE LICENSING BOARD’S EXPECTATIONS FOR MOL.

bility to the public to ensure the ongoing competence of physicians seeking relicensure.”^{31, 32}

Beginning in 2005, the FSMB sought input and commentary from leaders and representatives of major health care organizations and federal and state governmental agencies to consider options and programs by which state medical and osteopathic boards should or could implement maintenance of licensure. During the last seven years, multiple discussions, meetings and conferences have been held, with periodic surveys of state medical and osteopathic boards to continuously gauge their concerns and interests. To perform a comprehensive review and to make final recommendations to the Board of Directors about maintenance of licensure, the FSMB, under then Board Chair, Martin Crane, M.D., convened an Advisory Group on Continued Competence of Licensed Physicians in 2009. The Advisory Group was charged to issue an opinion to the FSMB Board of Directors concerning FSMB’s Maintenance of Licensure initiative and, more specifically, whether the framework proposed in the report of the Special Committee on Maintenance of Licensure was feasible, reasonable, consistent with a series of guiding principles adopted by FSMB’s House of Delegates in May 2008, and suitable for use by state medical and osteopathic

boards in ensuring the continued competence of licensed physicians.

The Maintenance of Licensure framework adopted by the FSMB House of Delegates in 2010 notes that as a condition of license renewal, physicians “should provide evidence of participation in a program of professional development and lifelong learning that is based on the general competencies model: medical knowledge, patient care, interpersonal and communication skills, practice-based learning, professionalism and systems-based practice.” One of the framework’s guiding principles is that “maintenance of licensure should not compromise patient care or create barriers to physician practice.”

Discussion and analysis is now under way with an FSMB-sponsored MOL Implementation Group that is guided by the framework and that receives regular input from an advisory council of chief executives from a range of health care organizations. A draft report from the MOL Implementation Group that outlines specific options for state boards will be reviewed this summer by the FSMB’s Board of Directors, then by state medical and osteopathic boards and then by other stakeholders in health care and in government. It is anticipated that a starter (pilot) plan for MOL may be initiated by interested state medical and osteopathic boards as early as the end of the calendar year.

Components of Maintenance of Licensure

While the specific details, methodologies and options by which state medical and osteopathic boards could implement a program for Maintenance of Licensure are being formulated at press time, several themes have emerged around the three specific components identified in the MOL framework document adopted by the FSMB’s House of Delegates.

The first component of MOL, *reflective self-assessment*, addresses physicians’ professional obligation to commit to lifelong learning to maintain their skills and acquire updated knowledge affecting their practice. This could involve the use of an assessment tool such as an accredited continuing medical education (CME) pre-test, as one example, to identify needs or opportunities for improvement, followed by a tailored improvement activity based on those outcomes. State licensing boards will likely need to modify or enhance, where appropriate, their existing CME requirements.

While the second component of MOL, *the assessment of knowledge and skills*, does not mandate the

passage of a secure or proctored examination as part of its second component, it notes that physicians enrolled in the ABMS' Maintenance of Certification (MOC) program, or the American Osteopathic Association Bureau of Osteopathic Specialists' Osteopathic Continuous Certification (OCC) program, could substantially comply with a state licensing board's expectations for MOL. Because more than 30 percent of actively licensed physicians are not specialty board certified,³³ most physicians with time-unlimited ("grandfathered") specialty certificates have chosen not to become recertified³⁴ and a plurality of physicians with time-limited specialty certificates are not seeking renewal of specialty board certification,³⁵ state licensing boards will need to consider additional options (e.g., computer-based clinical case simulations, hospital procedural privileging) for physicians to demonstrate ongoing clinical competence. The FSMB's MOL Implementation Group, guided by the adopted framework and its advisory council, is reviewing those options now.

For the third component, *performance in practice*, physicians could use data derived from their own practices supplemented by practice improvement activities already being implemented by specialty societies, hospitals, physician groups and quality improvement organizations. As this component is similar to the fourth part of MOC and the "Practice Performance Assessment" part of OCC, state boards may elect to substantially qualify licensees engaged in such activities. According to Kathleen Sebelius, Secretary of Health and Human Services, 20 percent of doctors and 10 percent of hospitals currently use basic electronic health records.³⁶ As "meaningful use" regulations to promote electronic health records and health information technology advance,³⁷ and data-driven changes in physician practice gradually take hold, component three of MOL is also the most likely to evolve over time. Regina Benjamin, M.D., M.B.A., U.S. Surgeon General and Past Chair of the FSMB's Board of Directors, recently wrote of her prior experience with health information technology and how "practicing medicine became easier for the clinicians and better for the patients" following the adoption of electronic health records in her private practice setting.³⁸

As the MOL Implementation Group deliberates the specifics of how the states could proceed with MOL adoption, the group's members have agreed that the overall process of implementation by the states

should be evolutionary, not revolutionary, while recognizing the need to be anticipatory.

International Perspectives on MOL

The same year that the FSMB's House of Delegates adopted its statement of responsibility in relation to the ongoing clinical competence of physicians, the Federation of Medical Regulatory Authorities of Canada (FMRAC) adopted its framework for maintenance of licensure, a program called revalidation by some Canadian provincial authorities. The FMRAC announced in 2004 that all licensed physicians in Canada must participate in a recognized revalidation process in which they demonstrate their commitment to continued competent performance in a framework that is fair, relevant, inclusive, transferable and formative. The Revalidation Working Group that studied the issue said, "The demonstration of ongoing competence and performance of physicians is a pillar of professional self-regulation."³⁹ Several Canadian provinces have mandated that physicians participate in an educational program, such as the Royal College of Physicians and Surgeons' Maintenance of Certification program or the College of Family Physicians' Maintenance of Proficiency program, to maintain licensure.⁴⁰ Physicians in these programs report their participation in educational activities annually, with random audits of the documentation by the colleges and/or a peer review process involving office visits by physician colleagues.

In England, where the administration of Henry VIII passed legislation in Parliament aimed at

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regulating and licensing medical practitioners that endured without any amendments for 300 years,⁴¹ the General Medical Council began in 1998 to develop a means by which doctors' practices could be appraised and objectively assessed annually over a five-year period as a mandatory condition for what it also calls revalidation.⁴² While formal implementation of such a system has now been delayed by a year under the newly elected government in the United Kingdom, when it gets underway it is expected to include as part of its appraisal of

physicians several elements: colleague and patient feedback, continuous professional development (CPD) records and a clinical audit, all within a quality assurance process overseen by Medical Royal Colleges and Faculties and various health systems regulators. It is expected to be a single process for both general practitioners and specialists, regulated by the General Medical Council and implemented within local hospitals with specialist standards set by the individual Royal Colleges.⁴³

Other nations, such as Australia, New Zealand and Ireland, are in various phases of implementation of similar programs for maintenance of licensure. All international medical regulatory authorities will differ in the details of how they implement ongoing clinical competence assessment of physicians, but it will be helpful and appropriate for these nations to share best practices, lessons learned, and research emanating from implementation of such programs, perhaps supported by the International Association of Medical Regulatory Authorities, for which the FSMB serves as Secretariat. While the medical regulatory laws may be different around the world, notions of medical professionalism, quality health care, and protecting the public are substantially aligned.

Concluding Thoughts

A system by which physicians with active licenses to practice medicine in the United States will be required over time to periodically demonstrate ongoing clinical competence in their area of practice as a requirement for renewal of licensure is going to become reality in the near term.

As Cyril Chantler notes with respect to the growing global movement within the medical regulatory community to establish assessment programs for ongoing clinical competence, “Physicians need trust more than regulation, but it is up to them to introduce systems that are comprehensive and fit for most purposes but not too bureaucratic or burdensome.”⁴⁴ ■

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