

# **AN ANALYSIS OF THE IMPACT OF IMPLEMENTATION OF MAINTENANCE OF LICENSURE REQUIREMENTS**

## **PREPARED AT THE REQUEST OF THE FSMB BOARD OF DIRECTORS**

### **EXECUTIVE SUMMARY**

In 2003, the Federation of State Medical Boards (FSMB) convened the Special Committee on Maintenance of Licensure to assess the role of state medical boards in assuring the continuing competence of licensed physicians and to develop recommendations regarding such. Acting on a recommendation of the committee, in May 2004 the FSMB House of Delegates adopted the following policy statement:

State medical boards have a responsibility to the public to ensure the ongoing competence of physicians seeking relicensure.

The Special Committee issued its final report to the Board of Directors in February 2008. The report recommends state medical boards take a proactive role in improving the quality of care patients receive by requiring licensed physicians to participate in programs that enable them to maintain or improve their competence in the scope of their daily practice and sets forth a framework for how to accomplish this objective. Specifically, the committee recommends state medical boards require physicians seeking licensure renewal to periodically demonstrate competence within the scope of their professional practice, and that such demonstration should include evidence of the following:

1. Participation in an ongoing process of reflective self-evaluation, self-assessment and practice assessment, with subsequent successful completion of educational activities tailored to meet the needs or deficiencies identified by the assessment.
2. Demonstration of continued competence in the following areas: medical knowledge, patient care, practice-based learning and improvement, interpersonal and communication skills, professionalism, systems-based practice and, if applicable, osteopathic philosophy and osteopathic manipulative medicine; including the knowledge, skills and abilities to provide safe, effective patient care within the scope of their professional medical practice.
3. Demonstration of accountability for performance in practice.

The Special Committee also recommends that licensees be expected to provide documented evidence of compliance with the state medical board's maintenance of licensure requirements, and that state medical boards provide guidance to licensees as to the types of evidence deemed acceptable for purposes of meeting maintenance of licensure requirements, such as active participation in Maintenance of Certification processes or participation in recognized quality improvement activities such as those required by The Joint Commission or the AOA Clinical Assessment Program.

The Board of Directors considered both the committee's final report as well as state medical board feedback on the proposed framework. The feedback consisted primarily of concerns and questions about implementation of continuing competence requirements and the potential

impact of such requirements on the physician workforce as well as the additional regulatory burden on physicians and the necessity to develop the evidence to support the need for MOL. Given the lack of information available to answer these questions, the Board deferred forwarding the committee's report to the House of Delegates and instead recommended the House of Delegates direct the FSMB to research how state medical boards and other stakeholders would be impacted if the proposed recommendations were implemented by state medical boards.

The House of Delegates approved the board's recommendation and directed FSMB to conduct the analysis and report its findings at the 2009 annual meeting of House of Delegates. The House also adopted as policy the following five principles to guide FSMB's ongoing activities related to maintenance of licensure.

- Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.
- Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders. The authority for establishing maintenance of licensure requirements should remain within the purview of state medical boards.
- Maintenance of licensure should not be overly burdensome for the profession and should not hinder physician mobility.
- The infrastructure to support physician compliance with maintenance of licensure requirements must be flexible and offer a choice of options for meeting requirements.
- Maintenance of licensure processes should balance transparency with privacy protections.

On October 9-10, 2008 FSMB convened representatives from 13 state medical boards to assist in evaluating the potential impact of the proposed MOL policy on state medical boards and other stakeholder groups. Following a series of activities designed to identify, illuminate and analyze potential issues arising from the implementation of continuing competence requirements, the taskforce concluded that the model framework outlined in the report of the Special Committee on Maintenance of Licensure was the most feasible with regard to minimizing impact and cost on state medical boards and practicing physicians. The taskforce also agreed that the most viable way to accomplish what will be a sea change in physician regulation is for states to use a consistent model in implementing MOL programs and to move forward in a timely manner. Ultimately, however, the taskforce recognized that regardless of what model policy is adopted by FSMB, the decision as to whether and how to implement continuing competence requirements remains the responsibility of each state medical board.

## **METHODOLOGY**

The MOL taskforce met in Westlake, Texas, on October 9-10, 2008 and comprised representatives from 13 state medical boards as well as three representatives from the testing, continuing medical education and practicing physician community. Two FSMB director-level staff also participated in the taskforce discussions. A facilitation team was retained to lead the group through its discussions. A listing of the taskforce members, consultants, and staff is provided in Appendix 1.

Prior to the meeting taskforce members were invited to participate in webinars designed to provide information about two initiatives that could contribute to state medical board efforts to assure the ongoing competence of licensed physicians: the first was on the American Board of

Medical Specialties' Maintenance of Certification program and the second on hospital-based programs being developed as a result of new Joint Commission privileging and credentialing standards that aim to assure the ongoing competency of physicians. In addition, the taskforce received a briefing on research regarding issues relevant to physician competence and maintenance of licensure, including recently published studies indicating patients do not receive the full amount of recommended care and physician performance decreases with increasing years in practice or age.

During the first day of the meeting taskforce members participated in a series of small-group discussions which focused primarily on various implementation models for MOL and potential implications of each for state medical boards and key stakeholders, including consumers/public; practicing physicians; affiliate organizations (e.g., certifying boards and continuing medical education providers); and the provider community (e.g. insurers, payers, VA, hospital associations, etc.). The intent of reviewing multiple models was neither to advocate for or against any model nor to debate the merits of any model. Rather, the models were used as a way to catalyze discussion about the implications and dynamics of implementing a MOL process. The referenced models are included as Appendix 2.

During the second day of discussions, taskforce members began to coalesce around an MOL implementation model consistent with the guiding principles adopted by the FSMB House of Delegates. Participants were asked to consider more deeply the implications of the emerging MOL model on state medical boards, physicians and other stakeholders. The taskforce was finally asked to develop implementation timelines, both from an “evolutionary” and “revolutionary” perspective, and to develop a list of common themes emerging from their discussions.

## **ANALYSIS OF TASKFORCE DISCUSSIONS**

It is clear from the discussions of the taskforce that the impact of the Special Committee’s recommendations on various stakeholder groups will depend on choices a state medical board makes regarding the processes, tools and reporting methodologies used to administer the requirements. The taskforce looked at two possible scenarios for how a state medical board might approach MOL: 1) assuming responsibility for all aspects of MOL, including development of tools/resources as well as collecting and assessing individual physician data sets; or 2) establishing MOL requirements as a condition of licensure renewal and deferring to the market to develop the tools and resources needed by physicians to meet those requirements.

The implementation model identified by the taskforce as being the most efficient and least burdensome for state medical boards was one in which the state medical board sets the standards for MOL and relies on the market to develop the tools to support licensees in meeting the requirements. This conclusion was based in part on the taskforce’s acknowledgement that many physicians already participate in programs offered by the ABMS or AOA-BOS and that such programs would likely meet criteria defined by most boards. The model included

1. a nationally recognized or accepted vetting or accreditation process that assures states of the validity of the programs or tools used by physicians to meet MOL requirements;
2. agreement by the state board to accept documentation verifying that the physician is actively participating in a board-approved program or has completed appropriate MOL requirements;

3. a web-based IT infrastructure to enable electronic submission of the required documentation;
4. a willingness on the part of the state board to partner with external experts and vendors to develop research and data regarding the impact of MOL, particularly on patient care.

In this model, licensees have a choice of programs or tools approved by the medical board for purposes of meeting MOL requirements; and are responsible for assuring documentation verifying either active enrollment in or completion of board-approved tools or programs is submitted to the board at the time of license renewal. Performance or practice data used by the physician as part of the assessment and educational process would remain confidential and not be accessible to the board for purposes of complaint investigations.

This model is similar in some aspects to that used currently by states to administer continuing medical education requirements, in that states require the CME to be accredited (i.e., board approved), and expect the licensee to submit an attestation that he/she has met the CME requirement. The state may conduct a random audit of a small percentage of renewals to assess compliance with the CME requirement. The primary difference between the maintenance of licensure model and CME is the content of the learning activity – MOL requirements are practice-relevant, pertain to competencies beyond medical knowledge, and require use of practice data to identify opportunities for improvement. No such requirements exist currently for CME.

### **Implications for state medical boards**

#### *Staffing and financial implications*

States that choose to assume responsibility for all components of an MOL program, including development of tools and educational resources as well as data interpretation will need significant resources to administer the program. Such a model will require additional board staffing, particularly in the licensing and investigative units, as well as staff with different competencies, such as the ability to develop assessment tools or to interpret self-assessment or practice data for use in designing educational plans. In this model, it is highly likely that the medical board will need to acquire additional funding either from the state or through an increase in licensing fees.

In the collaborative model, state boards would incur costs primarily at the start-up of the program. These would include costs associated with licensee notification/education about the new requirements, IT development to support electronic information transmission, staff training, and in some cases, monies to obtain statutory authority to implement MOL requirements. The board may choose to dedicate a staff person to assist physicians through the MOL process for the first few renewal cycles and to monitor physician compliance with the new requirements. Ongoing costs to administer the requirements would be minimal.

In either model, depending on what evidence is acceptable to boards for meeting MOL requirements and how that information is to be submitted, boards will incur IT costs for website enhancements to support licensee compliance with the requirements.

#### *Statutory/legal implications*

Boards will need to determine if they have the statutory authority to implement continuing competence requirements as a condition of license renewal. It may be possible for jurisdictions

that currently require CME for license renewal to reinterpret their rules to allow for the development of an MOL process. States that have very specific and narrow statutory language will need to revise their statutes to gain the authority to implement MOL.

If a state requires licensees to submit performance or self-assessment data as part of their MOL documentation, the medical board will need to assess its public record and open-meeting laws to determine which MOL information may be kept confidential and which must be made public. Further, even if the information is confidential, the board will have to consider whether the information is discoverable in a civil or criminal action.

In addition, the development of an MOL process may impact case law in such areas as the physicians' reasonable expectations in continued licensure as a property right, the legal differences between a denial and a revocation, patients' detrimental reliance upon the boards' determination that the physicians are currently competent and negligent licensing.

### *Standards*

The taskforce was in agreement about the need for states to use a consistent approach to implementing MOL programs and to do so in a timely manner. This would be the only viable way to accomplish what will be a sea change in the approach to regulation of the profession. Otherwise, the task becomes exponentially more difficult and could lead to a variety of unintended consequences. MOL requirements should be as consistent as possible across jurisdictions to lessen the potential impact to licensees and the physician workforce. Implementing a system in which states have varying standards for MOL increases the potential for licensees to migrate to states with less stringent requirements, which could impact access to care, and raises questions and concerns about the impact on license portability and physicians with multi-state licenses.

In considering these issues, the taskforce felt that technology might help address some of these concerns by making it easier for physicians to submit documentation of compliance with MOL requirements to multiple jurisdictions. Additionally, as noted above, being able to utilize tools for multiple purposes will alleviate some of the burden to physicians.

The taskforce agreed that, as part of the implementation of MOL requirements, state medical boards should provide licensees with a menu of options to use in meeting the requirements. The taskforce also agreed that such tools should be vetted or accredited by a nationally recognized external organization, such as the Accreditation Council for Continuing Medical Education (ACCME), which is already listed in many state statutes as a board-approved/recognized accreditation agency.

### **Implications for physicians**

In reviewing the draft model MOL policy, the taskforce acknowledged that many physicians will be able to meet MOL requirements through participation in continuous certification programs such as those offered by the ABMS and AOA-BOS. However, a significant percentage of physicians are not board certified and will need access to tools or resources in order to comply with MOL requirements. As noted above, the taskforce felt that such physicians should be provided with a menu of valid, reliable, vetted options/tools for meeting MOL requirements. However, there would still be many concerns on the part of licensees about how they might be impacted by MOL policies. Such concerns are addressed below.

### *Cost*

Implementation of MOL requirements will undoubtedly have some costs implications for physicians, whether through increased licensure fees or costs associated with participating in MOL activities. While physicians who choose to meet MOL requirements through participation in board certification activities would not likely incur additional costs, those who must meet MOL requirements through other means may. The taskforce felt that tools/activities developed for use in meeting MOL requirements should also be useful for other purposes, such as assisting physicians in meeting quality improvement requirements or activities for other agencies, hospitals, employers, insurers or others. Additionally, market and vendor competition could result in a decreased price for MOL tools.

### *Meeting MOL requirements*

The draft model MOL policy recommends that state medical boards mandate that the requirement for demonstration of continued competence be met, at least in part, by passage of a valid, secure, proctored examination in the physician's current practice area at least once every 10 years. The taskforce was in agreement that if the purpose of MOL is to improve practice, more formative assessment methodologies may be as or more effective in fulfilling this objective than requiring physicians to pass a high-stakes multiple choice exam. In addition, given the pushback that will most likely occur as states move forward with MOL, the taskforce felt this particular recommendation may serve as an unnecessary barrier to successful implementation of MOL requirements. Providing a menu of options to licensees for meeting MOL requirements will enable all licensees to meet MOL requirements without undue burden and will help alleviate physicians' concerns about the impact of MOL on their licenses.

### *Workforce issues*

Boards will likely encounter pushback from licensees as they implement MOL requirements. The concerns expressed by licensees in response to MOL will need to be carefully considered by the boards, especially given the potential for impact to the physician workforce and access to care. States that are early adopters of MOL will need to exercise extra care and caution as they implement MOL requirements, as they most likely run the risk of licensees migrating out of the state.

### *Confidentiality of physician-specific data*

The taskforce agreed that while the processes used by boards to administer MOL need to be transparent, the data used by physicians to identify opportunities for practice-improvement must remain confidential. One of the benefits of the collaborative model developed by the taskforce is that the information provided to the board to verify compliance with MOL requirements would simply attest to whether the physician is actively engaged in or has completed board-approved MOL programs. The data generated through self-assessment or practice assessment activities would remain the property of the physician and would not be transmitted to the medical board. If a medical board were to mandate that such data are to be submitted as part of the MOL documentation, the taskforce suggested that the board could address physician concerns about confidentiality in part by setting up a secure web-based system or portal by which physicians would submit their data to the boards.

## **Implications on Affiliate Organizations**

In the collaborative model supported by the taskforce, much of the onus for developing the infrastructure necessary to support physician compliance with MOL requirements would fall to partner organizations. As the taskforce worked through the model, members were increasingly

cognizant that most if not all of the elements of that infrastructure were in place in some form or fashion. For example, organizations such as the ACCME or AOA that currently accredit CME could be called upon to develop new standards or enhance existing standards to accommodate MOL policies.

Several national organizations have or are developing programs that could support a MOL process. For example, ABMS is considering allowing non-board certified physicians to access some of the tools and resources available through board certification programs. Most specialty societies either have or are in the process of developing tools and services to help their members comply with board certification requirements and would view non-board certified physicians as yet another market in need of their services. CME providers have developed new methods of CME, such as performance improvement CME that are practice relevant and require physicians to document changes in practice. A web-based technology platform currently being used by medical boards in New Hampshire, Ohio, Kentucky and Rhode Island to gather and transmit data for purposes of initial licensure could be enhanced and expanded to facilitate transmission of documentation concerning MOL compliance.

With all of this work underway by partner organizations, state medical boards still need to collaborate and dialogue with other stakeholders on matters such as agreement on the use of common standards, recognition and acceptance of tools and programs that may be used by physicians to meet multiple reporting requirements, development of a research agenda to assess the impact of MOL systems on patient care, and clear communication strategies to ensure accurate dissemination of information about MOL.

### **Implications for FSMB**

As the national organization representing state medical boards, FSMB could play a major role by working with state medical boards and partner organizations to survey, measure, evaluate and distribute outcomes data regarding MOL models. This will require a commitment of sufficient resources to help states adopt and implement MOL policies.

FSMB should also consider “rebranding” MOL so that it is perceived as a quality improvement or skills enhancement initiative. The taskforce voiced concern that the phrase “maintenance of licensure” has negative connotations, especially to practicing physicians, which could create significant barriers for medical boards as they consider moving forward with such policies. Likewise, FSMB can assist boards in managing public expectations and reactions as states adopt MOL policies.

### **CONCLUSIONS**

There is no right or wrong model for implementing maintenance of licensure policies. Each state medical board is authorized to determine whether and how to assure the public that licensed physicians in that jurisdiction are maintaining the skills and knowledge necessary to provide safe care. The degree to which state medical boards, physicians, and other stakeholders will be impacted by efforts to assure the public that physicians are maintaining their competence will depend on how states choose to implement such policies.

Based on the conclusions of the MOL taskforce, the framework recommended by the Special Committee on Maintenance of Licensure – i.e., states require physicians to provide evidence of continuing competence as a condition of licensure renewal and depend upon the external

community to develop the resources to be used by physicians to comply with such requirements – is the most feasible and least burdensome to both state medical boards and the practicing community. Such a model is collaborative in nature and distributes accountability across multiple stakeholder groups, thus minimizing the financial and human resources needed by state medical boards to implement continuing competence requirements. The success of this model will depend on numerous factors:

***A vetting or accreditation process that medical boards may rely upon to assure tools and programs are valid:*** While the majority of physicians will use ABMS Maintenance of Certification or AOA-BOS Continuing Certification to meet continuing competence requirements, a significant percentage of physicians will need access to tools and resources developed by third party vendors from the assessment and continuing medical education communities, such as patient registries with learning collaboratives, 360-degree surveys, and validated self-assessment modules. Criteria will need to be developed for use by state medical boards in determining whether to accept a tool or program as acceptable for MOL. Most states mandate that CME required for license renewal be accredited by the Accreditation Council for Continuing Medical Education or the AOA; it is reasonable to assume similar accreditation processes could be developed and applied to MOL tools and programs.

***A willingness to allow repurposing of data:*** The impact that continuing competence requirements has on the practicing community will be significantly minimized for the majority of physicians if they are allowed to “repurpose” tools and data from programs they already participate in to meet MOL requirements. For example, state medical boards could provide physicians with a listing of programs or activities the board has deemed acceptable for purposes of meeting MOL requirements, such as ABMS Maintenance of Certification, the AOA CAPS program, or certain types of accredited CME programs. Multiple requirements may also be satisfied simultaneously by certain types of programs. At the time of license renewal, the physician would submit documentation verifying that he/she is actively participating in or has successfully completed the requisite activities needed to meet MOL requirements. Ideally, such verification would be transmitted electronically so as to minimize paperwork for both parties. The Trusted Agent Platform currently being used by several state medical boards to facilitate license portability could be used for this purpose as well.

***Agreement to protect the confidentiality of physicians’ data:*** Data used by a physician to identify opportunities for improvement should be considered confidential and the property of the licensee. Working under this premise, medical boards would mandate that physicians submit verification that he/she is actively participating in or has completed the requisite activities selected from the board-approved list of resources. The data used by the physician to complete the activity or program would remain confidential and the property of the physician. In this model, the physician is held accountable for submitting evidence that he/she is engaging in appropriate self-assessment and learning processes and is addressing areas of improvement identified through those processes. The process is confidential; and the only way physicians get in “trouble” is if they refuse to participate/comply. If the physician does not submit the required documentation, his/her license would not be renewed until such time as the requisite documentation is provided, similar to how state medical boards hold physicians accountable for completing CME.

***Minimizing financial and operational impact on state medical boards:*** The financial and operational impact that a state board will experience if it implements an MOL program will depend on what model is implemented. In a collaborative model, wherein the state implements

requirements and the external community develops the necessary tools and resources, the impact could be minimal, with expenses being primarily start-up in nature and relating to staff training, technology enhancements, licensee communications/education, and any necessary activities needed to gain statutory authority. In contrast, operational and staffing costs could be significant if states choose to bring all elements of maintenance of licensure in-house, including development of tools and education programs.

***Gaining statutory authority to implement MOL requirements:*** Currently 62 states require CME for licensure renewal. In states where statutory language is broad, it may be possible for the state medical board to reinterpret their existing statute or rule so that the board has the authority to broaden their definition of “CME” to include continuing competence requirements. Such a reinterpretation could be based on the movement within the CME community towards a “continuous professional development” model wherein physicians use assessment data from their practices to identify opportunities for improvement – a concept consistent with the recommendations proposed by the Special Committee on Maintenance of Licensure. States that have statutory language specifying what is required at the time of license renewal or that currently do not require CME will likely need to go through the process of gaining statutory authority to implement MOL requirements.

***Managing public expectations:*** The taskforce noted that implementing MOL policies could result in increased public awareness that physicians are not currently required to periodically demonstrate to the public’s satisfaction that they are maintaining their competence. The public is increasingly aware that traditional CME has little to no effect on physician behavior. State medical boards that choose to maintain the status quo run the risk of increased liability and public dissatisfaction. On the other hand, implementing maintenance of licensure processes will clearly illustrate state medical boards’ and the profession’s commitment to putting patients first.

***Emphasizing maintenance of licensure as a mechanism for improving physician practice and facilitating lifelong learning:*** According to FSMB policy, the purpose of maintenance of licensure is to improve physician practice and facilitate lifelong learning. Research suggests that the CME model – currently used by 62 states as a requirement for license renewal is not effective in changing physician behavior. The objective of MOL is consistent with what states have sought to achieve since adopting CME requirements in the early 1970s – what has changed is the knowledge that in order to facilitate learning, CME should be data driven, practice relevant, and framed within the context of the 6+1 core competencies. Further, given the emphasis on practice improvement and lifelong learning, the taskforce agreed that requiring passage of a high-stakes proctored examination should not be mandated but rather, offered as one of the options available to physicians for use in complying with continuing competence requirements.

## **COMMON THEMES EMERGING FROM THE TASKFORCE DISCUSSIONS**

- Medical boards hold the authority and autonomy to decide whether and how to move forward with MOL.
- FSMB must adopt a model MOL policy and commit sufficient resources to supporting member boards in making it a reality. While the draft MOL policy carries no weight of law, it will serve as a guide to states who are eager to move forward with continuing competence requirements.

- Having a nationally recognized vetting or accreditation system for use in determining the acceptability of tools and resources as appropriate for meeting MOL requirements will be critical to any future implementation model. Having this in place 1) removes any subjectivity regarding what states will accept for purposes of meeting MOL requirements; 2) minimizes the potential negative impact on license portability because states are using the same standards for determining acceptability of MOL programs and 3) provides clear parameters to licensees and vendors as to what constitutes a valid MOL program.
- Coordination and collaboration with other stakeholders is critical. The FSMB must take a leadership role in working with appropriate organizations and facilitating the development of tools and resources that will be acceptable to multiple end users.
- The choice of words used to describe maintenance of licensure needs to be reevaluated. MOL should be viewed in an educational context, not a punitive one. Using terms like “quality improvement program” or “enhanced skills initiative” may be better received by the practicing community.
- Remove physician barriers by shifting towards quality improvement methods and away from “high stakes, high risk exams.” If the purpose of MOL is to improve physician practice and facilitate lifelong learning, passage of a high stakes exam should not be mandated but rather offered as one of several options a physician can use to demonstrate competence in his or her scope of practice.
- States should move forward with implementing MOL programs in a consistent and timely manner in order to minimize the potential unintended consequences on work force issues, particularly for early adopters.
- Consistent evaluation, validation and quality improvement of maintenance of licensure system will be critical. To accomplish this, FSMB and state medical boards need to partner with outside experts to gather, evaluate and analyze data regarding the impact of continuing competence requirements in areas such as patient care outcomes and physician performance.

## APPENDIX 1:

### Taskforce Participants

<b>Participating State Medical Boards</b>			
<b><i>Board</i></b>	<b><i>Structure</i></b>	<b><i>Representative</i></b>	<b><i>Title</i></b>
California-M	Semi-Independent	Kimberly Kirchmeyer	Deputy Director
District of Columbia	Umbrella Agency	John C. Greenhaugh, Esq.	Attorney Advisor
Florida-M	Semi-independent	Robert Cline, MD	Member, Chair
Idaho	Independent	Nancy Kerr	Executive Director
Kansas	Independent	Katy Lenahan	Licensing Administrator
Massachusetts	Independent	John Herman, MD	Member, Chair
Michigan-M	Umbrella Agency	Melanie Brim	Director, Bureau of Health Professions
Minnesota	Independent	Linda Van Etta, MD	Member, President
Mississippi	Independent	H. Vann Craig, MD	Executive Director
New Mexico-M	Independent	Amanda Quintana	Licensing Director
Ohio	Independent	Richard Whitehouse	Executive Director
Virginia	Umbrella Agency	Ola Powers	Deputy Exec Director, Licensing
Washington-O	Umbrella Agency	Blake Maresh, MPA	Executive Director
<b>Invited Guests</b>			
<b><i>Representative</i></b>		<b><i>Organization</i></b>	
Richard Hawkins, MD		National Board of Medical Examiners	
William McCauley, MD		College of Physicians and Surgeons of Ontario	
Ramesh Sachdeva, MD		American Academy of Pediatrics	

## APPENDIX 2a:

### Straw Model

#### Assumptions:

- The program must be based on objective criteria
- The program must be executed by staff, not the board
- The program must give fair notice to physicians on how to demonstrate a commitment to life long learning
- The program must be feasible, practical and economical
- The program must not slow down the renewal process
- The program must provide the public with confidence that physicians have demonstrate continuing competency
- The program must provide due process access to the board for denials
- The program must not prohibit the board from ordering further evaluation and testing for physicians who meet the minimum criteria for renewal
- The program must allow staff to present unusual cases to the board
- The program must provide a mechanism for physicians to remediate deficiencies

#### Straw Model:

Staff is not equipped to make subjective conclusions about a physician's competence. An up-front evaluation or testing would be too time consuming, expensive and unnecessary. In addition, bringing each applicant in front of the board for a review is unfeasible. Instead, the board would need to establish a list of criteria for board staff to analyze based upon a rating system.

This rating system would need to be detailed and clear so staff would have no trouble using it to determine if a physician has demonstrated continuing competency. The list of qualifying activities would need to encompass as many actions that demonstrate continuing competency as possible to reduce the number of special circumstances that would need to be brought to the board's attention. As not all activities have the same weight in demonstrating continuing competency, the board would need to create a point-based rating system for staff to use when evaluating an application for renewal of license. This list of acceptable activities and the weight given to them must be made available to the physicians for fairness and to the public for transparency.

This is an example of how the board could develop a list of activities and the points associated with the activities. This is not a complete list; the board to develop a comprehensive list of acceptable criteria and the weight associated with each activity.

#### Program Assumption:

A physician must accumulate 40 points to qualify for automatic renewal.

These activities could include:

Maintenance of certification	40 points
General or non-live CME	1 point/hour, 5 points max
Specific live CME	1 point/hour, 10 points max
Presenting at CME	5 points

Publication in peer review journal	10 points
Maintenance of privilege in hospital that has Joint Commission-compliant maintenance of privilege program	10 points
Teaching at accredited program	10 points
Faculty staff at accredited program	40 points
Academic work	10 points
Participation on peer review or M&M committees for 40 hrs/year	5 points

**Examples:**

*Scenario One:*

Physician maintains board certification 40 points

Physician's license is renewed.

*Scenario Two:*

6 hours general CME (records)	5 points
14 hours specific CME (clinical)	10 points
Maintained Hospital Privileges	10 points
Published Article	10 points
Peer Review Member	5 points
Total	40 points

Physician's license is renewed.

*Scenario Three:*

10 hours general CME	5 points
10 hour specific CME	10 points
Presenting at CME	5 points
Maintained hospital privileges	10 points
Total	30 points

License would be reissued on a probationary basis. Staff would refer physician to board to determine what remediation is necessary. The board could extend the time for physician to gather sufficient points to qualify for unrestricted license or board could send physician for evaluation and testing. If the evaluation or testing demonstrated that the physician was deficient in a particular area, the board could restrict the physician from practicing in that area until the physician remediates the deficiency and passes an evaluation or test.

This model meets most of the assumed requirements.

- The model is objective in that it lists the qualifying activities and the points associated with each activity. Except for unusual circumstances, the staff can administratively implement and manage the program without direct board involvement.
- Publicizing the list to physicians gives them fair notice of the requirements for demonstrating continuing competency.
- This model is feasible, although developing a complete list of qualifying activities would be difficult and may require editing as new activities are brought to the boards attention.
- The model is practical, as it does not require subjective evaluation by board staff.

- The model is economical, as it does not require independent testing or evaluation of every non-board certified physician.
- This model will not slow down the renewal process, especially if the renewal application lists all qualifying activities with the points for the physician to check and total.
- This model, if the list of activities is all-inclusive and the weighting is reasonable, would provide public confidence in physicians demonstrating continuing competency.
- The model provides due process for a physician who is denied license renewal by allowing the physician to appear before the board to plead his or her case.
- If the physician comes to the board's attention through the complaint process, the board could order evaluation and testing even if the physician had sufficient points for renewal of his or her license.
- The model would allow staff to bring novel or unusual cases to the board for the board's determination. This is especially important for situations where a new activity may need to be added to the list.
- This model does not provide the physician with a mechanism for remediating deficiencies, only for the board to order remediation.

This model describes the basic program an executive director might present to the board for its consideration. As the person with the most experience with the daily operations of the board, the executive director would ensure any program was practical, feasible, economical and would not interfere with the efficient renewal of licenses. As the board would be the experts in what activities demonstrate continuing competency and the weight to ascribe to those activities, the executive director would defer to the board on those issues. The board's attorney would have to ensure that the program meets all legal requirements for notice and due process.

## **APPENDIX 2b:**

### **FSMB Model**

#### **Continuing Competence: FSMB MODEL**

##### **Guiding Principles**

- Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.
- Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders. The authority for establishing maintenance of licensure requirements should remain within the purview of state medical boards.
- Maintenance of licensure should not be overly burdensome for the profession and should not hinder physician mobility.
- The infrastructure to support physician compliance with maintenance of licensure requirements must be flexible and offer a choice of options for meeting requirements.
- Maintenance of licensure processes should balance transparency with privacy protections.

##### **Requirement for Relicensure**

Physicians seeking relicensure shall demonstrate ongoing competence within the scope of their professional practice.

##### **Maintenance of Licensure components**

1. Participation in an ongoing process of reflective self-evaluation, self-assessment and practice assessment, with subsequent successful completion of educational activities tailored to meet the needs or deficiencies identified by the assessment.

Acceptable activities include: participation in self-evaluation exercises or modules, self-review tests, home study courses and web-based materials, or passage of a state medical board approved examination in the physician's current practice area.

Remediation and educational activities could include review of literature in the physician's current practice area; CME in the physician's current practice area that enhances patient care, performance in practice and and/or patient outcomes; or participation in other educational programs targeting areas of weakness or deficiency identified through the self-assessment.

2. Demonstration of continued competence in the following areas: medical knowledge, patient care, practice-based learning and improvement, interpersonal and communication skills, professionalism, systems-based practice and, if applicable, osteopathic philosophy and osteopathic manipulative medicine; including the knowledge, skills and abilities to provide safe, effective patient care within the scope of their professional medical practice.

Acceptable activities shall include passage of a valid, secure, proctored examination in the physician's current practice area once every 10 years.

### 3. Demonstration of accountability for performance in practice.

Acceptable activities include: peer assessment; 360-degree evaluations; letters of attestation of clinical activities; patient reviews; satisfaction surveys; collection and analysis of practice data, such as thorough review of office records, chart review, case review and submission of case logs.

#### **Documentation requirements**

At the time of license renewal, licensees shall provide documentation of compliance with the board's Maintenance of Licensure program components. Active participation in ABMS Maintenance of Certification and AOA BOS Continuous Certification shall be deemed acceptable for purposes of meeting maintenance of licensure requirements. Participation in recognized quality improvement activities such as those required by The Joint Commission or the AOA Clinical Assessment Program shall be deemed as meeting requirements for self-assessment and accountability for performance in practice. If a licensee's clinical practice is outside the scope of his or her board certification or training, the licensee's documentation shall include evidence of competence in that practice.

#### **Reporting of Practice Data**

Licensees shall report information about their practice as part of the license renewal process. Such information shall include: scope of practice, type of practice (to include location, supervisory responsibilities), status (e.g., full-time, part-time, number of hours in patient care duties per week), 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 shall keep the board apprised of their practice status at all times by reporting any subsequent changes in practice status or scope of practice to the board within 30 days.

## **APPENDIX 2c:**

### **CPSO Peer Assessment Model**

The College of Physicians and Surgeons of Ontario

Peer Assessment Programme - Quick Facts

#### Background Facts:

Population of Ontario: 12.8 Million

Number of Physicians: 26,000 (active, in practice in Ontario)

#### Peer Assessment Program

Year started: 1980

Peer Assessments 2006: 776

#### Description of Program

The Peer Assessment program of the College of Physicians and Surgeons of Ontario assesses physicians in their practice environment. Physicians are selected for peer assessment for one of two reasons – Random and age-related.

**Random:** The College randomly selects physicians for assessment every year. Physicians are excluded if they have been assessed within 5 years, if they are less than 5 years since certification or if the physician works in a discipline for which the program does not have protocols.

**Age-related:** Every physician in the province is assessed every 5 years once they reach the age of 70.

Once a physician is selected for assessment, they are notified by the CPSO. The College then appoints a Peer assessor whose practice is matched as closely as possible to the subject physician. The Physician submits a Pre-Visit Questionnaire (PVQ) that contains information such as demographics, practice information, educational activities and goals for the assessment.

The Assessor meets the physician in his/her practice and reviews the PVQ. The physician's facility/office/clinic is inspected. The Assessor then randomly selects 20 – 30 of the physician's charts to review. The Assessor completes the assessment protocol using tools provided and prepares a report that comments on the physician's documentation and care. At the end of the assessment, the Assessor meets again with the physician to review and summarize their findings.

The Assessment report is forwarded to the College. The Quality Assurance Committee reviews the Assessment reports. The reports are considered and graded into three categories:



# **APPENDIX 2d:**

## **CPD Michigan Model**

### **Continuous Professional Development: Michigan's Model**

In advocating for an alternative to the current continuing education model used by a number of the health profession boards in Michigan, the following basis tenets were adopted:

- Continuous Professional Development (CPD) is an essential part of any person's professional development.
- There needs to be a mechanism to ensure that knowledge, skills, and abilities at least remain current and at best are continuously improved.
- Competence is diverse and difficult to measure objectively.
- There is rapid turnover of knowledge in all health professions.
- Self-reflection and objective testing are an important part of one's professional development.
- Experiential learning or "event-based learning" provides some of the best evidence of meaningful CPD.
- A planned approach to the maintenance of existing skills and knowledge or the acquisition of new skills and knowledge for the purpose of demonstrating competency is essential.
- A portfolio model for planning and documenting participation in CPD activities has added benefit.
- It is important to focus on the needs of the individual practitioner.

In thinking out what an alternative model might look like, there was acknowledgement that continuing education is an essential part of a professional's career life, however, not sufficient in and of itself to assure competency. Important to the design of the model was also the acknowledgement that a variety of learning activities needed to be acceptable to ensure that all learning style preferences would be accommodated.

Three categories of acceptable CPD activities were identified:

- Continuing education activities, including activities such as publishing in professional journals, participation in approved educational programs, webinars, peer review, participation on patient care and health related committees, teaching, and special residencies or fellowships
- Hands-on learning activities, including demonstration, simulation, direct observation, and event-based learning
- Competency assessments such as certification and recertification examinations, self-assessment tools, participation in national examination development and administration, and participation in employer credentialing programs

Health profession boards are encouraged, through their administrative rules, to address the need for licensees to participate in activities that fall within a minimum of 2 of the 3 approved categories, to participate in a minimum number of hours of activities that are live and interactive, and to participate in continuing education programs that include an evaluative component.

The CPD portfolio model to be used in Michigan includes the following four components:

1. Learning Assessment

- *Core elements*: identification of short and long term learning goals, focus on current and anticipated scope of practice, areas to improve or expand, and results of quantitative or qualitative assessment tools.

2. Learning Plan

- *Core elements*: development of an individual plan that identifies and targets appropriate professional development activities based on learning assessments, describes CPD activities to be accomplished over the coming licensure cycle and targets CPD activities based on learning style preferences.

3. Learning Activities Log

- *Core elements*: documentation of accomplishments and demonstration of successful completion of the learning plan.

4. Learning Evaluation

- *Core elements*: determination as to whether or not learning needs were addressed, evaluation of progress in meeting goals established in the learning plan, and providing direction for the next learning cycle.

Implementation of the CPD model by participating boards is a shared responsibility of the Bureau of Health Professions, which has jurisdiction over board activities, and each of the boards.

- Responsibilities of the Bureau of Health Professions include:
  - Develop a standard framework for Administrative Rules
  - Develop general requirements for portfolio documentation
  - Design portfolio templates
  - Develop roll-out plan and training materials
- Responsibilities of the board include:
  - Decisions regarding essential elements
  - Modifications to standard Administrative Rules
  - Feedback on portfolio requirements and documentation templates
  - Educating licensees on new requirements

The model also includes a plan for verifying participation. The Bureau of Health Professions will continue to utilize a random audit process to evaluate compliance with portfolio requirements.

Licensees will be required to submit the following documentation:

- Affidavit attesting to completion of the learning assessment
- Completed learning plan
- Learning activities log
- Learning evaluation completed at the end of the licensure cycle.